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The Experiences of Black Men Living with Hypertension in Ontario, Canada: A Critical Narrative Study

Rob Haile, *The University of Western Ontario*

Supervisor: Dr. Lilian Magalhães, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Health and Rehabilitation Sciences

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THE EXPERIENCES OF BLACK MEN LIVING WITH HYPERTENSION IN
ONTARIO, CANADA: A CRITICAL NARRATIVE STUDY

(Thesis format: Monograph)

by

Rob Haile

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science

The School of Graduate and Postdoctoral Studies
Western University
London, Ontario, Canada

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Abstract

To date, most Black hypertension literature centers on the risk factors predictive of hypertension, and the treatment of this condition within this population. The purpose of this critical narrative inquiry is to better understand how Black men make sense of their hypertension diagnosis, and how they negotiate this condition into their everyday lives. Eight individual in-depth interviews were utilized to elicit stories from four Black men living in Ontario, Canada. Additionally, a critical stance was used in this study to illuminate how racism and power dynamics embedded within social, historical, and political contexts affected participants' experiences of living with hypertension. Individual narratives for each of the men were created, while a cross narrative was constructed to tie-in common themes. In all, this study revealed how racism and a range of factors affected participants' hypertension experiences, and challenged commonly held perceptions regarding the categorization of Black individuals into one uniform population.

Keywords

Black men, Ontario, Canada, hypertension, narrative inquiry, qualitative, critical race theory

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Chapter One: Introduction and Literature Review

Introduction

High blood pressure, commonly known as hypertension, is the greatest risk factor contributing to mortality (13%) worldwide. It is estimated that hypertension contributes to roughly 51% of strokes and 45% of heart disease deaths globally (World Health Organization [WHO], 2009). Findings from the 2009-2011 Canadian Health Measures Survey (CHMS) indicate that nearly one-quarter (22%) of adults aged 20-79 have high blood pressure (Systolic Blood Pressure [SBP] ≥ 140 mm Hg or Diastolic Blood Pressure [DBP] ≥ 90 mm Hg), and a staggering 17% of Canadians are unaware of having this condition (Statistics Canada, 2012a).

Hypertension has typically been acknowledged as a condition associated with old age; however, disparities in its prevalence have also been shown in certain ethnic populations (Leenen et al., 2008; Wilkins et al., 2010). For many years, increased rates of hypertension have been found in Black populations in the United States and the United Kingdom (Detection, 1977; Hull, Dreyer, Badrick, Chesser, & Yaqoob, 2011; Lennard & Glock, 1957). Yet, these ethnic disparities have only recently been studied in Canada. In their article *Results of the Ontario Survey on the Prevalence and Control of Hypertension*, Leenen et al. (2008) determined that Black individuals have the highest prevalence (31.5%) of hypertension amongst population groups in Ontario, Canada, and are three times more likely than Whites to have high blood pressure. Studies have shown that once diagnosed, Black populations residing in North America and Europe struggle with controlling their hypertension (SBP < 140 mm Hg and DBP < 90 mm Hg) (Hull, Dreyer, Badrick, Chesser, & Yaqoob, 2011; Redmon, Baer, & Hicks, 2011). The majority

of the Black hypertension literature employs biomedical perspectives and has shown that a disparity in prevalence, treatment, and the ability to control hypertension exists for this population. However, in spite of this, limited research exists concerning the first-hand experiences that these individuals have while living with this condition. This gap in the literature, thus, fails to show how other factors outside of traditionally held medical views could potentially impact how this population experiences high blood pressure.

The purpose of this qualitative study is to explore the ways in which Black men in Ontario, Canada, experience and negotiate hypertension in their daily lives. Men were chosen as the sole focus for this research, because according to Macdonald, Chilibeck, Affleck, and Cadell (2010), and Polit and Beck (2008), men in general are underrepresented in qualitative health research. Additionally, as a critical narrative inquiry, this study aims to provide Black men with a voice to illuminate how racism, along with power dynamics embedded within social, historical, and political contexts can affect their respective hypertension experiences. In doing so, it is hoped that this study can provide health professionals, researchers, and educators alike with a better understanding of how this condition is not only being perceived and managed by individuals within this particular population, but also how other factors outside of traditionally held medical notions of hypertension can affect certain Black men's hypertension experiences.

Thesis Layout

In this chapter I present an overview of previous research relating to high blood pressure in Black populations. I review factors that have been linked to the disparities in diagnoses and control rates amongst this group of people, and point to a significant gap in

the literature concerning the experiences of Black men with this particular condition. In Chapter Two, the methodology, methods and ethical considerations for this research study are presented. The results in the form of individual participant narratives are discussed in Chapter Three, while cross-narrative themes are explored in Chapter Four. In Chapter Five, I place the findings of this study in relation to previous research by attending to similarities and differences, and addressing how the findings add to the current body of literature surrounding Black hypertension experiences. Additionally, future directions, limitations and methodological considerations are also provided.

Literature Review

The purpose of this review is to provide a summary of literature relating to hypertension and its effects on Black populations. In doing so, I examine previous research highlighting various risk factors for high blood pressure, and present evidence to suggest that disparities concerning diagnoses, and subsequent control/treatment rates exist amongst this group of people in comparison to other minority or ethnic populations. Furthermore, literature concerning treatment non-compliance and adherence are compared, while perceptions of high blood pressure, Black health care experiences, and notions of masculinity are all explored in the latter half of this chapter. Lastly, the research goals and objectives are presented.

Factors Potentially Leading to Hypertension

Traditionally cited risk factors for hypertension in general include: a) obesity; b) salt-rich diets; c) high levels of alcohol consumption; and d) physical inactivity (WHO, 2009). However, these general risk factors, which focus on individual behaviours and lifestyle *choices*, do not sufficiently explain reasons for the increased prevalence of

hypertension in Black populations specifically (Williams, 1992). In recent years scholars have offered other suggestions relating to factors leading to hypertension amongst Black populations; however, these theories have yet to be completely understood. Below, some of these other factors are discussed and organized in the following subheadings: a) the slavery hypertension hypothesis; b) genetics; c) racism; d) socioeconomic status; and e) hypertension control.

The Slavery Hypertension Hypothesis

The Slavery Hypertension Hypothesis suggests that the increased prevalence of hypertension in Black populations is caused by genetic changes that may have occurred as result of the Atlantic slave trade. It is argued that survivors from the Atlantic voyage to the Americas during slavery required enhanced sodium conservation mechanisms to endure salt-depletive diseases, such as diarrhea and vomiting. Subsequently, the drastic changes from Africa's salt-poor environment to America's sodium-rich surroundings is said to have increased the slaves' and their descendants' susceptibility to hypertension (Kaufman & Hall, 2003; Wilson & Grim, 1991). While this hypothesis is difficult to confirm or refute, researchers have been vocal about its shortcomings. Nesbitt (2005), for example, cites issues with the methods used for testing salt sensitivity, and the unlikelihood that enhanced salt retention mechanisms could still be present in contemporary populations because of the time that has lapsed since the abolishment of the slave trade. In spite of this, evidence does suggest a genetic underpinning to hypertension may exist (Levy et al., 2000).

Genetics

Genome-wide association studies (GWAS), research focusing on whether genetic variants are related to certain traits in individuals, have been utilized to evaluate biological links to hypertension. For instance, GWAS have been conducted on European populations wherein findings have indicated select genetic variants were associated with high blood pressure (Levy et al., 2009; Newton-Cheh et al., 2009). Researchers have also utilized GWAS to ascertain if certain genetic variants relating to hypertension are more common in Black populations. Fox et al. (2011) conducted a study measuring SBP and DBP utilizing GWAS and candidate gene associations on over 8,500 African American samples in the United States. Their results indicated two loci, one SBP and one DBP, associated with hypertension in their sample of African Americans. However, the researchers failed to replicate their findings in separate African ancestry cohorts. More recently, Franceschini et al. (2013) performed a meta-analysis of 19 GWAS that included nearly 30,000 samples from African-Ancestry participants in the United States. Findings from their study indicated four novel gene variations associated with high blood pressure in African-Ancestry populations. Though studies of this nature reveal the potential for genetic susceptibility to high blood pressure, additional risk factors beyond these biomedical markers, such as the environment in which people live, have also been recognized as possible factors contributing to hypertension (Lang, Lepage, Schieber, Lamy, & Kelly-Irving, 2012). The social determinants of health play an integral role in the lives of Canadians, wherein visible minorities, in particular, are said to be more at risk due to the nature of the “adverse living conditions that threaten [...] [this population’s] over health and well-being” (Mikkonen & Raphael, 2010, p. 47).

Racism

In spite of Canada's celebration of cultural diversity, encountering racism is still an unfortunate reality for visible minority populations. It can be expressed and manifested in various ways (i.e., interpersonal, institutional, internalized), and while research demonstrating a link between psychosocial stressors and hypertension, cardiovascular disease, coronary heart disease and other health conditions has been well documented, evidence linking racism-related stress to hypertension is still growing (Carrol, Ring, Hunt, Ford, & Macintyre, 2003; Dimsdale, 2008; Mikkonen & Raphael, 2010; Spruill, 2010; Yusuf et al., 2004). In recent years, investigators have examined if relationships exist between the different forms of racism and certain health conditions such as hypertension. For instance, Brondolo, Love, Pencille, Schoenthaler, and Ogedegbe (2011), conducted an empirical literature review outlining the relationships between the different variations of racism and hypertension. Specifically, literature was sought by Brondolo et al., (2011) which investigated interpersonal, internalized and institutionalized forms of racism and its relationships with hypertension diagnoses, ambulatory blood pressure, and hypertension risk factors. Their review found considerable evidence linking interpersonal racism with higher ambulatory blood pressure, and mixed evidence linking institutional racism (using a racial residential segregation index) to ambulatory blood pressure or hypertension prevalence. Lastly, though Brondolo et al., (2011) concluded empirical evidence failed to link internalized racism to increased blood pressure, it is important to note that the authors found very little literature concerning internalized racism that matched their inclusion criteria. As a

result, additional studies need to be implemented before making further conclusions regarding whether or not internalized racism is associated with hypertension.

Hicken, Lee, Morenoff, House, and Williams (2014) investigated whether anticipatory racism-related stress (vigilance) was a potential explanatory factor for disparities in hypertension prevalence amongst populations belonging to different ethnicities. Their study used data from the Chicago Community Adult Health Study and included, amongst other measures, survey responses relating to how participants prepared for racial discrimination. After analyzing results from over 3000 Black, Hispanic, and White adults, Hicken et al., (2014) found that Black respondents had a positive and significant relationship between vigilance and hypertension, and were more likely to report racism-related anticipatory behaviours (i.e., preparing for insults) in comparison to other minority or ethnic groups. The researchers noted that a positive correlation between vigilance and hypertension disparities amongst ethnicities existed. For instance, when vigilance was low, the disparities amongst the populations were low. However, as vigilance increased, hypertension disparities amongst the different ethnicities increased as well. Their results showed, Blacks had a 4% increase in odds of having hypertension with every unit of increase in vigilance. Though this correlation does not imply causation, it does, however, point to the need for future studies to be carried out to investigate this relationship even further.

Dion and Kawakami (1996), and Veenstra (2012) respectively, have demonstrated that Black populations have higher levels of perceived group and personal discrimination. Findings indicating a correlation between discrimination and hypertension, however, have been mixed. In a systematic review conducted in the United States by Cuffee,

Hargraves, and Allison (2012), the researchers found an association between reported racial discrimination and hypertension among African Americans. Yet, in a telephone survey sample collected from individuals in Toronto and Vancouver, Canada, Veenstra (2012) demonstrated that despite Black Canadians being more likely to report discrimination and hypertension, discriminatory experiences were not found to be potential explanatory factors for the heightened risk of hypertension found in this population. Veenstra's (2012) reasoning for this outcome was that the data collected "may [have] reflect[ed] a lack of attention [...] to moderating factors that influence how a person deals with or reacts to perceived discrimination" (p. 9). Therefore, differences may exist amongst individuals who use different coping strategies to counteract discriminatory/racist events (James, 1994; Veenstra, 2012).

This notion concerning how individuals cope with hypertension relates to the John Henryism hypothesis. This theory states that certain African American individuals belonging to low Socioeconomic Status groups (SES), and who are regularly exposed to stressors (i.e., racism, finances), can potentially use significant amounts of daily energy to manage these particular psychosocial strains. As a result, it is hypothesized that individuals belonging to this group (high John Henry scorers) are more susceptible to hypertension because of the "high-effort coping" mechanisms they display to counteract their daily stressors (James, 1994, p.168). Studies concentrating on this phenomenon have shown that sex differences may in fact exist when it comes to associating John Henryism scores to hypertension. For instance, Dressler, Bindon, and Neggers (1998) conducted a survey in the United States with 600 African Americans aged 25 to 64, and found that men who scored highly on the John Henryism scale were more likely to either

have high blood pressure, or be at risk for having this condition. In comparison, findings for women showed the opposite effects, wherein high scores of John Henryism were related to lower risks and prevalence's for high blood pressure.

Recently, in a study conducted in the United States by Subramanyan et al., (2013) the researchers found that income mediated a relationship between African Americans and hypertension in their investigation. It was concluded that men with lower income and high scores on the John Henryism scale were associated with having higher rates of hypertension. In contrast, however, women with lower income and with lower scores on the John Henryism scale were shown to have higher rates of hypertension. The studies carried out by Dressler et al., (1998) and Subramanyan et al., (2013) indicate the complex relationships that exist when measuring John Henryism and hypertension, and suggest that further research be conducted to understand the underlying dynamics between this phenomenon, SES, and blood pressure.

Socioeconomic Status

Although Veenstra (2012) was unable to fully demonstrate a relationship between perceived discrimination and hypertension amongst Black Canadians, SES was identified as a possible explanatory factor for the heightened risk of hypertension found in this population. SES is generally characterized as the position of individuals or households based on income, educational attainment, and occupational standing (Bradley & Corwyn, 2002; Hauser & Warren, 1997). In their respective studies, Leigh and Du (2012) and Brummet et al., (2011) demonstrated that income was inversely related to systolic blood pressure. This correlation is particularly significant for Canadians, because despite Black populations' equal likelihood of holding a university education with the Canadian-born

population, their average employment income is much lower than the Canadian-born. In the year 2000, the average income for Canadian-born Blacks and foreign-born Blacks, aged 25 to 54, was \$29,700, and \$28,700 respectively. In contrast, Canadian-born individuals belonging to the same age bracket had an average income of \$37,200 (Milan & Tran, 2004). In Ontario specifically, the average household income for Blacks in 2010 was \$55,000, while in comparison Whites had an average household income of \$79,000 (Chiu, Austin, Manuel, & Vu, 2010). These findings indicate that Black Canadians are socioeconomically disadvantaged; thus, potentially placing them at a greater risk for certain health conditions such as hypertension.

Hypertension Control

All population groups included, Canada has higher overall control (SBP < 140 mm Hg and DBP < 90 mm Hg) rates amongst hypertensive individuals in comparison to the United States and the United Kingdom (Egan, Zhao, & Axon, 2010; Falaschetti, Chaudhury, Mindell, & Poulter, 2009; Gee et al., 2012). Still, roughly 36% of hypertensive Canadians continue to have uncontrolled hypertension (Statistics Canada, 2012a). When left in this state, high blood pressure can increase the risk of stroke, coronary heart disease, and heart and kidney failure (He & Whelton, 1999; Lewington, Clarke, Oizlibash, Peto, & Collins, 2002). Black populations, specifically, continue to be disadvantaged when it comes to their risk for developing a stroke. Howard and colleagues (2013) conducted a longitudinal cohort study in the United States spanning four years with over 27,000 African American and White participants, and concluded that for every 10 mmHg difference in blood pressure, African Americans (24%) demonstrated three times more risk for developing a stroke in comparison to their White (8%) counterparts.

Similar results from the United States were found in studies conducted by Bibbins-Domingo et al. (2009) and Okin, Sverre, Kjeldsen, Dahlof, and Devereux (2011), whereby hypertensive Blacks were found to be at a greater risk to develop heart failure than hypertensive non-Blacks.

Published data regarding hypertension amongst ethnic populations in Canada is limited. Chiu, Austin, Manuel, and Tu (2010) pooled data from a variety of statistical sources, and highlighted that Black people residing in Ontario, Canada had the highest prevalence of hypertension in comparison to other ethnic populations. Similarly, Leenen et al., (2008) randomly surveyed Ontario households and discovered that Blacks displayed the highest prevalence of hypertension (49.8%) amongst all ethnic groups. The researchers also found that despite Black populations' having the highest percentage of antihypertensive medication rates (90%), this population still demonstrated the lowest percentage of hypertension control (56%) amongst all ethnic groups. While this latter statistic was not found to be statistically significant, it is still interesting to note considering the shortage of research chronicling hypertension prevalence and control amongst the different ethnic groups residing in Canada. Yet given this shortage of information, the Canadian literature is not unanimous in showing that Blacks are at a disadvantage when it comes to hypertension prevalence. For example, Lebrun and LaVeist (2013) collected nation-wide estimates from the Canadian Community Health Survey (2003-2008), and found that Black Canadians had lower odds of obtaining hypertension than White Canadians. However, after further analysis and adjusting for confounding variables, no statistical significant differences were found. Additionally, since their investigation was limited to only Canadian-born Blacks, these findings are

greatly limited in scope, as their conclusions fail to extend to a great proportion of the Blacks living in Canada.

