CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The White Paper on Health identifies hypertension as one of the major conditions contributing to disability in South African adults (Steyn 1998:917). Factors like lack of knowledge about the disease itself, side effects of the anti-hypertensive drugs, lack of support and stress brought by the disease may lead to non-compliance with regular check-ups. The aims of hypertension management are to improve quality of life and prevent complications (Lahdenpera & Kyngas 2000:826). According to Bushnell and Smith (1998:158), nurse practitioners can implement several interventions to achieve their goals in hypertension management. Some hypertensive patients may respond well on non-drug intervention, which requires lifestyle modifications. Drug intervention is implemented when non-drug intervention is ineffective. Milne (1995:34) is of the opinion that support groups can increase patients’ responsibility for their own health.

1.2 BACKGROUND AND RATIONALE

Seven primary health care centres in Carletonville District established support groups for patients with chronic diseases. These groups consist of specific patients and meet on a monthly basis on different dates and at different clinics. There are specific dates
for patients with hypertension only and different dates for ones with hypertension plus diabetes mellitus or asthma.

The nurse teaches the patients about their conditions, the importance of treatment compliance, side effects of specific drugs and lifestyle modifications during the support group sessions. They are encouraged to share their experiences, fears and ideas. They also give each other moral support and counsel on how to improve the quality of their lives. According to Kurtz (1997:21), support groups often rely on professional information brought to the group by experts. Therefore, nurses at clinics facilitate these support groups.

After the above-mentioned activities, the blood pressure levels of the patients are measured and those on drug intervention are given medication. Those on non-drug intervention are reassured about their blood pressure levels and encouraged to improve their lifestyle modifications and keep on attending support group sessions. The dates for the next sessions are then given. Sometimes groups are so large that they need to be divided into two or more groups that will be attended to on different dates.

The researcher realised that in one of the clinics in the Carletonville District, West Rand region of the Gauteng Province, not every hypertensive patient attended the established hypertension support groups. This made the researcher wonder whether the support groups were of any benefit to those who attended or not. The researcher observed that some hypertensive patients missed the hypertension support group sessions and came on a different date for their blood pressure check and medication
only. As these hypertension support groups are newly established, it is imperative to monitor their progress to ensure that they reach the expected goal. It is of no use to form a support group that is perceived to be unnecessary by its members. According to Kurtz (1997:80), one has to see a need to be affiliated to a support group in order to be committed to regular attendance. This study seeks to explore and describe the perceptions of hypertensive patients regarding the established hypertension support groups in Carletonville District. Hypertensive patients who do and ones who do not attend these support groups will be asked about the support groups.

Lahdenpera and Kyngas (2000:827) state that compliance is poorer in diseases that demand a change in lifestyle than in ones that do not require any action. Collins and Ivey (1999:331) state that despite the fact that hypertension has serious consequences, most hypertensive patients do not adhere to medication or lifestyle modification. According to Kurtz (1997:501), support groups are useful in chronic diseases because similarity of suffering from a specific common problem creates environments with a high frequency of expressed empathy, personal disclosures, sense of belonging and respect of members as unique individuals.

In a study to identify the need for diabetic support groups in an urban black community in Umlazi “E” Section, Mkhize (1996:ii) found that there was a great need for diabetics to be informed about their disease. The need for support groups for hypertensive patients should also be explored. Hypertensive patients need to be fully taught about their condition in order to avoid serious complications that may arise due to lack of knowledge. If hypertensive patients can understand the causes, effects and
treatment of hypertension well through the help of clinic-based support groups, they can be a great source of information to the entire community.

Although there are various support groups currently running in South Africa, there seems to be no easily available information regarding these groups (Mkhize 1996:16). The perceptions of hypertensive patients about hypertension support groups in Carletonville District have not been documented before.

Mkhize (1996:13) cites Seevers (1991), who states that support groups in Colorado are powerful and constructive tools for helping people to help themselves and others. According to Kriegsman, Pennix and van Eijk (1995:39), positively perceived family support in Amsterdam was associated with a favourable course in chronic diseases. Not every hypertensive patient may experience sound family support. Clinic-based hypertension support groups may be of great help in such a case. In their study in Alexandra (South Africa), Stewart, Eales and Shepard (1999:14) to determine barriers to compliance with health advice and clinic attendance, it was found that compliance with health advice was poor compared to clinic attendance. This implies that clinic attendance does not guarantee health advice acceptance. Therefore, members of support groups may experience a sense of belonging and freedom, identification with fellow members and acceptance of the problem, which may lead them to perceive health advice as a viable strategy for self-care and management of the disease.

Lack of knowledge may lead to misconceptions about hypertension. In a study to determine how people in Ga-Rankuwa Township understand high blood pressure, Henbest and Tau (2000:13) found that people understood hypertension as “boiling
blood” and “excess blood in the body”. Hypertensive patients may correctly understand hypertension uniformly only if they are involved in hypertension support group sessions. However, patients may not always be able to attend the clinic due to transport issues, financial constraints and long queues (Stewart et al 1999:14). In Carletonville District transport and financial constraints might be barriers.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Kurtz (1997:17) is of the opinion that support groups exist for the purpose of helping their members and cannot remain in existence without new members. Members cannot benefit without attending. Steyn (1998:918) states that hypertensive patients should be active participants in their own hypertension management. In Carletonville District this participation is ensured through support groups of which some hypertensive patients attend and some do not. This study, therefore, seeks to explore and describe the perceptions of hypertensive patients regarding the support groups.

1.4 PURPOSE OF THE STUDY

The purpose of this study is to explore and describe the perceptions of hypertensive patients regarding hypertension support groups in Carletonville District in order to make recommendations based on the research findings that could lead to the improvement of the quality of management of hypertensive patients.
1.5 RESEARCH QUESTIONS

The following research questions will direct this study:

• What are the strengths of the hypertension support groups as perceived by hypertensive patients in Carletonville District?

• What are the weaknesses of the hypertension support groups as perceived by hypertensive patients in Carletonville District?

• Why do some hypertensive patients in Carletonville District not attend the hypertension support group sessions?

1.6 SIGNIFICANCE OF THE STUDY

Focusing on the strengths and rectifying the weaknesses of the established hypertension support groups will contribute to quality hypertension management in the Carletonville District. The study results will be used as a viable strategy to improve quality of life for hypertensive patients and has the potential to help reduce the number of hypertensive patients attending the clinic at a time.
1.7 DEFINITION OF CONCEPTS

Hypertension

Hypertension is the elevation of blood pressure above 150mmHg (systolic) and/or 90mmHg (diastolic) for those below 30 years of age, and above 160mmHg (systolic) and/or 95mmHg (diastolic) for those over 30 years of age (Edwards 1997:22). Collins English Dictionary (1991:765), defines hypertension as “abnormally high blood pressure”. Edinburg (1995:39) defines hypertension as “a condition in which the level of the arterial blood pressure is raised”.

Hypertensive

Hypertensive refers to “a person affected with hypertension” (Blackwell’s Nurses Dictionary 2005:288).

Nurse

Nurse refers to a person who has completed a comprehensive programme of basic training as a nurse (general nursing, midwifery, psychiatric nursing and community service) and is registered under section 16(iii) of the Nursing Act, 50 of 1978, as amended (South Africa 1978:5) as approved by the South African Nursing Council (SANC).

In this study, a nurse relates to a person registered as