Black populations, therefore, have clearly been found to be vulnerable to hypertension, yet limited research exists on their experiences living with this condition. To date, Black hypertension literature is mainly based out of the United States. It is important to distinguish that the population dynamics of Blacks living in Canada are very different from those in America. For instance, the cultural backgrounds of these populations are different: whereas the United States' Black population is comprised mainly of African American's (93%), over half of the Blacks living in Canada are foreign-born (55%). Within this group, 48% are from Africa, while 47% are from countries in the Caribbean's, and Central and South America (Milan & Tran, 2004; Rastogi, Johnson, Hoeffel, & Drewery Jr, 2011). As a result, issues relating to hypertension amongst Canadian Blacks have remained unclear, because this dynamic population possesses different cultures, traditions, lifestyles, and languages that could differentially affect their hypertension experiences. Additionally, it is important to note that differences between American (private) and Canadian (public) health care systems exist, and that these differences could potentially play a significant role in the ways in which Black individuals living on either side of the border manage their blood pressure on a daily basis.

Hypertension Treatments

According to The 2014 Canadian Hypertension Education Program guidelines, the treatment recommendations for hypertensive individuals include the following: a) physical exercise; b) weight reduction; c) reduction in alcohol consumption; d) healthy

diet (Dietary Approaches to Stop Hypertension [DASH], reduce sodium intake, increase potassium, calcium, and magnesium intake); e) stress management; and f) antihypertensive drug therapy (Dasgupta et al., 2014). Health advice regarding dietary changes and healthy behaviours (i.e. reducing stress, limiting alcohol consumption, engaging in physical activity) play an integral role in controlling blood pressure. Still, research has indicated that hypertensive individuals may not receive such important information. For instance, roughly 30%-55% of Canadian hypertensive individuals that took part in the “2009 Survey of Living with Chronic Disease in Canada” did not recall receiving advice about the benefits of maintaining various health behaviours (Walker et al., 2011). This disregard for recommending rather acute life changes could be seen as troubling for Blacks, because the DASH diet (containing high potassium, calcium, magnesium, and low fat foods) for example, has been shown to be particularly noteworthy in reducing hypertension in certain Black populations in the United States (Appel et al., 1997; Sacks et al., 2001).

Pharmacological treatments can play an integral role when controlling hypertension and reducing the risk of cardiovascular events, yet studies have shown that receiving medication may not translate to hypertension control in Black populations specifically (Corrao et al., 2011; Leenen et al., 2008; Munger, Van Tassell, & LaFleur, 2007). For instance, Hertz, Unger, Cornell and Saunders (2005) conducted a study in the United States and demonstrated that even though the percentage of Blacks receiving antihypertensive treatments was higher than Whites, they still yielded lower blood pressure control rates in comparison to their counterparts. In Canada, this relationship was also found in research conducted by Leenan et al., (2008). Therefore, this seems to

suggest that medication compliance alone may not be indicative of blood pressure control for this particular population, and implies that other factors outside of traditional biomedical treatments can potentially play a role in managing this condition.

Treatment Non-Compliance

According to Haynes, Sackett, and Taylor (1979) compliance refers to “the extent to which a person’s behaviour...coincides with medical advice” (pp. 1-2). For some, this definition carries a negative connotation. As discussed by Vermeire, Hearnshaw, Royen and Denekens, (2001) the term compliance assumes a unilateral and paternalistic doctor-patient relationship, where “compliant patients ‘submit’ to the prescriptions of doctors and take their medicine, or follow their advice” (p. 332). In this context, the personal qualities of patients are then attributed to non-compliance, when in fact they are situated in a rather passive role in relation to their care provider (Delamater, 2006). As a result, it is argued that unilateral biomedical advice restricts patient autonomy and the ability for individuals to partake in shared decision-making with their health care professional (Sandman, Granger, Ekman, & Munthe, 2012).

In the United States, poor medication compliance amongst Black populations has been well documented. Shaya et al. (2009), for example, measured compliance rates (Medical Possession Ratio [MPR] of 80% or higher) from retrospective Medicaid medical and pharmacy claims data for a two-year period. Their results showed that African Americans had 16% lower compliance rates than both Whites and other ethnic groups. Additional studies by Holmes et al. (2012), Dickson and Plauschinat (2008), and Poon, Lal, Ford, and Braun (2009) have all indicated poorer medication compliance amongst Blacks when compared to other populations. In Canada, research on treatment

compliance rates amongst various ethnicities is limited. Therefore, it is not well known if disparities in medication noncompliance persist to the degree observed in the United States.

To date, Black Canadians' experiences regarding hypertensive treatment and daily living has yet to be documented in published literature. Elsewhere, qualitative research has been an important means for understanding the underlying reasons behind medication non-compliance in hypertensive individuals. For example, Gascon, Sanchez-Ortuno, Llor, Skidmore, and Saturno (2004) utilized focus groups to conduct a study in Spain with 44 hypertensive individuals. Following analysis, their findings revealed the following three themes for understanding medication non-compliance: (a) fears about long-term medication use (i.e. repercussions); (b) beliefs that the absence of symptoms meant that hypertension was controlled; and (c) inadequacy of clinical encounters with physicians. This study provides insightful information regarding factors associated with medication compliance. However, it is important to consider that medication non-compliance, according to Gascon et al. (2004), tends to focus solely on the patient, leaving out broader factors such as physician communication strategies, socioeconomic status, and financial means to afford such medications.

Treatment Adherence

According to Berger (2004) adherence refers to the "extent to which health behavior reflects a health plan constructed and agreed to by the patient as a partner with a clinician in health care decision making" (as cited in Gould & Mitty, 2010, p. 290). This form of terminology acknowledging the bilateral relationship between patient and physician has seen its fair share of attention in the literature. A number of studies have

indicated that enhanced patient-physician collaboration is positively correlated to better patient treatment adherence (Arbuthnott & Sharpe, 2009; Bennett, Fuertes, Keitel, & Phillips, 2011; Fuertes et al., 2007). Findings from a qualitative study conducted by Ogedegbe, Harrison, Robins, Mancuso, and Allegeante (2004) in the United States showed that factors affecting medication adherence amongst African Americans, specifically, included the following four broad categories: a) patient-specific (i.e. forgetfulness, beliefs, attitudes); b) medication factors (i.e. side effects, treatment duration, quality of pills); c) disease-specific (i.e. symptoms); and d) logistics (i.e. access, inconvenience). Ogedegbe et al., (2004) specifically highlighted Black individuals' common beliefs regarding medication adherence and non-adherence. Their reasoning for non-adherence included feelings that drugs could cause impotence, and that the absence of symptoms meant that medication was not necessary. The facilitators for medication adherence included: a) frequent reminders for medications; b) knowledge of hypertension and medication use; c) the quality and quantity of doctor-patient interaction and/or communication; d) routine activities that aid medication uptake; and e) social support networks that encouraged medication adherence. Though Ogedegbe and colleagues' study (2004) includes non-patient factors regarding barriers and facilitators to medication adherence, broader issues to medication adherence, such as the ways in which health care practices may be imbued with discrimination, were not addressed.

Perceptions of Hypertension / Illness Beliefs

Prior research has shown a distinction between conventional medical understandings of hypertension and the lay illness beliefs about this condition held by African American populations in the United States (Wilson et al., 2002). According to

Pickett, Allen, Franklin and Peters (2014) one's beliefs regarding his/her condition can be shaped by knowledge attained from a variety of sources such as: a) their socio-cultural environment (i.e., friends, media), b) respected figureheads (i.e., health professionals), and c) their individual experiences with said illness(es). Thus, in terms of lay beliefs regarding the causes of high blood pressure, it has been widely reported that hypertensive and non-hypertensive African Americans tend to attribute high blood pressure to general life stresses caused by racism, interpersonal issues, work, finances, etc., (Bokhour et al., 2012; Higginbottom, 2006; Lukoschek, 2003; Pickett, Allen, Franklin & Peters, 2014; Wilson et al., 2002). Furthermore, even though the literature has deemed hypertension as an essentially symptom-less condition, multiple studies focusing on African American populations found that participants spoke of symptoms such as dizziness and headaches being associated with their hypertension (Lukoschek, 2003; Rose, Kim, Dennison, & Hill, 2000; WHO, 2013; Wilson et al., 2002).

A qualitative study conducted by Bokhour et al., (2012) that included participants of various ethnicities (African Americans, Latino, and Whites) illuminated the dangers associated with hypertensive individuals' lay beliefs about their condition. The researchers declared that participants either experienced symptoms, or failed to experience any symptoms relating to their blood pressure. In light of this, it was reported that individuals belonging to the latter group felt as though they did not need to adhere to their treatment recommendations, because of the lack of symptoms they experienced. Similarly, Rose et al., (2000) found that nearly half of the African American men in their study modified their medication intake based on how they felt the medication worked. These studies clearly highlight that different hypertension perspectives exist, and that lay

experiences of this condition may need further consideration from researchers and practitioners alike to generate the best possible prevention and treatment plans for individuals belonging to this specific population.

Black Populations' Health Care Experiences

Healthcare experiences can have a large impact on individuals' utilization of primary care services. Black populations' healthcare experiences have been well documented using quantitative studies in the United States. For instance, results from research conducted by Armstrong et al. (2013) and Jacobs et al. (2011) found that African Americans were more likely to report being discriminated against both in and out of their respective healthcare settings. In turn, these experiences of discrimination were said to have been strongly associated with this particular populations' distrust of the healthcare system. Regarding patient-physician experiences, specifically, studies have indicated that African-American patients have a lower trust in their doctors in comparison to White patients (Halbert, Armstrong, Gandy, & Shaker, 2006; Martin, Roter, Beach, Carson, & Cooper, 2013). Amongst other things, this is particularly noteworthy since added trust in physicians has been shown to improve the adoption of certain lifestyle behaviours (i.e., dietary changes, performing exercise) amongst hypertensive patients (Jones, Carson, Bleich, & Cooper, 2012).

The quality of the patient-physician relationship has also been documented. In terms of length in clinical visits, Cené, Roter, Carson, Miller III, and Cooper (2012) found that Black individuals with controlled and uncontrolled high blood pressure experienced shorter appointments, and less communication with physicians than White controlled hypertensive individuals. Furthermore, other studies have revealed that

physicians tend to exhibit less patient-centered communication with Black patients (Martin et al., 2013; Johnson, Roter, Rowe, & Cooper, 2004)

In Canada, however, research is limited regarding the healthcare experiences of Black individuals solely. Instead, studies have focused their attention on capturing these experiences from a range of different ethnicities. One such study conducted by Pollock, Newbold, Lafreniere, and Edge (2012) in Ontario, Canada explored a diverse group of immigrants and refugees, including African and Caribbean participants, and their experiences facing discrimination in the healthcare context. Their findings demonstrated that 17 out of the 26 participants experienced either subtle or overt discrimination by health care providers and/or support staff. In particular, several participants expressed instances of cultural stereotyping and cultural insensitivity when relaying their experiences with healthcare providers in Ontario, Canada. These findings not only bring to light the healthcare experiences of visible minorities, but also suggest a need to further explore the experiences of the ever-growing ethnic and migrant populations in Canada. They also raise questions regarding how such experiences influence the ways in which Blacks perceive medication and other lifestyle recommendations. While statistics on various minority groups are collected in the Canadian census, the use of the term ‘visible minority’ (non-Aboriginal and non-white individuals) to report national census data by Statistics Canada can impede understandings of health patterns that may lie within various ethnic communities (Rodney & Copeland, 2009). For minority groups that have historically endured oppression, such as Black populations, these knowledge gaps need to be addressed to adequately understand and reduce any inequalities that may persist in the

Canadian health care system (Pollock, Newbold, Lafreniere, & Edge, 2012; Rodney & Copeland, 2009; Statistics Canada 2012b).

Black Masculinity

It has been theorized that disparities in health between men and women can in part be due to men's unwillingness to perform health-promoting behaviours for fear of projecting notions of femininity (Courtenay, 2000). Researchers, therefore, have suggested that societal constructions of manhood have the ability to dictate the ways in which men often risk their health in hopes to strive towards the ideal form of masculinity (Evans, Frank, Oliffe, and Gregory, 2011). According to Evans et al., (2011) modern Western hegemonic masculinity favours notions associated with White, middle-class, heterosexual men that possess traits such as strength and emotional restraint, amongst other characteristics. For those belonging to different subcultures (i.e., Black men), however, living up to these ideals can prove difficult. Thus, as way to compensate for their inability to live up to traditional Western hegemonic masculine roles, scholars such as Courtenay (2000) suggest that minority men engage in risky health behaviours to validate themselves as men.

Very little published research exists concerning health and masculinity amongst Black men in Canada. Evans et al., (2005) conducted a qualitative study that explored cultured and gendered experiences of cancer amongst African Nova Scotians. In their findings the authors reported that male participants in their study avoided prostate screening tests, because it interfered with common notions of masculinity (i.e., sexual virility) afforded to African Nova Scotians. In addition to this, men equated masculinity with strong family ties, and characteristics such as health, respect, and physical and

emotional strength. Interestingly, though coping with racism was seen as a form of strength, men in their study declared this type of prejudice ultimately “undermined [...] [their] sense of themselves as [Black] men” (p. 265). While these findings seem to suggest that Black men’s affirmation for masculine roles puts them at a greater risk to perform unhealthy behaviours and/or practices, other research in the United States has noted otherwise.

In a study conducted by Hammond, Matthews, Mohottige, Agyemang, and Corbie-Smith (2010), the authors explored whether forms of masculinity (i.e., self-reliance and salience of traditional masculine norms) found amongst African American men in the United States were associated with preventative health care service delays. The investigators found that African American men with higher ratings of masculinity experienced decreased delays in cholesterol and blood pressure screenings. Similarly, results from a study completed by Wade (2009) in the United States demonstrated that African Americans that had higher scores of masculinity (i.e., self-reliance and aggression) held qualities or participated in behaviours that favoured personal wellness.

Thus, contrary to the Canadian findings outlined by Evans et al., (2005), the results from the studies conducted in the United States by Hammond et al., (2010) and Wade (2009) suggest that certain Black male populations that maintain notions of masculine norms present with health-related attitudes and behaviours that are conducive to their health. Though the three studies all used different measures to determine Black men’s risk for poor health, it is important to note that differences between African Nova Scotian and African American men may exist when it comes to associating masculinity to

health behaviours. Thus, this highlights the need for more research on how masculine norms can influence the health of Canada's diverse population of Black men.

Research Goals and Objectives

Presently, research is lacking concerning the experiences that Black men endure while living with hypertension in Canada. The bulk of the literature surrounding hypertension in Black populations predominantly centers on the risk factors and the management and treatment of hypertension. As such, studies need to be conducted to grasp how this condition is being perceived and managed within this population. Studies conducted by Macdonald, Chilibeck, Affleck, and Cadell (2010), and Polit and Beck (2008), have found that men have been underrepresented in qualitative health research. In an attempt to “give a voice to the voiceless” this study will be conducted on Black men (Atkinson & Silverman, 1997, p. 311). Thus, the purpose of this qualitative study is to understand how Black men in Ontario, Canada, experience and negotiate hypertension in their daily lives. By situating Black men's health care experiences and ongoing negotiations of high blood pressure within aspects of the social, political, and historical contexts in which their lives are lived, it is hoped that this study reveals and critiques the underlying power structures affecting their hypertension experiences (Carpenter & Suto, 2008, p.24). As such, this research intends to inform the existing body of literature concerning Black hypertension experiences, and is hoped to provide insight to care providers, educators, and researchers who work with this population.

Chapter Two: Study Design and Methods

In this chapter I state the research questions for this study, and present the methodology and methods used to explore these particular questions. Specifically, I discuss my philosophical position as it relates to this research, and present an overview of narrative inquiry. In the latter half of this chapter, I outline the recruitment process, and describe the procedures used for data collection and analysis. Lastly, I provide reflexive thoughts concerning my role as the researcher, while also addressing the quality criteria and ethical considerations that informed this study.

Research Questions

Given that research has consistently shown that Black individuals are at an increased risk for acquiring hypertension, and once diagnosed, Black individuals have been shown to have lower chances of controlling their blood pressure, attempts to investigate how these individuals make sense of their condition is necessary. To address the gap in the literature concerning Black Canadian men and their experiences living with hypertension, I conducted eight in-depth interviews in total with four Black hypertensive men (two interviews per participant). Their ages ranged from 54 to 78 years old, and all participants were residents of Ontario, Canada.

While utilizing narrative inquiry to guide this investigation, I explored how four Black men constructed stories relating to how they made sense of, and lived with, hypertension on a day-to-day basis. By examining their stories and situating their narratives within a critical framework, my aim was to provide Black men with a voice to illuminate how racism, along with power dynamics embedded within social, historical, and political contexts may have affected how they constructed their narratives, and their

experiences of living with hypertension. For the purpose of this study, racism is defined as “the belief in the inherent superiority of one race over all others and thereby the right to dominance,” as well as “a system of ignorance, exploitation, and power used to oppress African-Americans [...] and other people on the basis of ethnicity, culture, mannerisms, and color” (Lorde, 1992, p. 496; Marable, 1992, p. 5). By using these definitions, one realizes that those in power have the ability to perform these acts to those belonging to various minority and ethnic backgrounds (Solorzano, Daniel, Ceja, & Yosso, 2000). The research questions explored for this study were:

1. How do Black men in Ontario, Canada come to make sense of their hypertension diagnosis?
2. How do Black men in Ontario, Canada negotiate their hypertension diagnosis in their daily lives?
3. What experiences do hypertensive Black men in Ontario, Canada have while accessing health care for hypertension in Ontario, Canada?

Critical Theory

For this research, a critical theory approach to narrative inquiry was utilized. According to Guba and Lincoln (1994), this paradigm assumes a “historical realism” ontology, employs a “transactional and subjectivist” epistemology, and a “dialogic and dialectical” methodology (p. 110). As such, by adopting this ontology and epistemology, I not only commit to a reality that is mediated by power relations embedded within social, political and historical contexts, but also embrace that knowledge is “value mediated” and established through communications between the investigator and the investigated (Guba & Lincoln, 1994, p. 110; Ponteretto, 2005). In light of this positioning, I also

maintain that a goal of this research is to critique and reconstruct previously held understandings relative to this particular group of men and their hypertension experiences. This critical perspective, thus, facilitated the underlying processes (i.e., design, collection, and analysis) involved with conducting this study.

Critical Race Theory

Oftentimes, the terms “race” and “ethnicity” are used interchangeably in the literature. However, for this study I situate the term *race* as a socially constructed term used to classify, distinguish, and at times handicap those that have different phenotypic traits than the majority population (Ballard, 2002). Ethnicity, on the other hand, is defined as:

the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry, and physical features traditionally associated with race (Bhopal, 2004, p. 443).

Since the aim for this study was to explore how Black men in Ontario, Canada experienced hypertension, Critical Race Theory (CRT) was also utilized illuminate the “voice of people of colour:” a voice that has historically been shaped by forms of discrimination and oppression (Cole, 2009, p. 7; Parker & Lynn, 2002).

CRT emerged in the 1970s as a movement in American law whereby activists, scholars, and lawyers felt racial inequities regressed despite the initial advances of the civil rights movement (Delgado & Stefancic, 2001). During this time, visible minorities desired a scholarly outlet to discuss *race* from a theoretical standpoint that addressed the hegemonic structure of White America (Parker & Lynn, 2002). Most notably, this

movement was shaped by the under acknowledgement of *race* within the emerging Critical Legal Studies (CLS) field. Members of the CRT movement argued CLS scholars, whom sought to uncover the underpinnings of American law, critically failed to recognize the underlying role of racism embedded within American history and its legal system (Cole, 2009; Parker & Lynn, 2002). As a result, CRT emerged as a means to illuminate and transform the social hierarchies that existed amongst the different ethnicities in society (Delgado & Stefancic, 2001).

Over the course of time CRT has expanded into movements such as Asian American, Latino-Crit, and Queer-Crit studies (Delgado & Stefancic, 2001). Scholars from feminist legal studies have also used CRT principles to illuminate issues of power, *race*, and gender inherent within the field of law and other common discourses (Parker & Lynn, 2002). Most commonly, though, CRT has been utilized in education research to critique forms of racism and highlight the inequities that exist in the education system that has historically placed Blacks and other minorities at a disadvantage (DeCuir & Dixson, Ladson-Billings & Tate, 1995; Cole, 2009). In spite of the different movements using CRT, users of this academic discipline have in common the aim to shed light on the dominant forces that shape society.

Though scholars have differing opinions on CRT, its basic principle is that it aims to illuminate the voice of visible minorities (Cole, 2009). For this study, I chose to use additional principles of CRT that were illuminated by multiple authors. For instance Delgado and Stefancic, (2001) state that the basic tenets of CRT include: a) racism is ordinarily embedded within society; b) those in power, namely Whites, have little to gain by eradicating racism; and c) *race* is not objective, but is simply a product of social

constructions that society uses to bestow certain characteristics to certain populations (Delgado & Stefancic, 2001). According to Parker and Lynn (2002):

CRT has three main goals: (a) to present storytelling and narrative as valid approaches through which to examine race and racism in the law and society; (b) to argue for the eradication of racial subjugation while simultaneously recognizing that race is a social construct; and (c) to draw important relationships between race and other axes of domination (p. 10).

By utilizing aspects of Delgado and Stefancic (2001), and Parker and Lynn's (2002) principles of CRT, I explored how issues of power and racism existed within the context of Black men and their hypertension experiences. It is important to note that from this point of view, *race* is considered an "arbitrary system of visual classification" that is falsely used to distinguish and subsequently categorize human beings based on their physical characteristics (Fullilove, 1998, p. 1297). For the purpose of this research, the word *race* is utilized to coincide with the terminology found within specific literature. Thus, I use the term with italics to merely indicate that it is a social construction that fails to have any scientific merit when used solely to classify individuals based on their phenotypic traits.

Since this study involved examining how Black men made sense of their hypertension diagnosis and how they negotiated this diagnosis into their daily lives, it was important to situate their understandings of this condition, their ongoing negotiations, and their corresponding health care experiences within aspects of the social, political and historical contexts in which they lived their lives. For example, exploring if and how experiences of perceived discrimination in health care have influenced how they

understood and managed medication or the extent to which they trusted and acted upon medical advice. Also, by revealing and critiquing “the distribution of power and privilege” inherent within participants’ respective societies, it was hoped that this study could further illuminate the structures that implicitly shaped the lived hypertension experiences of these particular Black men living in Ontario, Canada (Carpenter & Suto, 2008, p.24). In doing so, I felt as though it was important to give a voice to those whom most notably were affected by this particular condition, so that it could provide end users an opportunity to make sense of this illness from an alternative viewpoint that may very well have stayed dormant if not for the inclusion of their perspectives.

Critical Narrative Inquiry

Critical narrative inquiry was implemented for this study to attend to the research questions and objectives highlighted above. This form of inquiry has an array of different methods and approaches that can be utilized to explore how individuals create meaning to their lives (Lieblich, Maschiach-Tuval, & Zilber, 1998). However, in spite of these differences investigators utilizing this form of inquiry commonly use stories as a means to examine human experiences (Pinnegar & Daynes, 2007).

Central to narrative inquiry is that stories not only enable individuals to create meaning to aspects of their lives, but also have a tendency to change over time, as tellers are shaped by their ongoing life experiences (Bruner, 1991; Clandinin, 2006; Duff & Bell, 2002; McAdams, 2008). As storytellers then illuminate their “inner reality to the outside world,” inquirers focus not on historical truths, but rather the meanings that narrators retrospectively dedicate to certain events and/or experiences (Bochner, 2007; Lieblich, Maschiach-Tuval, & Zilber, p.7; Polkinghorne, 1995). Given that stories are

oftentimes told in sporadic order, narrative inquirers also seek to understand how stories are constructed by analyzing the temporal and spatial unfolding of events within stories (Riessman & Quinney, 2005). Therefore, through the “construction and reconstruction of personal stories,” narrative inquirers have the ability to address the complexities that underlie human activities (Webster & Mertova, 2007, p.71).

Even though the terms “story” and “narrative” are often used interchangeably in the literature, it is important to clarify what either entails before advancing any further. For the purpose of this study, the term “story” refers to participants’ accounts of particular phenomenon’s, events, and/or experiences, while the term “narrative” alludes to the organization and co-construction of these individual stories into a greater whole (Connelly & Clandinin, 1990).

In all, I chose this method of inquiry to address gaps in the literature by enabling Black men in Ontario, Canada to voice their first-hand experiences of living with a condition that disproportionately affects this marginalized population. In doing so, it is hoped that the particular meanings that participants imbue to their hypertension can provide a Canadian perspective to how individuals belonging to this population come to make sense of hypertension.

Critical Race Theory and Narrative

Counter-storytelling is an integral aspect of CRT that aims to illuminate preconceived notions about *race* within society by providing visible minorities an opportunity to voice their own experiential knowledge to challenge the majoritarian views and systems that oftentimes places these individuals in an inferior social position (Ladson-Billings, 1998). From my perspective, it was important to hear stories from

those men most affected by hypertension to illuminate how being a visible minority might influence their daily negotiations of this condition. On the surface, I utilized elements of counter-storytelling in this study to simply offer participants an opportunity to voice their experiences of living with hypertension in Ontario, Canada. However, on a greater level, by engaging in counter-storytelling I was able to situate participants' experiences within the greater context of being Black within a Canadian society to expose the power structures inherent within their hypertension experiences. In accordance with Strauss and Corbin (1990), Delgado Bernal (1998), and Solorzano and Yosso (2002), counter-stories were created for this study through: a) the participants' stories; b) the existing literature concerning subject matters relevant to their stories; and c) from my own personal experiences.

Sampling

Sampling in qualitative research relies on adequately identifying the right number of suitable participants to best inform the phenomena being studied (Fossey, Harvey, McDermott, & Davidson, 2002). For qualitative researchers, purposeful sampling is ideal for selecting participants that can provide rich, in-depth information on the topic of inquiry (Patton, 1990).

With respect to the nature of narrative studies and the time it takes to obtain in-depth information, only a small number of participants (four to six) were required for this study (Carpenter & Suto, 2008; Wells, 2011). I sought help from gatekeepers within the community and local organizations to aid in recruiting individuals for this study. Once interested participants were identified, information was passed along to these individuals so that contact could be made with either investigator. Snowball sampling was also

utilized by asking recruited participants to identify individuals whom they: a) thought met the inclusion criteria; and b) thought were interested in participating in this study (Crosby, DiClemente, & Salazar, 2006). If individuals were identified as being interested in taking part in the study, the recruited participants were asked to pass on information about the study so that potential participants were able to initiate contact with either investigator. Additionally, posters and flyers were advertised at local businesses and community organizations to recruit participants (see Appendix A).

Inclusion and Exclusion Criteria

The inclusion criteria for this study consisted of self-reported Black hypertensive adult men over the age of 18 whom were fluent in reading and speaking English. Black individuals were defined as persons whom self-identify as being “Black” (Statistics Canada, 2012b). Though “Black” is oftentimes erroneously viewed as a singular ethnicity, an effort was made to recruit Black men from various ethnic and cultural backgrounds, so that similarities and differences of hypertension experiences could be illuminated. For this reason, during the recruitment phase I made sure to contact a variety of different community and ethnic organizations in an attempt to capture stories from a diverse group of men. Additionally, participants could either be foreign or Canadian-born, and a physician’s diagnosis of hypertension had to have been communicated in order to participate in this study. According to the Canadian Hypertension Education Program (CHEP) guidelines for diagnosing hypertension, a positive diagnosis can be made immediately or after a number of visits depending on the extent of an individual’s blood pressure and his/her medical history (see Appendix B).

Several authors have stated that men are not only exceedingly disadvantaged when it comes to health risks, but also are underrepresented in qualitative health research (Courtenay & Keeling, 2000; Macdonald et al., 2010; Polit & Beck 2008; Schofield, Connell, Walker, Wood and Butland, 2000). Thus, since the purpose of this investigation was to explore Black men's hypertension experiences, the exclusion criteria for this study also included women, as a gender-based approach was utilized to focus on this specific population.

Research Setting

This study took place in Ontario, Canada: the region that has the highest percentage of Black residents (3.9%) out of all provinces in Canada. In spite of this, the demographics of Black populations differ from one census metropolitan area to another (Statistics Canada, 2010a; Statistics Canada, 2010b). London, Ontario, for example, has a low visible minority population (16%), wherein Blacks comprise only roughly 2.2% of the overall population (Statistics Canada, 2013a). In contrast, Toronto, Ontario is comprised of an almost equal visible minority (49%) to majority population (51%) in which Blacks consist of 8.5% of the total population (Statistics Canada, 2013b). Therefore, the specific locale of participants' residencies were taken into consideration during analysis to draw further insights into contextual factors (i.e., access to culturally sensitive care) that could affect Black men's experiences with hypertension given their minority status (Dustmann, & Preston, 2001).

Once telephone contact was made with potential participants, I detailed all aspects of the research study and answered any questions individuals had regarding the study. During initial contact, I ensured potential participants met the inclusion criteria for this

study. The narrative interviews took place in comfortable settings as chosen by study participants. The interview locations were void of distractions, and included settings such as participants' residences and private rooms in community settings.

Data Collection Process

Data collection for this study consisted of two interviews that I conducted in-person. During the recruitment process, and subsequently prior to the start of each interview, participants were reminded of the voluntary nature of their contribution to this study. To ensure the accuracy of capturing the narratives, all interviews were audio recorded and field notes were used to document nonverbal forms of communication, and my reflexive thoughts throughout both interviews. Consent form each participant was obtained to audio record each session prior to the first interview.

The narrative interview was utilized to gather in-depth accounts of hypertension experiences from each participant. The information gathered from each participant was subsequently collected and analyzed into individual narratives. Then, themes across narratives were constructed to tie in storylines that were consistent across the participants' hypertension experiences (Mishler, 1991; Riessman, 2008).

By providing a platform for individuals to narrate their stories, the interviews presented participants with opportunities to highlight their lived experiences of negotiating hypertension in their daily lives (Nunkoosing, 2005). As acknowledged by Webster (1998), the questions for the interviews were constructed to encourage individual reflections and recollections of significant events (as cited in Webster & Mertova, 2007, p. 86). During the first interview, I asked two broad initial open-ended questions to begin the elicitation of the narrative, and used prompt questions in the event

that I needed to further stimulate conversation (see Appendix C). While the first interview transpired, I also generated questions pertaining to topics that were raised by following the same temporal sequence and language that participants utilized to convey their stories (Wengraf, 2001). Once the first interview was completed, I debriefed by making notes on ideas and memories that I thought could stimulate further discussion for the second interview.

Once the preliminary data was analyzed from the first interview, the second interview was scheduled at a date and time that best fit the participants' agenda's. Prior to the second interview, participants received a summary of the collection the stories they shared. This provided participants with a period of reflection, a means to expand on the initial findings, an opportunity to clarify any misinterpretations from the initial interview (Morrow, 2005). Thus, while the questions for the second interview were not decided upon until after the data from the first interview had been iteratively analyzed, the focus still remained on understanding the hypertension experiences of the Black men in this study. In turn, these questions were then utilized to stimulate further discussions on important themes that may/may not have been brought up in the first session (Wengraf, 2001). These particular themes were derived from topics brought up in the initial interviews, as well as information gathered from previous participants' interviews. In all, the first interviews ranged from approximately 30 to 55 minutes, while the second interviews were about 50 to 65 minutes long.

Data Analysis

Although the iterative nature of narrative inquiry entailed analysis to begin immediately after the initial interviews, a flexible design was utilized for this part of the

study since the process of analyzing data involved “reviewing, synthesizing, and interpreting” stories to make sense of participants’ experiences (Fossey, Harvey, McDermott, & Davidson, 2002, p. 728). On a greater level, a critical narrative analysis approach was utilized to make sense of how stories constructed at the personal level were connected to the greater contexts of participants’ lived experiences with hypertension (Souto-Manning, 2012; Wells, 2011). Specifically, I chose the holistic content approach to analyze stories from a larger contextual lens. In doing so, I examined participants’ stories as a whole, interpreted parts of their stories in relation to one another, and analyzed the specific contents of participants’ stories relating to their lived hypertension experiences (Lieblich, Tuval-Mashiach, & Zilber, 1998).

The first phase of data analysis involved creating a temporal line of events for each participant, wherein stories or parts of stories were extracted and documented under this particular timeline. Once the material was compiled, the data was examined using the holistic content approach to identify patterns and storylines that were embedded within the larger social, political, and historical contexts of participants’ lived hypertension experiences. To ensure that a systematic process was conducted, the findings for each of the participants were recorded and categorized on separate documents by their respective storylines. Further, a CRT lens was also applied during all stages of data analysis to highlight instances where participants’ ethnicity affected their lived experiences of hypertension in Canada.

According to Lieblich et al., (1998) the five steps involved in holistic content analysis include: a) continually reading the data until a pattern materializes; b) writing preliminary thoughts on findings and highlighting issues regarding the general pattern

that emerged in the first step; c) identifying specific themes within stories; d) continually reading the themes separately; and e) writing concluding thoughts on each theme. Since it was important to provide participants with a space to express their experiences, their words and stories were used to construct each of their respective narratives highlighted in the next chapter.

The second phase of analysis involved identifying common storylines found across the participants' narratives. This process of analysis again involved iteratively reading each of the narratives, while also utilizing the holistic content approach previously identified to develop a greater narrative that illustrated how these Black men experienced their hypertension on a daily basis. It is important to note that even though the aforementioned approaches to data analyses were outlined in a linear fashion, the actual process was flexible because of the ambiguous and dynamic nature in which findings often emerged during this study (Lieblich et al., 1998).

Insider Perspective

During a research investigation, insiders are oftentimes afforded an instinctive advantage in gaining entrance and acceptance within a particular population, because participants often feel as though they have an enhanced level of trust and experience more openness with researchers to whom they share a likeness (Dwyer & Buckle, 2009). I chose this research topic because despite the heightened prevalence of hypertension in this particular community, *my community*, at the time of this study only a few published articles existed chronicling Black health experiences in Canada. Therefore, I inherently became an insider for this study by conducting research on the very visible minority population to which I belong.

Reflexivity and Role of the Researcher

Reflexivity encompasses the investigator's "conscious self-awareness" whereby subjective thought processes are iteratively analyzed during the entire course of the research endeavor (Finlay, 2002, p. 532). While some researchers use reflexivity as a measure to maintain objectivity, I, however, situated myself deeply within this inquiry. My personal values played an integral role throughout this endeavour, as I conducted this study while maintaining both an insider (i.e., being Black) and outsider (i.e., non-hypertensive) perspective (Ponterotto, 2005).

While practicing as a pediatrician prior to conducting this research, I was startled by the troubles that minorities faced when receiving health care treatments. Under my care, these diverse individuals would oftentimes have difficulties affording the recommended therapy to alleviate their particular health issues. I often struggled with this, and it was ultimately part of the reason why I left the profession. I then found myself at a crossroads, wanting to explore issues meaningful for the people of my community. I always envisioned that I would conduct research on a topic or a population that hit close to 'home.' Whether my focus was on migrants, visible minorities, or simply anyone who struggled to fit into society, I wanted to work on an issue that related to those whom shared similar experiences as I did. Perhaps, it was a little selfish, but those were the parameters I set when finally deciding to return to school.

It took some time to decide on a subject matter too. The boundaries I set included such a broad range of topics that it felt overwhelming at times. Eventually, though, after reading numerous articles pertaining to hypertension in Black populations, and following countless discussions with my supervisor, I settled on Black men's hypertension

experiences. The more I kept reading, the gloomier the outlook appeared. Despite not being hypertensive, I was overcome with a feeling that my being was merely a pending statistic. Given that I also have a history of this condition in my family, it was disheartening to see these statistics and to determine where I fit in exactly. I *felt* that first hand too. Trying to fit in has been a recurring theme in my life. Having been a visible minority for the majority of my life, I, along with other members of family and friends, have often experienced discrimination. While some shrugged it off, others like myself struggled to make sense of it. Growing up, there was always an inherent struggle that came along with being Black in a city that was populated in a sea of Whites. Sure, I could fit in with my peers, but it came at the expense of who I was as a Black migrant. I conformed to the majority, because that was how I was molded. In essence, I chose to pursue graduate studies and this area of research, in particular, to unearth this *silence*.

Quality Criteria

Qualitative research has made significant contributions to understanding health over the last few decades; however, considerable debate still exists today about issues concerning evaluating qualitative inquiries (Whitmore, Chase, & Mandle, 2001). The quality or goodness of qualitative research is difficult to evaluate because consensus on evaluative criteria do not exist. Traditional quantitative measures for evaluating quality in research focusing on post-positivist notions of quality often overlook the epistemological and ontological inconsistencies of using such criteria on alternative forms of qualitative research (Lincoln & Guba, 1985; Morrow, 2005). Conversely, pre-determined quality criteria set forth with the alternative paradigms in mind overlook the dynamic nature of qualitative research that cannot be explained by these established criteria. Researchers in

this frame hold qualitative research as being context-specific and ever changing. As such, I view goodness as being flexible (over time), and specific to a researcher's philosophy and his/her methodology of choice.

I share the sentiments forwarded by Forchuk and Roberts (1993), whereby the writers state qualitative research "must be evaluated within the context of the author's purpose" (p. 49). Since the purpose of the investigation was to highlight Black men's hypertension experiences in the context of a Critical Race Theory perspective, readers can formulate their expectations accordingly when reviewing my work. Secondly, in line with this notion of being forthright, I tried to be as reflexive and transparent as possible throughout this research endeavor. It was important for me to identify approaches to embrace my subjectivity for this research, because as a critical theorist I adopted the notion of being a co-creator of meaning. As such, by including my reflexive accounts, it was hoped that readers were able to gain insights into my experiences, while viewing the decision-making processes that were guided by my underlying assumptions (Morrow, 2005; Patton, 2002).

Lastly, I believe that coherence is an important marker for quality, as it allows readers to follow one's research unambiguously. For this study, I aligned my research aim and design with my underlying critical theory philosophies to the best of my abilities. Thus, by maintaining coherence, it was hoped that this research endeavor examined its intended purpose and allowed for readers and participants to "feel as though the piece lived up to what was promised" (Tracy, 2010, p. 848).

Ethics

During the course of this investigation, I attended to ethical considerations and guidelines concerning confidentiality and informed consent, and obtained ethics approval through Western University's Health Science Research Ethics Board (see Appendix D).

Since participants in this narrative study were asked to share personal information, ethical considerations began during recruitment. According to Smythe and Murray (2000) "the onus is on the researcher to use discretion in determining the suitability participants of specific individuals as research participants" (p. 329). Thus, during initial contact and prior to the first interview I used discretion in determining the vulnerabilities of prospective participants by gauging the following: a) their ability to respond well and openly regarding their experiences; and b) their understandings of the notion of multiple narrative meanings and how underlying themes may emerge that may differ from participants' personal narratives (Smythe & Murray, 2000). After undergoing initial conversations with the participants, it was determined that each fit the criteria's to partake in this study.

A letter of information (see Appendix E) was also given to participants prior to commencing their participation to provide them with thorough information regarding the parameters of this study. This letter outlined the ways in which I intended to protect participants' confidentiality and anonymity, and it highlighted any potential risks associated with partaking in this study. While there were no known physical risks for participating in this study, participants were forewarned that discussions during the interviews could bring up emotional or uncomfortable situations. In light of this, participants were reminded at the beginning of each interview that their participation, and

the stories they shared during our conversations were voluntary. Prior to beginning the participation in the study, participants were asked to sign a consent form indicating they had read and understood the letter of consent (see Appendix F).

According to Nyamathi (1998), vulnerable people are individuals who are “impoverished, disenfranchised, and/or subject to discrimination, intolerance, subordination, and stigma” (p.65). Therefore, since Black men are considered to be a part of a vulnerable population, I addressed concerns of cultural sensitivity and power relations by being sensitive to other cultural values. Additionally, I realized that power relations can be of concern when engaging such populations, so I made it a priority to establish a good rapport with the participants of this study by engaging in conversations reflecting common interests throughout the interviews (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC] & Social Sciences and Humanities Research Council of Canada [SSHRC], 2010; Flaskerud & Winslow, 1998).

Lastly, inherent within this inquiry, there lied a risk that during the course of this investigation, the meanings that I constructed from participants’ stories may /may not have reflected the particular ways in which the men of this study experienced these specific events (Smythe and Murray, 2000). To address this concern, participants received a summary of the initial interview prior to the second interview, and following the conclusion of this research participants were given the opportunity to obtain and review their completed, assembled, and consolidated narratives. In the event that significant discrepancies in narrative meanings arose, participants were reminded that the data in question could be withdrawn. However, after giving participants the option to

review and make alterations to their respective narratives each of the men declined to suggest any changes.

Chapter Three: Individual Narratives

Format of Narratives

The four participants' narratives are presented in this chapter. The format for each narrative is consistent for all participants and includes the following: a) my reflexive thoughts detailing my time with each of the participants; b) the global impression and form of the narrative; c) a brief overview of each participant; and lastly, d) the participants' storylines. Though only a select number of storylines were constructed for each of the participants' narratives, it is important to note that each storyline was ultimately pieced together from the numerous stories that the men in this study shared during their respective interviews. In turn, these storylines reflected and illuminated key lines of meaning or themes that characterized each participant's narrative. Lastly, throughout the presentation of these narratives, I used participants' quotations in an attempt to convey how their stories were told and shared during our discussions.

Joel

Investigator Reflexivity

Joel was the first participant to contribute to this study. He had an ease and calmness to him that made interviewing him all the more comforting. During our conversations, he spoke candidly about various aspects of his life experiences that resonated with me for the entire research endeavor. I could sense that at times this was not easy for him. Throughout both interviews, his voice travelled through different registers as he tore through the different layers of treating his condition. Specifically, I found his comments regarding his relationship with his medication incredibly poignant. His interpretation of being enslaved by the very medication that he relied so heavily upon

was striking, especially since this sentiment came from a man, whom from my knowledge, seems to fully understand the term enslavement and the feelings it evokes for Black individuals around the globe. Additionally, I found his discussion concerning Black men and their decisions not to openly discuss their health as a reaffirming concept. I suspected early on in this research endeavor that I would encounter difficulties getting members of this subgroup to talk about their health, on the basis of my experiences hanging around middle aged Black men in my community. For these men, talking about their health was somewhat taboo, and as Joel mentioned, perhaps this is linked to the potential of causing worry to family, friends, and even others in their community. In light of his comments regarding this matter, I commend Joel and the others that have taken part in this project for their honesty and their ability to look past these unwritten rules that seem to persist within their respective communities.

Global Impression and Form

The basic tone of Joel's narrative is decidedly earnest and sincere as he shows a great deal of vulnerability in communicating the implications of his condition and how it affects his way of life. During his interviews, he uses language rich with emotion (i.e., "bold," "empowering," "worry," and "traumatized,") that conveys contrasting periods of strength and fear. Joel's narrative can be viewed as largely an inward journey of struggle in which he continually negotiates his hypertension into various aspects of his daily life. The manner in which he constructs his stories to convey his experience of hypertension are relational in nature in that he grapples to make sense of his condition relative to his friends and family, and the greater environment in which he lives. The three main storylines that were discernable in Joel's narrative were as follows: a) intersecting

personal relationships with hypertension, b) intersecting migration with hypertension, and c) living with uncertainty.

Joel's Overview

Joel is in his mid-50s and lives in Ontario, Canada with his wife and two children. He was born and raised in East Africa and migrated to Canada in the 2000s, by way of the United States. Though previously employed as a professor in East Africa, Joel went through various jobs in Ontario, Canada before earning a living as a project manager at a local community agency. He remembers being diagnosed with hypertension during a routine checkup, while living in East Africa. He reports that at the time of his diagnosis, the experience was not traumatic; he was a teen and thought nothing of it. Over the years Joel experienced side effects that influenced his physical and emotional wellbeing, and while living in the United States it all came to a head when a harrowing experience led to a second hypertension diagnosis. Presently, his blood pressure is well controlled, and he feels as though participating in this study and being candid about his condition is a way to “help other people” who may also have hypertension.

Joel's Storylines

Intersecting personal relationships with hypertension

Throughout both interviews Joel drew attention to the varying side effects of his high blood pressure, often talking about how it negatively affected his relationship with others. In his early years, prior to “controlling” his hypertension, he would become “hot tempered,” and experience “severe headaches” and “occasional nose bleed[s].” These side effects then carried over into other aspects of his life. For instance, while teaching in East Africa he expressed, “[his] relationship with [his] students sometimes wasn’t very

good [...] because [he] would get worked out to the extent that even the students around [him] realized.” He also expressed a sense of sadness reminiscing about a period in time in which the effects of his condition “almost cost [him] his marriage.” According to Joel, in his early days he experienced “mood” swings that affected his relationship with his wife wherein [she] simply could not understand [him].” In spite of this, he acknowledged that after several years, his hypertension became a part of their “lifestyle,” and she became more understanding and “supportive in monitoring his medications.” For this reason, Joel asserted that it was almost as if she was the “one who suffered [from hypertension].” He felt that had “she married a normal man, [...] she wouldn’t have had to be dealing with” a lifestyle such as theirs. Joel further spoke about how his relationship with his children was affected by his hypertension as well. Occasionally during their childhood, he stated his “temper” would flare up and he would “[direct] his anger to the wrong person.” At the time, Joel noted that his children were not able to grasp the effects of his condition, so much like his wife, they “couldn’t understand [him]” during the early years of his condition.

Now, in the event that he starts acting “out,” he “take[s] [his] drugs” in order to maintain “control.” In these situations, he stated that his wife and children also make sure to ask him if he has taken his medications. In fact, Joel expressed that he now tries “as much as possible to be open about his high blood pressure” with friends and family, so they too can remind him about taking his medications. Though initially some are “shocked” to hear of his condition, “because they don’t expect someone of [his] size and age to be suffering from hypertension,” he acknowledged that being open with others also forewarns them that his “temper” or “mood changes” has “nothing to do with them;”

instead, he makes it known that his hypertension is to blame. Additionally, he stated that in the case that an extreme event were to occur, he would get the “consolation” of having knowledgeable people around that “know who to call,” and that can grasp the cause of such of an event.

In contrast to the openness that he displayed, Joel theorized that other Black men “rarely [...] [felt] free to discuss their health,” because they had to “act strong” to avoid scaring their families. However, on a personal level, he stated that not disclosing such information would be “dangerous” to those close around him, as being open has made things “easier” for him and his family. These candid discussions, in turn, have enabled those in his inner circle to take on responsibility in helping him manage his condition. For instance, he mentioned his “relatives get scared” when he informs them of his hypertension, because they are unaware “that it can be controlled.” As a result, they “tend to hide information from [him]” to prevent him from getting upset. Though Joel stated he had mixed feelings about being left in the dark regarding family matters, he acknowledged he was “happy” they were trying to help him “control” his health. Ultimately for Joel, sharing his condition with others makes him feel “bold,” and it gives him a sense of empowerment that enables him to “no longer fear [his] illness.”

Intersecting migration with hypertension

Joel had great difficulties adjusting to his surroundings when he and his family first migrated to North America. Initially, adapting to a different climate was troublesome, especially in the winter “when it was very cold.” He expressed that “[he] would get irritated all the time,” and experience frequent mood swings. In addition, after his move he had to adjust to being in a different social standing. While in East Africa,

“[he] was a professor [with] a good salary and a [nice] home, [...] but when [he] came here [he] had to start from zero. [He] had no job, no nothing.” Joel exclaimed the “challenges of joblessness and hypertension [were] real!” As he described:

If you’re hypertensive, and you don’t have a job, I’m telling you, you just feel it. Nobody can tell you the symptoms; you [just] know it. Your temper will always be high, and your heart will be pumping really hard.

Six months after Joel arrived in Canada, he obtained a job working as a gas station attendant. He stated that in order to secure the position, he “had to cheat” and declare that he was a high school dropout. However, he soon discovered “he couldn’t live with such guilt. [...] Cheating to survive [and] deceiving people upset [him].” Furthermore, “[he] realized that [he] wasn’t utilizing [his] potential” and he felt like there were other jobs he could perform “based on his training.” At the time, Joel felt “permanently annoyed.” He oftentimes questioned his “choice to come to Canada,” and exclaimed there were times where he would “just think about things that were upsetting him” and while doing so, his blood pressure would immediately rise.

Since Joel found that interacting with others helped him feel better during this difficult period in time, he formed a local African association to help migrants adjust to their new surroundings. He stated that it was, “key for networking [...] and sharing any [...] anxieties and challenges” that other Africans were going through at the time. It was also a way for Joel and others to feel a sense of belonging in their new homes. As he described, “I sort of transitioned into this society by carrying the community-type life [found in] Africa into [this environment].”

Then nearly two years after moving to Canada, Joel found a “real” job back in Africa that better suited his skills as an educator. He expressed that once the pressures of finding a job were removed, he felt much better mentally. Even though “life was challenging” in Africa, Joel found that it was more “predictable” than living in North America. He expressed that in Africa, people knew they had their job “until [they] died.” While in comparison he stated, “life in North America was okay, [...] but no such guarantees existed.” Life as a result was less “predictable” because according to Joel, one was not able to foresee whether or not he/she had a job “next month or next year.” Eventually, Joel moved back to Canada, but it was never discussed in our conversations how long he stayed in Africa, or when he returned to Canada.

For Joel, it was “very clear that the medication [...] [he] [took] in Africa was not the same” as the medication he received here in Canada. He was told the drugs he had taken previously “had been removed from the shelves [...] years ago.” Yet in spite of this, Joel stated the medication he was prescribed in Africa “worked for [him] there, [...] [but] seemed not to be working” in North America. As a result, with the help of his family physician in Ontario, Canada he was given a combination of medications that “eventually worked.” Joel enjoyed the great relationship he had with his doctor, as he stated that he liked that his physician “listen[ed] to [him] carefully” during their appointments.

Living with uncertainty

Throughout both interviews Joel repeatedly stated that his second diagnosis in the United States was a “traumatic” experience. He originally went to the hospital to attend to another illness that was causing him to experience “intense pains,” yet soon after his

arrival, his blood pressure was measured and it read, “220/180! [...] Everyone exclaimed he was going to die.” Although later his doctors assured him his condition could be “controlled,” he admitted that he was still “scared.” Joel “worried” about death. He felt as though anything “could happen [as result of his hypertension] at any time,” because shortly after his second diagnosis, he had relatives in his family who died from hypertension complications. According to Joel, his hypertension “[was] not a condition that could very easily be rectified.”

Since Joel was diagnosed with high blood pressure at the age of 15, he felt as though his condition had “nothing to do with [his] diet,” but instead he declared his hypertension was “physiological.” As a result, he felt “helpless,” because his hypertension “[would] always be there.” For this reason, he asserted that since his medicine could only help “control” his high blood pressure and not “eliminate” it, he would “have [to take] medication throughout” the remainder of his life. For Joel, this revelation bears a heavy cost. As he described, “you feel enslaved [...] [because] your life seems to revolve around medication. Your activity, time, budget...your whole life! [...] It’s just like drinking water and eating a meal.”

Joel also conveyed a deep concern about his future, and often expressed a sense of “worry” regarding his hypertension. He noted that as he aged, he became “more worried [...] because he [had] not prepared himself for retirement.” According to Joel, “doctors should’ve advised [him] to get life insurance” when initially being diagnosed with hypertension. At the present time, he stated it was too “expensive” for him to purchase because of his age and current condition. For this reason he expressed, “I want to get life insurance, but no life insurance wants me.”

*David**Investigator Reflexivity*

I could sense David was weary about the nature of this study when I first contacted him, so I tried to put him at ease when I met him prior to our first interview. Once we began, it took some time before we built a good rapport. Initially, short answers were met with awkward silences. However, after speaking elatedly about his birth country partway through our first interview, he became more comfortable discussing other aspects of his life.

Considering the various obstacles David had endured up until this point, I was taken aback about how calm he was when discussing his life experiences, and his outlook on his future. Specifically, David's ease in talking about death was startling. He spoke candidly about family members dying from diabetes: a condition that he also had. However in spite of this, like many of our other exchanges, he displayed a warm smile to keep the mood light. Hearing him talk about being "okay" with living only ten more years was an eye opening moment. In fact, for a period in time I felt selfish. Here I was, conducting an interview for my thesis to ultimately better *my future*, and yet David spoke as if *his future* was an impending countdown of sorts. This was incredibly striking to hear, especially from a man who exuded so much positivity in light of the many challenges he endured in his lifetime.

From then on, I was drawn to his every word. The silences at the end of his thoughts were no longer awkward as they provided a period of reflection for the both of us. I became more patient, and true to narrative form, these moments allowed me to step back and listen to David tell his stories.

Global Impression and Form

The tone of David's narrative is relatively positive, as he maintained an optimistic outlook on his life and health throughout both of his interviews. While his speech was slow and articulate, his choice of words reflected a man whom was at ease with his previous experiences marked by struggle. The three main storylines that were distinguishable throughout his narrative were: a) feeling normal, b) negotiations of diabetes and hypertension: awareness, acceptance, and action, and c) fitting in: experiences in Canada versus Africa.

David's Overview

David is a 67-year-old retiree residing in Ontario, Canada with his wife and daughter. He was born and raised in West Africa, and completed his university degree in the Sciences before migrating to Canada in 1970s. Shortly after his arrival, he registered in classes at a local university in the hopes of pursuing a career in medicine. However, the combination of being financially strapped, and not having the proper documentation led David towards a different path. He enrolled in an allied health professional program, and subsequently began practicing as a clinician in Ontario. After 10 years of working at a hospital, David contracted an infectious disease from a patient. Following this incident, he had a stroke and was later diagnosed with diabetes. Then several years later, after attending frequent check-ups with his physician, David was diagnosed with hypertension.

David's Storylines

Feeling normal

Shortly into the first interview David delved into his experience of being diagnosed with hypertension. He stated that after being informed about his diabetes, his

doctor frequently checked his blood pressure, and it was during one of these visits that he was diagnosed with hypertension. Although his blood pressure was consistently “high” during this period of time, David noted, he “didn’t feel anything at all.” As he described:

It wasn’t as though I was sick or anything! [...] I felt normal, [...] and [not] feverish, [...] shaky, or anything of that nature. [...] If [my] [family physician] hadn’t told me about [...] [my] high blood pressure, I wouldn’t have known. I wasn’t showing any signs, I wasn’t affected. I was normal. You know, everything was normal to me.

Since then, he noted his “[blood pressure] has been fine,” and that he “[hasn’t] had any adverse reactions” while living with his condition. In fact, throughout both interviews David repeatedly stated this notion of not feeling any “side effects” of his hypertension. For this reason, he referred to his condition as a “silent killer” because while he “[hadn’t] really noticed anything,” he was “aware that [he] had to be on guard” in terms of checking his blood pressure, exercising regularly, and maintaining a balanced diet.

Negotiations of diabetes and hypertension: Awareness, acceptance, and action

Over the course of his two interviews David showed a change in his line of thinking regarding the cause of his diabetes. First, he stated that had he known his diabetes was “genetic” (his mother and siblings had the disease), he would have taken “certain steps” to counteract the effects of his condition. In his second interview, however, he expressed that he was “sure that there was nothing [he] could have done” to prevent his illness given that he did not “overeat,” and he was not “fat.” Rather, he declared that since his father died of a “heart problem,” and his family had a history of

being diabetic, he felt as though his diabetes was certainly “genetic.” In terms of his hypertension, however, he was less sure. Though he was not aware of any family members with the condition, he mentioned that an increased amount of stress and being diabetic might have increased the likelihood of him acquiring high blood pressure.

Following his hypertension diagnosis, David’s family physician prescribed him medications, and instructed him to maintain a healthy lifestyle (i.e., physical activity, healthy diet) and to limit the amount of stress in his life. Although he stated at the time “[he] wasn’t doing anything that was stressing” him out, David noted that he encountered other trying circumstances over the years. For instance, while working at the hospital David would “tense up a lot.” Therefore, after he contracted an infectious disease, he stopped working at the hospital and “took it easy” to better his health. In subsequent years, David worked sparingly; he helped his wife run her business, and worked at a pizzeria for a short time. Referring to the latter, he declared that even though he previously “couldn’t [envision] [himself] doing that” type of work, over time he realized “[his] health was more important” to him than the stress caused by his previous occupation.

During the periods in which David was off work tending to his health conditions, he and his wife experienced difficult times when deciding to send money back “home” to friends and family. He described the situation as a “concern” at times, because his family’s finances were sometimes limited. This was further exacerbated several years later when his wife’s business “failed.” As he expressed, “I think I stressed up a lot because of that. [...] We were left with all the bills!”

According to David, “things have [since] stabilized.” His family was “okay,” and his “health [was] pretty good.” He was simply “taking it easy” by doing his best to maintain a healthy lifestyle, while relaxing as much as possible. For David this meant: a) cutting back on his social drinking; b) improving his diet by eating breakfast more consistently, and incorporating more fruits and vegetables into his daily meals; and c) walking or biking on a daily basis. Additionally, he took medicine for his diabetes and hypertension, as well as “aspirin and other related medications.” In light of this, he felt “bad” since the medication was “too much,” at times. He stated that he would often “think about” the possible side effects (i.e., “stomach upsets”) of taking all of his medications, and even conveyed these concerns to his doctor. His physician, however, informed him these medications were required if he had any aspirations to live “past 70.” Nowadays, David noted that taking all of his medications were “very much like a [daily] routine.” As he described, “I can’t do without them!” Specifically, David expressed the diabetic medication he was prescribed was “solid;” he felt as though he “[had] to take them.” In comparison, he stated “the high blood pressure and cholesterol” drugs were “preventative medications.” Since he had done “so well” taking care of his blood pressure “over the last 5 years,” he felt as though the diabetic medication carried more weight in terms of importance.

In all, David was happy with his health, and he was “pleased” with the relationships he forged with his physicians. Specifically, he declared with great enthusiasm his appreciation for his specialist, because in addition to “tak[ing] care” of his diabetes, he offered him extra time during his visits to discuss relevant matters. In

comparison, however, he stated that his family physician was “always [too] busy” for them to “discuss issues” during their appointments.

Fitting in: Experiences in Canada versus Africa

Though he’s been in Canada for over 40 years, David sticks to his West African roots by travelling “home” annually to visit his friends and family. For David, these “yearly visits to Africa [have] paid dividends.” As he described:

I don’t stress over there. [...] I feel more relaxed when I go to Africa then [when] I’m here, because I associate with more people. People smile, laugh and joke around [...] every day, and [I’m] not on a time constraint to do anything.

According to David, the North American lifestyle has become too “consumer driven.” He noted Western society’s fixation with buying “cars [...] and houses,” and the exchanging of gifts during Christmas as “stressful” moments in time. In contrast, he stated life in West Africa was “quite different.” It was a more “relaxed atmosphere” in which holidays such as Christmas simply revolved around spending quality time with family and friends. Thus for David, the very thought of preserving his West African ancestry enabled him to “counter balance” his daily Canadian experience.

David was also aware that cultural differences existed between Black African men and White North American men. For this reason, he stated that even though he thought it was rare for Black men to talk about their health with others in North America, he noted it was even less common in West Africa. Referring to hypertension in particular, he expressed that “many people [probably] died [back] home, because they didn’t know [much about] the condition, and they just didn’t talk about it.” Therefore, since “it [was] a silent killer,” David felt as though “people [were] probably walking around with [a blood

pressure of] 200 over 90.” He noted specifically that discussions concerning healthy eating habits were not taken “seriously” in West Africa. For instance, he talked about a period in time prior to his late brother’s death in which he spoke to him about cholesterol content in certain foods. After David shared his concerns, his brother rubbished any of his talk by stating, “We don’t have cholesterol here!” David was shocked, even still. After relaying this story many years later, his first thoughts were, “Can you believe that? [...] That was their thinking!”

James

Investigator Reflexivity

From the moment I met James, he always had a smile on his face. I could sense that my presence was welcomed, as he greeted me into his home with a big grin and a hearty laugh. This automatically lightened the mood, and eased any tensions I had prior to our first meeting. During our conversations, James conveyed his stories quite differently than the other participants. He was very matter of fact, and short with his words. Occasionally, I felt as though I was grasping for answers, and though it was slightly frustrating at the time, I soon recognized that this was *his* way of telling *his* story.

Early on, once James revealed he was born and raised in Nova Scotia, I was eager to hear his stories regarding his upbringing, and his take on any instances of racism or discrimination he may have encountered. I anticipated that many of his stories regarding his upbringing would be shaped by the colour of his skin. Yet, to my surprise, he distanced himself from talking about any acts of prejudices that were seemingly carried out against him. On the rare occasion he spoke of instances of racism or discrimination, he quickly dismissed them as if they were one-off cases. I was startled. Given that James

grew up in a segregated community, I expected to hear the opposite. For example, that this form of intolerance was the real reason that drove him and his family out of Nova Scotia. However, I soon realized that that was my perspective of what I thought I would have done if I were in his position. Gradually, as I contextualized his experiences to his greater surroundings, I began to understand his viewpoints more clearly.

In all, James had a warm energy, and a positive worldview that carried over into all aspects of our conversations. Even in our discussions revolving around his health, it was clear that he had a lot of optimism going forward. I learned a great deal about the nature of narrative research as a result of my conversations with James. I became more aware that storytelling had no bounds, or rulebooks. Rather, individuals communicate their stories in a manner that best suits them. Given that this study aimed to understand how Black men experienced hypertension, this was a fitting revelation. Even though all the participants were Black men, each conveyed their experiences through stories that were no more or no less important than the other.

Global Impression and Form

The tone of James' narrative is fairly casual, as he showed a tendency to maintain a light-hearted and positive outlook regardless of the conversation at hand during his interviews. He employed a style of language that was direct and straightforward, yet still kept the mood light with his lively personality. Furthermore, even though James occasionally veered off topic, he had a great propensity to steer himself back into related territory on his own.

James' narrative is characterized by a pattern in which he displays a tendency to cede control to the various challenges affecting his daily life. The three main storylines

that were apparent in his narrative were: a) early experiences in Nova Scotia, b) hypertension diagnosis and physician relationship, and c) spirituality in everyday life.

James' Overview

James, a widower of two years, is in his late 70s and lives alone in a rural retirement community in Ontario. His children, who are now adults and have families of their own, live in a nearby city and visit often. He was born and raised in a small segregated town in Nova Scotia, and served in the military for three years, before moving to Ontario in his early 20s. While he was employed in the manufacturing industry for the majority of his working life, he spent his off time with his wife and children back at home. Approximately twenty to twenty-five years ago, a few years prior to his retirement, James was diagnosed with hypertension. Several years later he was diagnosed with diabetes. He was prescribed medication to control his blood pressure and his diabetes subsequent to each diagnosis. While both conditions are presently controlled, James was scheduled to meet with a nephrologist a few weeks after our second interview to discuss issues relating to his kidneys. In hindsight, James felt as though his contribution to this research made him think about his health in ways he did not consider prior to his participation.

James' Storylines

Early experiences in Nova Scotia

James “loved” growing up in Nova Scotia, because life there was straightforward. He and his family simply lived with “whatever was there,” and “didn’t look for anything extra.” As he described, “we always just accepted what we were handed, and didn’t question it.” For James, this meant not working at places like “grocery stores and banks,”

but instead being complacent with domestic-type work. His mother, for instance, “did a lot of cooking and house cleaning, [while] his father worked out in the woods.” James too was relied upon to cut wood alongside his father. He “wasn’t crazy for it,” but his siblings were either “too lazy” or “too young,” so his father always picked him to help with the chores. Despite spending a great deal of time together, he and his father had a distant relationship. As James expressed, he “wasn’t easy on anybody,” because he was always consumed by his work.

Throughout the years, James’ father suffered from various health conditions. One of which was high blood pressure. James stated that even though his father “always had” hypertension, he did little to counteract the effects of his condition. He “didn’t take any pills,” and with a laugh, James declared his father only avoided foods “if it wasn’t there.” Furthermore, when asked if his father talked about his hypertension, James empathically stated, “No! All he ever talked about was to go out in the woods and cut wood.”

Though James stated racism could have existed during his earlier years, he declared that “[he] didn’t notice it.” In spite of this, he noted an example in which after moving to Ontario and marrying his wife, they would sometimes be rejected housing because of what his wife described was the result of his skin colour. After further probing though, James declared that “if [he] was really sincere, it might have been there, but [he] didn’t look at it that way.” James “didn’t hold any grudges,” and accepted his circumstances like he did time and again throughout his lifetime.

Hypertension diagnosis and physician relationship

Once James was diagnosed with hypertension, he was prescribed with antihypertensive medication to lower his blood pressure. For James, taking medication on

a daily basis was like “taking a meal [...] [or] a drink of water” everyday. He felt as though it was “automatic.” In addition to being prescribed medication, he was initially “told not to drink pop.” While for a brief period in time he followed these orders, not long after his diagnosis “[he] slid back to normal,” and continued living the lifestyle he was familiar with prior to his diagnosis. James noted the only recognizable change in his life subsequent to his hypertension diagnosis was a decrease in his sexual desire. In spite of this, he still felt as though his hypertension did not affect his day-to-day life. For this reason, he expressed he had “no special diet” that he currently prescribed to, and that he “[ate] pretty well anything that [he] [wanted].” James enjoyed cooking so much that he would prepare meals for neighbours from time to time.

In terms of his diagnosis specifically, James felt as though little could have been done to prevent it, since it was already prevalent in his family and Black populations in general. In fact, had it not been for his physician, James expressed he would not have known that his condition even existed. Throughout both interviews he repeatedly stated he enjoyed a “great” relationship with his doctor. He expressed his doctor was “on top of everything,” because he frequently checked his blood pressure, and kept tabs on his diabetes. Though James stated he did not remember the details of his hypertension diagnosis, he conveyed that during his time under the care of his physician he did not recall his doctor explaining his conditions to him in a clear and detailed manner. Later, he reconsidered these comments, and suggested his doctor “might have” told him information about his conditions, but “[he] probably wasn’t listening.” James was fine with this revelation. As he described, “if he says, ‘take this pill, because you need it.’ I’ll say, ‘That’s fine I’ll take it,’ because I need it.” James simply followed his doctor’s

orders, and “never ask[ed] any questions,” because he felt as though his physician was “smarter” than him. For this reason James declared, “like they say, curiosity kills the cat. I figure he’s a good doctor, so if there’s something wrong, he’ll tell me.” James also noted that he “sometimes” talked to friends about his health, and suggested that these open dialogues could be a way to help others who suffer from similar conditions as him.

Spirituality in everyday life

Faith has played a large role in James’ life. He grew up in a religious household, and his father was a minister. When asked to recall things that he would do in his spare time as a youth, James stated that he and his siblings took part in weekly prayer meetings. As he described:

“On Sundays, we would get dressed up, and sit there all day with the good clothes on. We didn’t go play, [...] ride a bicycle, or speak, or drink. But it did us good. Honestly, it really did us good. I didn’t mind it one bit, you know. Maybe I did want to do things, but we didn’t. We accepted it.”

Throughout his adulthood James continued to live by the practices of his faith. He attended weekly services, and even tried to get family members to “make a commitment to the Lord.” These days, James “depend[ed] on the Lord a lot.” He conveyed that his commitment to his faith “very much” effected his decisions regarding his health, and while articulating this concept further, he likened his well-being to that of a sin punishable by God. For this reason, he stated “every morning and every night” he asked God for “forgiveness” in the hopes that: a) he heard the words, “well done thy good and faithful servant,” and b) it could influence his health for the better. Referring to the latter he expressed, “see, they check [...] my blood pressure, [and] it’s always perfect. My

cholesterol? I never have any problems with that. It's always right on. That's what happens when you're serving the Lord, [...] miracles work out for you."

In all, having both diabetes and hypertension "doesn't bother" James "one bit." He stated that he "had a pretty good life," and he would be just "fine" if he were afforded another "20 years" to live.

Michael

Investigator Reflexivity

At the onset of our first meeting, Michael seemed as though he had mixed feelings in regards to sharing stories concerning his hypertension. He came prepared with questions relating to the nature of the study and his responsibilities, and as I answered them, I briefly scanned his living room and observed a picture on his wall that resonated with me. Following his line of questioning we struck up a conversation about this picture, and while I noticed his guard come down, I could sense he was ready to share his experiences.

Given that Michael was the last participant to partake in this study, it was fitting that I was able to put into practice some of the previous lessons that I had learned. This time around I was more comfortable with sitting back, and allowing Michael to direct our exchanges. For example, Michael responded to an initial question relating to his background by conveying stories uninterruptedly for nearly forty minutes. There were times where I was tempted to interject and ask him more direct questions; however, after displaying some patience I noticed that on a number of occasions, the longer he spoke the more likely he was to answer my questions on his own.

Throughout our conversations, Michael spoke a great deal about his experiences encountering racism here in Canada. It was apparent that these events had a lasting effect on Michael. His body tensed and his voice grew louder with every mention of racism or discrimination. I was personally moved by his stories. They made me reflect back to my experiences dealing with this form of intolerance, and similar to other times I hear stories about racism or discrimination I was overcome by a range of emotions, such as anger, annoyance, and frustration. However, this time I also felt an odd sense of validation, that someone else close to home felt it too. In hindsight, it was interesting to look back at how all the participants either directly or indirectly alluded to racial discrimination.

Global Impression and Form

The overall tone of Michael's narrative is relatively earnest, and he conveys himself as a man who likes to be in control in the face of adversities. In telling his stories, Michael paired moments of resistance (i.e., racism), with his ability to take action and overcome such barriers. His speech was oftentimes emphatic, as his words conveyed great intensity and conviction when relaying life experiences marked by an early struggle to fit into a predominately White society. Though at times veering off topic, Michael recounted story after story in great detail concerning the majority of his life, from his early beginnings as a migrant to Canada to his present day experiences managing his hypertension, in his initial response to the first question about his background. This was quite different from the other participants who all spoke for just a few minutes.

The three storylines that were evident in Michael's narrative were as follows: a) racial discrimination and segregation: resisting and attempting to get in control; b) health

struggles and the need for lifestyle changes; and c) the diagnosis: a sense of defeat and regaining control.

Michael's Overview

Michael is a divorcee in his early sixties, and is a father of three adult children. He was born in the Caribbean's, and migrated to Ontario, Canada with his family at the age of six. His father, an activist, played an influential role in his upbringing, as he faced several challenges growing up in a largely segregated city. Over the years he succeeded in overcoming these initial barriers and went on to college, university, and then obtained several noteworthy jobs. Then, in his 40s, Michael's health deteriorated. He was forced to relocate his family, as his job was not conducive to his health. Though, his condition (an autoimmune disease) was later treated with medication, several years later, after many visits with his family physician, he was diagnosed with hypertension.

Michael's Storylines

Racial discrimination and segregation: Resisting and attempting to get in control

In stark contrast to his early beginnings in the Caribbean's, Michael was openly exposed to racial discrimination subsequently after migrating to Ontario, Canada with his family. It was the 1960s, the city in which he lived was still largely segregated, and at the behest of his father, Michael attended a predominately White school. As he described:

[In my native country] everybody is like you, and when you see tourists, like White tourists, you worship them. Whereas here, you come here and you're not like them, they don't want you here. [...] They don't worship you, that's [sic] for sure!

From an early age, Michael stated he “knew [he] always had ‘something’ else” that he had to deal with: his skin colour. According to Michael, this often meant being “looked at differently” than other students and having to watch his back for people that did not like him. High school was “tough.” He felt as though it was not a “comfortable place” for him to thrive. He did not have many friends, he sat alone during lunch hours, and he was often picked last for activities. As he expressed:

Even though I [would have] loved to [have spent time] around White people to learn about their culture and to learn about them, because I didn’t grow up here, [...] I couldn’t, because [I was not] allowed in. [I was] discriminated against.

Michael noted a vivid experience near the end of his freshman year all but confirmed the feelings of isolation he had endured throughout his childhood in Ontario. Though he “struggled” with courses, Michael felt as though he was not given a chance to succeed. He stated, “there was nothing about helping” at his high school. School officials, however, thought otherwise. They suggested Michael transfer to a nearby school for “slow learners,” because he had a low “mental capacity.” Michael stated his father was skeptical all along, because he realized the school for “slow learners” was in reality a school comprised of “people from immigrant families, low-income families, [and] Black people.” For Michael’s father, the thought of his son being shipped off to an institution designated for minorities irked him. Thus, he declined their recommendation and stood by his son, reassuring him that if he put in the work “[he] could [overcome] anything.” Michael declared:

My dad told me [I was] going to stay at [this] school. And the way I overcame [this] was that I accepted the reality that [it was] not that I was retarded [sic] or [it

was] not that I was a slow learner or whatever they were saying, [it was] the fact that they [did not] like [me] because [I was] a Black boy at [their] school.

Michael's father played a pivotal role in his upbringing. He was an activist representing the Caribbean community, and often fought for equal rights on behalf of Black persons in their region. During Michael's adolescent years, his father often drove him to local establishments and relayed stories to him of times he and his friends got tossed out merely because they were Black. Michael stated the police's resolution: "if they don't want you there, don't go back," did not sit easy with his father. Thus, he would return time and again for it was his belief that he and his friends were to be held in the same light as all citizens. Michael declared his father shared these stories and experiences with him to encourage him to persevere through the discrimination and racism that persisted in their environment at the time.

According to Michael, there was a difference amongst Black populations and their perceptions of racism. He stated that in comparison to foreign-born Black Canadians, domestic-born Black Canadians failed to "see" racism and discrimination. For this reason he suggested that while foreign-born Black Canadians were at one time exposed to "normalcy," or life without racism in their home countries, domestic-born Black Canadians, on the other hand, were instead "ingrained" with racism because that was everyday "life, for them." He further provided an example in which he noted that for foreign-born Blacks, such as himself, their birth countries (specifically, his native country) would declare "bad" persons, "bad," in terms of their actions. In contrast, he stated that in Canada the mere colour of one's skin automatically insinuated if he/she was a "bad" person.

During high school Michael took refuge in the army cadet movement to escape the harsh realities he encountered on a daily basis. His time there was met with more ease, because he was judged on his individual merit rather than the colour of skin. As he stated, “it was almost like sports: it [didn’t] matter if you [were] Black or White, as long as you [scored] [...] you [made] the team.” However in spite of this, Michael still felt as though he “had to work [three] times as hard to be on equal terms with the White person.” In time, he stated his hard work and determination paid off, as he moved up the ranks to a commander while still in high school. Michael declared that he learned to accept that he was ultimately responsible for “[his] own success[es] or failure[s],” and eventually used this mentality to graduate from the very high school that turned its back on him so early on.

Michael would later face other instances of racism and discrimination throughout his lifetime. Though he experienced great difficulties with this at that time, in retrospect, he stated it was a “blessing in disguise,” because “it made [him] more progressive in [proving] *them* wrong.” He showed *them* (his teachers, school officials, and all the naysayers) that he could excel even though he was Black. Michael expressed that he now reached a point in his life where “every other thing [he] came up against,” he felt like he was “in control.” Even with the racism, he noted that he could “mitigate the circumstances” by reassuring himself that he “[could] do it,” despite the ignorance of others.

Health struggles and trying to gain control through lifestyle changes

By the time Michael hit his mid-40s, his health began to take a turn. He experienced aggressive coughs, contracted numerous infections, and because of this, he

relocated to another city to work in an environment less hazardous to his health. Initially the examinations he underwent were inconclusive. He stated, at first the specialists' thought it was AIDS, and then they suspected Leukemia. However, after conducting several tests he was finally diagnosed with an autoimmune condition prevalent amongst African Americans. The disease was treated with a steroid, and though it worked to rid him of his condition, he gained fifty pounds. For Michael, this added weight was ultimately too "difficult to lose."

Following his diagnosis, Michael frequently visited his family physician to check on his health. His doctor often examined his blood pressure and though his initial readings were "always sort of in the middle and high-normal range," he refrained from prescribing any medication. According to Michael, his doctor was not the ordinary "pill pusher," so they mutually agreed that Michael engage in a routine exercise regimen, and that he maintain a healthy diet. At this point, Michael recognized that he had to be "vigilant" with these early recommendations because the condition was prevalent in his family: his mother, father, and grandmother were all hypertensive. In fact, he now relates his grandmother's early side effects, hearing noises in her ears, due to her rising blood pressure.

He was "reluctant to go on medication" again too, because while he witnessed firsthand the physical side effects of taking certain drugs (i.e., weight gain), he also saw how much his parents relied upon medicine to control their hypertension. This was difficult for him, as he did not want to be classified in the same company as family members that were not afforded the benefits of the Internet, the advancements in research, and the increased access to exercise facilities. He felt as though he had every

opportunity to counteract his rising blood pressure on his own without the aid of medication. For Michael, this meant going to the gym several times a week, and doing his best to maintain a healthy diet despite the difficulties it imposed on his Caribbean lifestyle. As he described, “I tried to cut off salt completely, [but] the food [...] just tasted so bad.” He stated the Caribbean foods he was accustomed to were “very rich,” so he simply could not “cook low fat curry goat or low fat ox tail.” Instead, Michael declared he had to find a middle ground that allowed him to preserve his cultural identity, while maintaining a healthy balanced diet. Therefore, his solution was to accept that the Caribbean diet was not always the healthiest choice, and that he had to be more aware of his portion sizes and how often he was eating such foods.

The diagnosis: A sense of defeat and regaining control

As Michael began to age, he started experiencing chest pains and a shortness of breath. After a series of visits with his doctor, and his blood pressure reading higher than threshold on numerous appointments, his physician diagnosed him with hypertension. During that moment, he admitted to experiencing a sense of “defeat,” as the optimism he once held about beating his hypertension on his own quickly diminished. According to Michael, when his physician prescribed him medication for his blood pressure he immediately felt as though “the medication won over [him].” For this reason, he stated he experienced “a sense of hopelessness, [and] a sense that [he] couldn’t [...] mitigate” the circumstances on his own. In the past, everything he “ever came up against, he [always] felt like [he] was in control.” His father had taught him to fight and persevere, and though “[he] did everything there was to do, [like] the exercising [and] the dieting,” he still came up short. After leaving his physician’s office that day, he declared he “finally accepted

[...] it, [...] and eventually bowed down” to accept his fate. Looking back at his diagnosis, Michael expressed that it was “inevitable, [...] [and] that it didn’t matter what he did,” he was always going to be diagnosed with high blood pressure one way or another, because it was in his bloodlines.

That initial defeated mind-set is now gone, as Michael declared his hypertension was “fully under control with [his] medication.” His initial fears of taking medicine were laid to rest when his family physician reassured him the implications of taking the antihypertensive medication was far less risky than the steroid he received while battling his autoimmune disease. He trusted his family physician too, because he had a great relationship with him. His doctor was “patient” and “[spent] lots of time” with him. He often shared his honest opinions, and explained things in such a way for Michael to understand the situation at-hand. Michael liked the way his physician worked “along[side] [him] [...] to mitigate whatever it [was they] were working on” together. Today, in addition to his medicinal treatment for his blood pressure, he continues to exercise at the gym four to five days a week, and even tries his hand at cooking healthy Caribbean meals.

In light of the fact that he thought that it was uncommon for Black men to do so, Michael even declared that he was an advocate of speaking openly about his condition. As he described, “the average Black man probably didn’t like to talk about [his] health situation, [because] [...] it show[ed] a sign of weakness.” He stated there was a sense of “pride,” and a “macho” type feeling that existed amongst these men. This, in turn, he said created a false belief that “Black men never [got] sick.” However, unlike his counterparts, Michael liked being candid about his condition, because he believed that hiding it from

others would actually cause his blood pressure to rise. Furthermore, he stated that being open with others about one's hypertension would allow men to realize that others suffered from this condition as well, and that it could "probably [...] [decrease] [one's] blood pressure" by doing so.

Conclusion

The four narratives that were presented in this chapter capture participants' unique experiences making sense of their hypertension diagnosis, and their subsequent negotiations of this condition into their everyday lives. In the following chapter, a number of similarities found across the participants' narratives are discussed in relation to relevant literature.

Chapter Four: Cross-Narratives

The purpose of this investigation is to explore the ways in which Black men in London, Ontario, Canada, experience and negotiate hypertension in their daily lives. In Chapter Four, individual narratives were presented to highlight how participants made sense of, and negotiated, their hypertension in their own unique ways within particular contextual and temporal conditions. The focus for this chapter is to draw attention to the similarities across most, if not all, of the individual narratives, as well to compare my findings to conclusions drawn from other research. In doing so, the narratives will be situated within a Critical Race Theory perspective, wherein issues concerning racism and the distribution of power are explored to better understand how participants make sense of their hypertension.

Cross-Narrative Themes

The seven cross-narrative themes that materialized from my interviews with each of the participants are as follows:

- Connections to homeland
- Racism
- Heredity
- Medication: The primary source for control
- Patient-physician relationship
- Perceptions of high blood pressure
- Reluctance to talk about health

Connections to homeland

An important theme identified through the comparison of the individual narratives was that three of the participants had experienced geographical and cultural transitions from their respective homeland to Canada, and all had attempted to remain connected to their cultural roots. In relation to their hypertension, participants spoke of both the stress that accompanied the transition, and of the sometimes-conflicting goals of maintaining their cultural identity and changing their lifestyles to manage hypertension.

The three migrants in this study (Joel, David, and Michael) all reported close ties to their nation of birth. Michael's ties to his birth country, for example, was highlighted by his love of Jamaican food, and his insistence to fit it into his diet despite not always being the healthiest choice. For Joel and David, the two spoke of their roots in relation to helping them feel situated in the Canadian context. In particular, Joel mimicked the "community-type life" found back in Africa by organizing a local community group to help him and others "transition into this society." David, on the other hand, said the very thought of preserving his West African ancestry enabled him to "counter balance" his daily Canadian experience. In keeping to his roots, he maintained close contact with those in West Africa via recurrent travels to his homeland, and by sending money back home to support his family and friends.

Findings from this study indicate that participant interactions and practices from their home countries facilitate the ways in which they settle into their new surroundings, and in turn, contributes to their overall health and well-being. This is consistent with research concerning transnational migration: an emerging area of study that focuses on

the dual lives of migrants, and their cross-border experiences living with ties to more than one nation (Portes, Guarnizo, & Landolt, 1999). David's experience, specifically, is similar to findings from Owusu's (2003) research regarding transnationalism amongst West African-Canadians. In his study, he reports that West African-Canadian's, individually, maintained ties to their homeland via frequent phone calls, regular travels, and the remittance of monies to support family members and investments (i.e., home ownership, humanitarian causes). Additionally, he found that local West African associations were formed in Canada to maintain communal ties to their country of birth. According to Owusu (2003), these formal and informal networks sought to improve the well-being of community members by providing West African-Canadians with social and economic assistance, while offering them an outlet to "preserve and express their unique cultural identities" (p. 407).

Another interesting observation that can be seen throughout the narratives is the favourable depictions migrants bestow their countries of birth in comparison to Canada. This was particularly evident for Joel and David, as they each shared stories whereby they portrayed life in Africa as more easy-going than life in Canada. For instance, Joel said East Africa was more "predictable," because people knew they had their jobs "until [they] died." In comparison, he said North America "had no such guarantees." Similarly, David identified that his annual travels to West Africa were a result of his birth country simply being more "relax[ing]" and less "stressful" than his host country. David's thoughts are augmented by previous research which indicates that, for some, the simple thought of regular travels back to their mother country acts as a form of coping, because

this hope to one day return to their homeland lessens the stress of migration in their host country (Henry, 1994).

Racism

Given that one of the tenets of Critical Race Theory identifies racism as ordinarily being embedded within society, it was important that I address issues of racism in this research (Delgado and Stefancic, 2001). Even though it was never explicitly stated by any of the participants, the ways in which the men in this study spoke about the isolation and stress caused by the discrimination they faced could have been their way of making sense of their hypertension. For James, stories regarding racism during the interviews were elicited via probing while, for the others this topic was introduced solely on their own by way of discussions about their experiences living in Canada.

Michael was the only participant to explicitly articulate his experiences dealing with racism directly. For instance, he described that during his adolescent years “[he] [would have] loved to [have spent time] around White people,” but due to the colour of his skin he was never “allowed in.” His stories regarding racism ultimately became a focal point of his narrative, as he illustrated a more explicit comparison to the racial discrimination found in Canada versus his birth country. Michael noted those from his homeland were less apt to discriminate based on one’s skin colour, because locals “worship[ed]” White tourists when they visited. In comparison, he described that living in Canada was different, because the mere colour of one’s skin automatically insinuated if he/she was a “bad” person. Michael’s sentiments regarding lay perspectives on skin colour is consistent with research by Maddux and Gray (2002). While their study found participants were more likely to attribute negative traits (i.e., poverty, aggressiveness,

lack of intelligence, lack of education, and unattractiveness) to dark skinned individuals, Black men in particular were also more likely to be ascribed with traits associated with criminal behaviour. Even though in hindsight, Michael declared the discrimination he encountered was a “blessing in disguise,” it is important to note the long-term implications of such events to one’s health. In recent years, research findings have indicated that Black individuals whom face interpersonal racism display higher measures of ambulatory blood pressure (Brondolo et al., 2011).

Given its distinct parallels with the ‘silent killer’ moniker commonly associated with hypertension, the silent presence of discrimination found across three of the participants’ narratives cannot be ignored. Joel, David, and James all implicitly referenced instances in which they were affected by racial discrimination. For Joel, it came in the form of his stories regarding his early years in Canada searching for a job. Though he was a university graduate, and previously employed as a professor in East Africa, Joel spent his initial years in Canada working as a gas station attendant. He knew “[he] wasn’t utilizing [his] potential,” and felt as though there were other jobs he could perform “based on his training.” He felt “permanently annoyed,” and it oftentimes left him questioning his “choice to come to Canada.” He declared that, at times, he would “just think about things that were upsetting him” and his blood pressure would immediately rise. When Joel was finally able to find a “real” job two years later, it was outside the country, and back in Africa. His stories regarding his struggles to find work commensurate with his educational and employment experience resonates with research findings that suggest sub-Saharan African migrants encounter “downward occupational mobility” once migrating to Canada. As a result of having to work low-end jobs, these

migrants often experience class dislocation (comparing pre and post migration occupation and status) that ultimately lead to disempowerment and a loss of social status (Creese & Wiebe, 2012, p.7).

Kept ever more silent was the notion of discrimination found within David and James' narratives respectively. David's talk of stress in the Canadian context was to some extent a result of his inability to connect with others while living in Ontario. He further discussed how life in West Africa was more "relaxed," because amongst other things he was able to "associate with more people" despite having lived in Canada for many decades. Though not stated explicitly, notions of social exclusion as a result of David's ethnicity might be an explanation for his feelings of isolation here in Canada. According to Galabuzi (2006), social exclusion, manifested via structural inequalities and limited access to various resources (cultural, economic, political, political), increasingly affect populations such as migrants and visible minorities. Thus, it has been said that individuals such as David are left excluded, and subsequently disadvantaged by those in power who only afford benefits to groups (i.e., Whites) not belonging to the "other" (Galabuzi & Teelucksingh, 2010, p. 9; Razack, 2002). In terms of its impact on health, it has been reported that the marginalization of visible minority populations from the rest of society can lead to poverty and a number of different chronic diseases (Mikkonen & Raphael, 2010). Social exclusion can also hinder disease management as it prevents individuals from accessing services and taking part in education and training (Wilkinson & Marmot, 2003).

James, on the other hand, was more apt to dismiss talks of discrimination even though he appeared to discuss events that constituted this type of mentality or behaviour.

For instance, he alluded to racial discrimination during his childhood when he declared he and his family “accepted what [they] were handed” without question, and instead of working at places like “grocery stores and banks,” they were complacent with performing domestic duties. Yet in spite of this, James declared that even though racism could have existed, “he didn’t notice it.” Then, after further probing, he admitted that “if [he] was really sincere, it might have been there, but [he] didn’t look at it that way.” One possible explanation for James’ unwillingness to acknowledge racists acts might be due to his strong ties to his spirituality. According to Este and Bernard (2006) spirituality amongst African Nova Scotians was seen as a coping strategy, and a source of strength and resilience for dealing with issues such as racism. Participants in their study spoke of being strong in the face of adversity, and looking to God for direction when faced with these kinds of obstacles. Indeed, James appears to use a similar approach of acceptance and relying on God when faced with health adversities.

Heredity

While the scientific community continues to search for evidence regarding the specific etiology of high blood pressure, studies concerning the underlying genetic factors that cause hypertension remain a common focus for researchers investigating this condition (Kato, 2012; Kraja et al., 2011; Lieb et al., 2013). In this study, the hereditary nature of chronic conditions was highlighted throughout all of the participants’ narratives. For example, David’s mother and his siblings were all diagnosed with diabetes, while Joel, James, and Michael each had family members that had been diagnosed with hypertension. In light of this, most of the men in this study showed a tendency in their narratives to attribute their diabetes or hypertension to their genetic predisposition for

either condition, while also placing their diagnoses and their ability to manage their blood pressure in other contextual factors such as experiencing racism or stress.

David showed a change in his line of thinking over the course of his two interviews. First, he declared that if he had known his diabetes was “genetic,” he would have taken “certain steps” in his earlier years to counteract the effects of his condition. He later said, however, that he was “sure that there was nothing [he] could have done” to prevent his illness given that he did not “overeate,” and he was not “fat.” Instead, he declared his diabetes was certainly “genetic,” because his father died of a “heart problem,” and his mother’s side of the family was full of diabetics. This same type of mentality was persistent across the other three narratives. James and Michael specifically declared they thought little could have been done to prevent their high blood pressure, because it was prevalent in their families and Black populations in general. Michael, after considerable effort to control his blood pressure through lifestyle changes, expressed that it was “inevitable, [...] [and] it didn’t matter what he did,” because he was going to be diagnosed with high blood pressure one way or another. Joel similarly declared that his hypertension had “nothing to do with [his] diet;” instead, he declared it was “physiological.” Accordingly, he felt as though his medication could only “control” his condition, but not “eliminate” it.

Medication: The primary source for control

It was evident across all the narratives that the use of pharmacological interventions carried greater weight as a form of treatment for hypertension, even though most of the participants spoke of engaging in physical activity or maintaining a healthy diet. Generally, throughout the narratives the men in this study showed a great tendency

to tie notions of hypertension control with their use of medications. For example, Joel declared that if he felt as though he was acting “out,” he knew to “take [his] drugs” in order to maintain “control.” Additionally, he was adamant to tell others about his hypertension, so they could remind him to take his medications in the event that he experienced “moods changes.” While Joel made no mention of not adhering to his prescribed medication on a regular basis, it is important to note that previous literature has shown that hypertensive individuals oftentimes take their recommended pharmacological treatments only when presented with observable symptoms (Marshall, Wolfe, & McKevitt, 2011). This is concerning since this form of intentional non-adherence has the potential to become long-term; therefore, increasing the likelihood for one to experience devastating health effects.

Though he initially struggled to come to terms with having to take this form of treatment, Michael now admits his condition is “fully under control” due to his medication. Initially, Michael viewed medication only as a source of treatment for his parents or other older populations, because they were not afforded the luxuries of modern-day technology. Thus, at the outset Michael felt as though he could control his blood pressure using other means (i.e., physical activity and diet). However, he now dismisses any talk of these lifestyle factors playing a role in preventing his hypertension, because of his failed efforts to curb his blood pressure using these treatment methods.

For some, taking medication was simply an act carried out to comply with their physicians’ demands. James, for example, declared that taking his “pills” was something his “doctor [told] him to do,” and so he did it without question. Eventually, it became “automatic,” almost “like taking a drink of water.” Though David similarly expressed his

daily medication intake was “very much like a [daily] routine;” he too, felt as though he had no choice but to comply with his physician’s recommendations. At times, he said the various drugs he was prescribed were “too much,” and they made him feel “bad.” However, his doctor merely suggested if he had any aspirations to live “past 70” that he continue to follow his daily dose of medications. This feeling of entrapment by the very medication intended to help one counter their blood pressure was also evident in Joel’s narrative. His relationship with his medication evoked strong feelings of “enslave[ment],” because it reluctantly became a daily routine that stole away his “activity, time, budget...[and] [his] whole life!” These findings coincide with research conducted by Lee, Mokhtar, Krauss, & Ong, (2014) wherein it was reported that strong negative feelings towards medicine existed amongst hypertensive individuals. In their study, some participants with these sentiments felt as though pharmacological interventions were harmful to their health, because they had unfavourable side effects and were unnatural. Others who had mixed feelings believed that even though prescribed medication failed to treat the actual root cause of their condition, taking this form of treatment was simply more convenient, scientifically proven (i.e., trustworthy), and provided temporary relief of symptoms.

It should not come as a surprise that the men in this study felt as though medication was an important indicator for control, considering the majority of the participants were able to manage their blood pressure without any trouble while using this form of treatment. In light of this, however, most of the participants held ambivalent feelings relating to blood pressure control, as they resented having to give up personal control to their medication.

Patient-physician relationship

An additional cross-narrative theme identified was the positive feedback participants bestowed upon their physicians. All the men in this study equated their satisfaction with their doctors in regards to them monitoring their health on a consistent basis. Michael, for instance, described how his doctor “spent the time he needed with [him]” during their appointments, and how his physician was able to spend time with him during times of need. Similarly, Joel and David both highlighted that the time spent with their doctors during their appointments was a catalyst for the relationships they forged with their respective physicians. In particular, Joel spoke of how he enjoyed his doctor’s willingness to listen to his concerns, and while David was “pleased” with his family physician, he felt as though his specialist allotted more time for their appointments. He described that he was “always just [too] busy” for them to “discuss issues.” These findings are of particular interest because as Flynn et al., (2013) reported, a great two-way patient-physician relationship is an important facilitator to hypertension self-management.

James also enjoys a “great” and trusted relationship with his physician. However, in stark contrast to the above-stated findings, he defers to his doctor for all of his medical decisions. He does not “ask questions,” and simply does what he is told, because he feels as though his doctor is “smarter” than him. These findings indicate that a universal demand for patient-physician collaboration did not exist for the participants in this study, as individuals had varying perspectives when it came to their role while receiving care from their physicians. Though the majority hoped for a greater partnership with their

doctors, James conceded authority to his physician and still was able to maintain hypertension control.

Perceptions of high blood pressure

As previously stated, it was evident that the men in this study interpreted their hypertension in different ways. In regards to their diagnostic experience, two of the participants, David and James, offered little detail of their actual appointment and spoke of no troubles accepting their diagnosis. David, for example, stated that his physician merely prescribed him medications and told him to “do exercises,” “eat healthy,” and limit the amount of stress in his life. He provided no further details of this particular experience. As for James, he was even less descriptive. He had little memory of his actual diagnosis, and after initially noting that it was rare for his doctor to give him any health advice, he later admitted that “[he] probably wasn’t listening” at the time of his appointment.

Conversely, Joel and Michael shared greater details about their diagnostic experiences. In addition to speaking about initial periods of neglect or struggles to accept their hypertension, both participants later reflected on a period in time in which the realization of being hypertensive set in. For Joel, it was the combination of having a “traumatic” diagnostic experience in the United States, followed by a hypertension related death in his family. This proved vital for him to finally accept his condition after sitting idly for many years subsequent to his first diagnosis in East Africa. Michael’s struggle, on the other hand, was reflected by his initial unwillingness to cede to his blood pressure medication. Like “every other thing [he] came up against,” he was “in control,” so he was deadest on controlling his blood pressure too. However, once officially

diagnosed, he conceded “defeat” and “bowed down” to “accept” his fate. This was made easier after: a) realizing he could continue on with his diet and exercise to maintain his health, and b) his physician reassured him his medication would be less problematic than the medicine he used for a previous illness. Therefore, the various meanings and significances that individuals attributed to their diagnosis can provide readers a basis for understanding participants’ narratives, and the ways in which these men initially made sense of their hypertension.

The participants in this study also had different experiences when it came to discussing the physical manifestations of having hypertension. Throughout both interviews, David and James were adamant their hypertension yielded no observable side effects. In comparison, however, Joel and Michael each alluded to symptoms being associated with hypertension. Joel, for example, discussed that in his early years his rising blood pressure would often cause “nose bleeds,” and “severe headaches.” Further, he stated that his side effects even carried over to his work-life, as his temper would oftentimes interfere with his relationship with students. Michael, on the other hand, was aware of symptoms being associated with hypertension through his grandmother’s experiences. He spoke about how her rising blood pressure would cause noises so loud in her ears that she had to use cotton balls to cover them up. This seems to suggest that the nature of high blood pressure may not be as ‘silent’ as frequently noted. Schoenberg and Drew (2002) highlight that a dichotomy exists amongst patients who attribute symptoms to hypertension versus health professionals who prescribe to commonly held notions of this condition’s asymptomatic nature. Under these circumstances, the authors argue that patients’ lay beliefs are invalidated as being “inferior” to the “expert” opinions of

medical professionals and scientists (p. 469). This is of great importance, as it highlights the power imbalance that exists between hypertensive individuals and their respective physicians, and points to how a “hierarchy of knowledge” can ultimately silence individual hypertension experiences in favour of the traditionally held objective notions that are associated with this condition (Schoenberg & Drew, 2002, p. 469).

Reluctance to talk about health

It has been well documented in previous literature that the adherence to traditional notions of masculinity amongst males negatively affects their health (Courtenay, 2000; Santana, Raj, Decker, La Marche, & Silverman, 2006; Williams, 2003). For Black men, specifically, this can prove costly since this population already faces many health inequities. Thus, an important observation found across most of the narratives in my study was how perceptions of masculinity prevented Black men, in general, to openly discuss their health with others. For example, Joel posited that Black men “rarely [...] [felt] free to discuss their health,” because they had to “act strong” to avoid scaring their families. While similarly, Michael spoke of how “pride” and a “macho” feeling existed amongst this community of men. He further declared that talking openly about their health not only showed “weakness,” but also went against the concept that “Black men [...] never [get] sick.” These particular findings augment existing research that highlight male perceptions of “being a man” (i.e., “tough,” “macho,” “stubborn”) can prevent them from “expressing pain or suffering” for fear of showing weakness (Hooker, Wilcox, Burroughs, Rheame, & Courtenay, 2012, pp. 82, 84).

David, on the other hand, explained this phenomenon on a macro-level, theorizing this population of men was unwilling to openly talk about their health because of

“cultural” differences that existed between African and Westernized populations. He specified that in comparison to Canada, it was even less common for Black men to speak openly about their health and wellness in West Africa. To explain this concept, he used an example from a time in which his brother in West Africa rebuffed any talk of healthy habits, because it was simply their “thinking,” or mentality, to do so. Literature concerning social constructions of masculinity amongst West Africans reveals a general consensus that ascribes physical and mental strength with men that refrain from publically expressing emotions such as “fear, anxiety, pain, or sadness.” In light of this, men such as David’s brother are expected to show strength, courage, and fortitude in the face of adversity (Adinkrah, 2012, p. 475; Miescher, 2005; Obeng, 2003).

In stark contrast to these findings, however, all four men in this study declared they were receptive to speaking candidly about their health with others. Their abilities to convey stories and share candid experiences of their dealings with hypertension and other health conditions with various persons stemmed from the fact that they believed that open dialogues concerning health matters could perhaps aid other individuals manage their respective illnesses. In addition to this, Joel and Michael each noted that withholding their hypertension from others in some ways hindered their way of life, as it was either more stressful to themselves or harmful to their family and friends to hide such information.

Conclusion

This chapter highlighted the similarities that existed amongst the individual narratives presented in the previous section. In the next chapter, I use examples from

previous research to examine how the broader cross narrative themes relate to Critical Race Theory concepts and Black men's hypertension experiences.

Chapter Five: Discussion and Final Considerations

Discussion

The ways in which Black men in Ontario, Canada experience hypertension were explored in this study. Drawing upon a critical perspective that was situated within a Critical Race Theory discipline, the findings of this study not only reaffirm common notions found within literature regarding Black hypertension experiences, but also illuminate novel information through a Canadian specific, critical and gendered approach. In this chapter I explore how overarching themes depicted in the previous chapter relate to previous ethnicity-based research on Black men's hypertension experiences.

In all, it was revealed that participants in this study were affected by various forms of power dynamics that placed them in an inferior position in comparison to their White counterparts. For these men, their experiences were mediated by the institutional policies that make it difficult for migrants to obtain education or employment commensurate with previous international training, as well as the social and historical contexts in which their lives were lived. In the past, many authors have indicated that exposure to racism can lead to elevated rates of blood pressure (Brondolo et al., 2011; Cuffee, Hargraves, and Allison, 2012; Dolezsar, McGrath, Herzig, & Miller, 2014; Hicken et al., 2014; Steffen, McNeilly, Anderson, & Sherwood, 2003). The findings from this study demonstrate that participants were each affected by this form of intolerance, as it was revealed that, much like the reported 'silent' nature of hypertension itself, the majority of men in this study reported opposing discriminatory practices that affected their lives in a silent manner. It was only through repeated analysis of the participants' narratives that it became evident that certain situations (i.e., systemic barriers, social

exclusion, and interpersonal racism) were manifested by the colour of their skin. This echoes CRT discourses that state racism exists ordinarily in society and that Black individuals are influenced by axes of domination, as participants' ethnicities ultimately affected their abilities to receive a quality education, obtain employment, or to simply fit into their surroundings (Delgado & Stefancic, 2001; Parker & Lynn, 2002). This was particularly evident for the migrants of this study, who each had difficulties adjusting to their new surroundings when initially arriving to Canada. Whether it was finding employment commensurate with their experiences, or simply integrating into their educational or social environments, the colour of their skin played a crucial role in the ways in which they were afforded certain opportunities while transitioning into Canadian society.

Additionally, it was revealed that racism, along with the power dynamics embedded within participants' social, historical, and political contexts also affected the ways in which they constructed their narratives. According to Sue (2013), dialogues concerning *race* can often place visible minorities in compromising positions, as they oftentimes conform to societal pressures that dictate they follow a "politeness protocol" (p. 666). As such, the silenced nature of discrimination found across the majority of the narratives could be a result of participants being compliant to this form of pressure.

While it cannot definitively be concluded that the discrimination that participants of this study encountered subsequently lead to their hypertension diagnosis or affected their blood pressure in any way, these stories were still included in their narratives of making sense of how they had come to have hypertension, and how they were managing it in their daily lives and relationships. These findings are of great importance and need

further examination in the Canadian context, given the country's ever-growing migrant population.

The literature shows that accepting a medical diagnosis can be quite challenging; however, very few studies have reported this experience from a hypertension lens (Duncan, Hart, Scoular, & Bigrigg, 2001; McBride, Clipp, Peterson, Lipkus, & Denmark-Wahnefried, 2000; Tobin & Begley, 2008). In this study, Joel and Michael expressed that their high blood pressure diagnosis caused initial concern. This was reflected in a study conducted by Higgenbottom (2006), wherein it was found that many African Caribbean (United Kingdom) participants displayed similar distressing emotions at the time of their hypertension diagnoses. David and James, on the other hand, experienced no such difficulties and had little to no recollection of their actual diagnostic experience. Furthermore, these two participants were adamant in highlighting that their hypertension yielded no physiological manifestations. The current scientific discourse on whether or not hypertensive individuals are presented with any symptoms is divided. The literature often falls in line with David and James' experiences and denotes high blood pressure as an essentially symptom-less condition (WHO, 2013). Studies conducted by Bokhour et al., 2012, Lukoschek (2003), Rose et al., (2000), and Wilson et al., (2002), however, indicate otherwise, as they illuminate participants' tendencies to directly associate symptoms to their high blood pressure. These experiences relate directly to Joel and Michael's interpretations of hypertension.

Research conducted by Walker et al., (2011) indicates that many Canadians often fail to receive pertinent lifestyle recommendations from their physicians to treat their blood pressure. It is interesting to note that in contrast to findings from Walker et al.,

(2011) the majority of men in my study not only received such information, but also framed themselves as having implemented physical activity and modified diets into their daily lives. In light of this, however, all of the participants still relied heavily upon their medication to control their blood pressure. For James, implementing this form of treatment into his daily routine was simple. In comparison, though, the other participants each had difficulties with either accepting or maintaining medication as a form of treatment for their hypertension. Commonly, research investigations have indicated that hypertensive individuals that encounter such difficulties with their medications (i.e., side effect, fear of addiction) oftentimes discontinue this form of treatment (Bane, Hughes, Cupples, McElnay, 2007; Beune, Haafkens, Agyemang, Schuster, & Willems, 2008; Connell, McKevitt, & Wolfe, 2005; Dela Cruz, & Galang, 2008; Gascón, Sánchez-Ortuño, Llor, Skidmore, & Saturno, 2004; Lee, Mokhtar, Krauss, & Ong, 2014). Yet, unlike these findings, Joel, David, and Michael continued taking their medications despite facing initial or continuous challenges with their pharmacological interventions. Perhaps this unyielding dedication was a result of some participants feeling as though they were controlled or “enslaved” by the very medication they relied upon on a daily basis. This points to the importance of looking beyond traditional biomedical views associated with pharmacological treatments (i.e., side effects) and instead, examining the meanings individuals assign to their respective medications to better understand factors associated with their health and well-being.

This study also indicated that most of the participants preferred being active agents within their health care contexts. While all of the men in this study referenced enjoying positive, friendly relations with their physicians, Joel, David, and Michael,

specifically, spoke highly of the bilateral and collaborative relationships they experienced with their respective doctors. Whether it was simply being afforded the time to ask questions, or having a say in their actual treatment plan, these three men felt as though they were truly engaged with their physicians during their appointments. Researchers have identified that a collaborative patient-physician relationship aids medication adherence as well as the hypertension management process as a whole (Flynn et al., 2013; Schoenthaler et al., 2009; Schoenthaler, Allegante, Chaplin, & Ogedegbe, et al., 2004; Ogedegbe, 2012). However, these findings lay in stark contrast to James' stories. He reported maintaining medication adherence, despite recounting his preference to defer any medical decisions strictly to his doctor. Since the men in this study adhered to their medication despite having different care preferences, this finding cautions against any homogenous understandings of patient needs.

In addition, findings from previous literature concerning notions of masculinity affecting Black men's health attitudes and behaviours have indicated that in certain instances, commonly held masculine beliefs influence this population's unwillingness to engage in health promoting behaviours (Evans et al., 2005). Further research has also shown that a common treatment barrier for Black men is their reluctance to discuss their health with friends, family, and health professionals (Forrester-Anderson, 2005; Friedman, Thomas, Owens, & Hébert, 2012; Wray et al., 2009). In some ways, these finding were reflected in this investigation, as the participants in this study expressed how notions of masculinity oftentimes interfered with Black men, in general, and their willingness to engage in open dialogues about their health with family and friends. However, in contrast to participants' generalizations about this specific population, the

men in this study expressed how they had no issues with discussing aspects of their health with others, and after being given the time and space to open up about their experiences, participants candidly talked about their hypertension/illness experiences with me. According to Dwyer and Buck (2009), being an insider while conducting this study may have inherently afforded me an advantage in gaining the acceptance and trust necessary for individuals such as these participants to openly discuss their health experiences with others.

Despite sharing common experiences, it appears that participants still interpret their hypertension diagnosis, and negotiate this condition into their everyday lives in various ways. This is of great significance, as Black populations are commonly erroneously grouped as a homogenous population, even though they migrate from different countries, speak different languages, and maintain different cultures and traditions. As a result, hypertension programs or treatments that are recommended for this population as a whole, in turn, fail to recognize the differences that persist amongst these groups of people (Dasgupta, 2014; Weber, 2014). Indeed, the participants in this study presented different perspectives regarding their hypertension experiences. Thus, simply categorizing these individuals only by the colour of their skin ultimately hinders our understandings of how a condition such as hypertension affects these different men, because we begin to lose sight of their unique individual experiences. Here, I am not suggesting that research focusing solely on Black individuals or other visible minority populations be ceased, as important contextual factors like those depicted in this study (i.e., racism) can certainly affect some segments of the population and not others. Rather, I argue for investigators, educators, professionals, and lay individuals alike to look for

other factors outside of phenotypic traits to gain better understandings of individuals belonging to particular ethnic or minority groups.

Methodological Considerations, Limitations and Future Directions

While the results from this investigation support knowledge drawn from previous research, it also adds to the current discourse concerning hypertension experiences by incorporating the voice and perspectives of a diverse group of Black Canadian men, that to the best of my knowledge was otherwise non-existent. It is hoped that the findings from this study will present care providers, educators, and researchers' unique insight into this subset of the population.

In recent years, considerable strides have been made in implementing tailored health programs for Black populations in the United States (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). For these men, some of the interventions have focused on raising awareness and educating individuals about hypertension prevention measures, and assisting diagnosed men attain blood pressure control (Hess et al., 2007; Savoca et al., 2013; Victor et al., 2011). Though these authors have suggested their interventions were carried out with success, their programs failed to recognize and address the broad spectrum of determinants that affect the well-being of these individuals. Furthermore, by implementing these types of interventions on an entire population of Black men, especially in Canada where this population is very diverse, researchers and professionals, in turn, categorize this entire population into one population, and disregard the fact that these men may hold different values, cultures, and traditions that may differentially effect the ways in which they seek or conduct health promoting behaviours.

According to the World Health Organization (2005), health promotion is defined as “the process of enabling people to increase control over their health and its determinants, and thereby improve their health” (p. 168). In light of this definition, the findings from my study suggest that discussions concerning health promotion amongst this community of men be equally inclusive of constructs existing at the individual, community, and organizational levels. It can be argued that neglecting these issues fosters a disempowering environment, as it fails to tackle important concerns that affect these individuals’ well-being. For instance, by only addressing typical biomedical views that attribute the source and maintenance of this condition to the individual alone, we lose sight of the greater processes (i.e., the social struggles created by racist interactions) that affect these men and the larger visible minority population as a whole. Thus, from a health promotion perspective, this study advocates for investigators, health professionals, and educators to broaden their discussions to be inclusive of the structures that place visible minorities in an inferior position in comparison to their White counterparts when implementing health initiatives or research while working with this population.

Additionally, pharmacological treatments are considered an important therapy for hypertensive individuals. The men in this study ascribed different meanings to their medication; it shaped how they made sense of their hypertension, and how they subsequently negotiated this condition into their everyday lives. Future research directed at examining how hypertensive individuals make sense of their medication can illuminate novel information regarding whether or not its sometimes disempowering properties affects physiological measures of blood pressure or their health and well-being in any way. Moreover, since participants in this study felt as though the greater proportion of

Black men shied away from discussions about health, research focusing on creating empowering environments for this population to discuss their well-being with others may provide useful tools to care providers working with this population.

Lastly, given that narrative inquiry has a variety of different methods and approaches that can be utilized to study the ways in which people create meaning in their lives, the findings from this study were bound by the methodology I chose to examine Black men's hypertension experiences in Ontario, Canada. Therefore, different methodological perspectives might add different insights into Black men's hypertension experiences. Additionally, it is important to note that the narratives depicted in this study were confined by the particular characteristics of the four men that took part in this investigation. Participants were all older Black men, and had their blood pressure well controlled. Therefore, given that hypertension oftentimes goes unnoticed, and is said to develop at younger age for Black populations, future studies concerning these groups of men may provide other useful interpretations of hypertension experiences (Olives, Myerson, Mokdad, Murray, & Lim, 2013; Weber et al., 2014). Since the men in this study were also of different nationalities, research focusing on the hypertension experiences of Black populations consisting of the same nationality may contribute further insight into specific ethnic disparities that may exist in and amongst different Black populations.

Final Considerations

The purpose of this investigation was to explore how Black men in Ontario, Canada made sense of their hypertension diagnosis, and how they negotiated this condition into their everyday lives. Utilizing narrative inquiry, I explored how four men

from this demographic and geographical area experienced and negotiated hypertension from its onset to its current manifestations. By situating this study within a Critical Race Theory framework, I was able to examine how stories concerning participants' hypertension, and other aspects of their lives, were shaped by power relations embedded within their social, political, and historical contexts. This approach illuminated insights into Black Canadian men's thoughts and understandings, and their experiences that otherwise have been predominately projected through biomedical views, which oftentimes portrays this population in a negative light.

Though many of the findings concerning this particular group of men's hypertension experiences were demonstrated in previous research, it is important to note that this study contributes to new understandings about how notions of ethnicity and health intersect in Canada. This investigation not only demonstrated how racism affected each of the participants, but also challenges mainstream perceptions of *race* and the classification of Black populations into one ethnicity. By illuminating participants' unique and varying perspectives that influenced their hypertension experiences, this study offers educators, researchers, and care providers insight into this diverse population of men.

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Appendix A

Text appearing on all study-related posters:

**PARTICIPANTS NEEDED FOR
RESEARCH Regarding High Blood Pressure**

We are looking for volunteers to take part in a study regarding
Black men diagnosed with high blood pressure.

As a participant in this study, you would be asked to
*take part in two interviews, at a location of your choosing, chronicling
your experiences handling hypertension in Ontario, Canada.*

For more information about this study, or to volunteer for this study,
please contact:

Lilian Magalhães (Principal Investigator)

[REDACTED]

[REDACTED]

OR

Rob Haile (Master's Student)

[REDACTED]

Appendix B

VISIT	RECOMMENDATION
First	<p>If patient demonstrates hypertensive urgency/emergency: diagnosis is made at initial visit</p> <p>If SBP is ≥ 140 and/or DBP is ≥ 90 mm Hg - second visit is scheduled within 1 month</p>
Second	<p>If SBP is ≥ 180 and/or DBP is ≥ 110 mmHg or 140-179/90-109 with organ damage, diabetes, chronic kidney disease– diagnosis is made at second visit</p> <p>If SBP is ≥ 140 -179 and/or DBP is ≥ 90-109 mm Hg - 3rd visit is scheduled</p>
Third	<p>If SBP is ≥ 160 mm Hg and/or DBP is ≥ 100 mm Hg – diagnosis is made at third visit</p> <p>If blood pressure is $\leq 160/100$ mm Hg - fourth visit is scheduled</p>
Fourth	<p>If SBP is ≥ 140 mm Hg and/or DBP is ≥ 90 mm Hg – diagnosis is made at fourth visit</p> <p>If blood pressure is $\leq 140/90$ mm Hg - continue with follow-up</p>

Source: Dasgupta et al., 2014

Appendix C

1. I would like you to tell me about a little about yourself (i.e., background, country of origin, occupation, etc.)?
2. I would like you to tell me about your story about having and managing hypertension. You can start whenever you like.

[Prompt] – Have you changed since your diagnosis? If so, how?

[Prompt] – How has hypertension affected your work? Recreational activities?

Habits? Future?

[Prompt] – What would have been helpful to you when you were diagnosed with hypertension?

[Prompt] – Some diseases have been described as empowering, would you say that having hypertension has empowered or disempowered you? Why/how?

Appendix D



Research Ethics

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Lilian Magalhaes
 File Number: 104023
 Review Level: Full Board
 Approved Local Adult Participants: 6
 Approved Local Minor Participants: 0
 Protocol Title: The Experiences of Black men living with Hypertension in Ontario, Canada: A Critical Narrative Study
 Department & Institution: Health Sciences/Occupational Therapy, Western University
 Sponsor:
 Ethics Approval Date: September 03, 2013 Expiry Date: August 31, 2014

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Recruitment Items	Appendix D - Email Recruitment	2013/07/03
Other	References	2013/07/03
Recruitment Items	Appendix C - Recruitment Poster & Flyer	2013/07/03
Letter of Information & Consent	Appendix B - Letter of Information & Consent Form	2013/07/03
Other	Appendix A - Interview Guide	2013/07/02
Western University Protocol		2013/07/07
Other	Revised References	2013/08/22
Other	Guideline for Revisions	2013/08/22
Recruitment Items	Revised Recruitment Flyer/Poster	2013/08/22
Recruitment Items	Revised Email Recruitment Script	2013/08/22
Revised Letter of Information & Consent	Revised Letter of Information and Consent	2013/08/21
Recommendations Form	Recommendations	2013/08/13

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussions related to, nor vote on, such studies when they are presented to the NMREB.

The Chair of the NMREB is Dr. Riley Hinson. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Signature

Ethics Officer to Contact for Further Information

Grace Kelly	Vikki Tran	Erika Basile
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This is an official document. Please retain the original in your files.

Western University, Research, Support Services Bldg., Rm. 5150
 London, ON, Canada N6A 3K7 t. 519.661.3036 f. 519.850.2466 www.uwo.ca/research/services/ethics

Appendix E

Letter of Information

The Experiences of Black men living with Hypertension in Ontario, Canada: A Critical Narrative Study

Principal Investigator

Dr. Lilian Magalhães, MEd, PhD
Associate Professor

School of Occupational Therapy

Faculty of Health Sciences

Western University

Elborn College, [REDACTED]

[REDACTED]

[REDACTED]

Co-Investigator

Rob Haile, MSc. Candidate 2014
Student Researcher

Health & Rehabilitation Sciences

Faculty of Health Sciences

Western University

Elborn College, [REDACTED]

[REDACTED]

[REDACTED]

This letter provides key information pertaining to a research study being conducted by Dr. Lilian Magalhães and Rob Haile, a Master's student, on Black men and their hypertension experiences. We invite you to participate in this study, so please take your time in reading this letter. If you have any further questions or concerns, please don't hesitate to contact either of the investigators.

Invitation to Participate

You are being invited to participate in this research study regarding Black men and their hypertension experiences, because you have indicated that you're a Black male experiencing hypertension as your primary health concern and you currently reside in London, Ontario.

Purpose of the Letter

The purpose of this letter is to provide you with information required for you to make an informed decision regarding participation in this research.

Purpose of this Study

The purpose of this study is to examine how Black men experience hypertension. Specifically, the researchers are interested in exploring how Black men make sense of, and how they manage this condition within their daily lives, as well as their experiences in the health care system. It is hoped the findings from this study will contribute to the

body of knowledge about the issues relating to hypertension control and management as perceived by the individuals affected, as well as how social, economic, cultural, racial, and other conditions influence this experience.

Inclusion Criteria

Individuals whom are male, self-identify as being black, over the age of 18, fluent in reading and speaking in English, diagnosed with hypertension and experience hypertension as their primary health concern are eligible to participate in this study.

Study Procedures

If you agree to participate, you will be asked to partake in two audio-recorded interviews to share your experiences regarding your hypertension and your resultant day-to-day activities. It is anticipated each interview will last between one-to-two hours. In the case that unforeseen circumstances prematurely conclude either of the two interviews, a third interview may be scheduled, at a date and time of your choosing to finalize data collection. The interviews will take place in comfortable settings as chosen by you. It is anticipated the locations will be void of distractions, such as private rooms in community organizations, the public library, or in designated interview rooms at Western University. There will be a total of four-to-six participants for this study.

The use of an audio recording device during the interviews is essential in ensuring the accuracy of the data. If you do not wish to be audio recorded then you should not participate in this study. However, if you choose to participate, you will be given the opportunity to read over the transcripts of your interviews and to clarify any misunderstandings.

Possible Risks and Harms

While there are no known physical risks for participating in this study, emotional, uncertain or uncomfortable situations may occur, since participants in this study will be asked to share personal stories. Participants will be free to choose what they wish to talk about and what they wish not to talk about.

During data analysis, how the researcher interprets the data may not always fit exactly with how participants interpret their experiences. Following the conclusion of the research, participants will be given the opportunity to obtain and review their narratives. If significant discrepancies in narrative meanings arise, both interpretations (researcher and participant) will be included. If participants continue to have reservations about having both accounts included in publications then the data in question will be withdrawn.

Possible Benefits

There are no known personal benefits to participating in this research. However, by partaking in this study your experiences will help inform the existing body of literature concerning hypertension and may help provide important insight to health care providers caring for Black men with hypertension.

Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your care and future endeavors in the community. Any data gathered/collected prior to withdrawal will still be used unless stated otherwise.

Confidentiality

The data collected from this research will be kept confidential, and access to this information will be limited to the investigators partaking in this study. When the resultant study is published as part of a Master's dissertation and as publications, your name and any information identifying you will not be disclosed. A pseudonym (i.e. fake name) will be used in place of your real name to conceal/protect your identity. Quotes from the interviews will be used in the publications, reproduced word for word, but your name will not be connected to the quotes. All hard copy materials will be locked in a cabinet within a secure research office at Western University, whereby access is restricted only to the research investigators. All electronic materials will be saved on an encrypted computer within a locked research office at Western University, as well as an encrypted laptop that will be transported by the co-investigator in a locked briefcase. The identifier list containing the real names of participants will be stored under secure conditions with Dr. Lilian Magalhães. Per Western University policy, all data pertaining to this research will be destroyed five years after the study has been completed. Representatives of Western University Non-Medical Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Contacts for Further Information

If you require any further information regarding this research project or your participation in the study you may contact the Principle Investigator, Lilian Magalhães at [REDACTED] or [REDACTED], or the Co-Investigator, Rob Haile at [REDACTED] or [REDACTED]. If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics at [REDACTED] or [REDACTED].

Publication

When the results of the study are published, your name will not be used. If you would like to receive a copy of any future study results, please contact the Principle Investigator, Lilian Magalhães at [REDACTED] or [REDACTED], or the Co-Investigator, Rob Haile at [REDACTED] or [REDACTED].

Other Information about this Study

Per Western University policy, data will be stored for 5 years and destroyed after this period. Hard copies will be shredded, while digital copies and audio files will be deleted.

Reimbursement for expenses will be provided to compensate you for incidental costs, such as bus tickets or parking that you may incur as a result of participating in this study. Compensation will be given at the completion of each interview. You will only be reimbursed for costs incurred during interviews that you attend. However, if you attend an interview and for some unforeseen circumstance have to leave before its completion, you will still be reimbursed for any incidental costs incurred for your participation.

This letter is yours to keep for future reference

Appendix F

Consent Form

**The Experiences of Black men living with Hypertension in Ontario, Canada: A
Critical Narrative Study**

Principal Investigator

Dr. Lilian Magalhães, MEd, PhD
Assistant Professor

School of Occupational Therapy

Faculty of Health Sciences

Western University

Elborn College, [REDACTED]

[REDACTED]

[REDACTED]

Co-Investigator

Rob Haile, MSc. Candidate 2014
Student Researcher

Health & Rehabilitation Sciences

Faculty of Health Sciences

Western University

Elborn College, [REDACTED]

[REDACTED]

[REDACTED]

I have read the Letter of Information and have had the nature of the study explained to me. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.

Name of Participant (Print)

Date

Signature of Participant

Name of Person Obtaining Consent (Print)

Date

Signature of Person Obtaining Consent

Curriculum Vitae

Name:	Rob Haile
Post-secondary Education and Degrees:	<p>Master of Science Candidate, Health Promotion Faculty of Health Sciences, University of Western Ontario London, Ontario, Canada 2012-2014</p> <p>Diploma Pedorthics Continuing Studies, University of Western Ontario London, Ontario, Canada 2008</p> <p>Honours Bachelor of Arts, Kinesiology Faculty of Health Sciences, University of Western Ontario London, Ontario, Canada 2003-2007</p>
Honours and Awards:	<p>Western University HRS Research Forum Best Poster Winner 2014*</p> <p>Western Graduate Research Scholarship 2013</p> <p>Western Graduate Research Scholarship 2012</p>
Related Work Experience	<p>Health Promotion Student/Research Assistant Oxford County Public Health 2013-2014</p> <p>Teaching Assistant The University of Western Ontario 2012-2014</p> <p>Research Assistant BLACCH Health Study 2012-2013</p>

Conference Presentations and Posters:

*Haile, R., Rudman, D., and Magalhães, L. (2014). The experiences of Black men living with hypertension in Ontario, Canada: A critical narrative study. Poster presented at *Western University HRS Research Forum*.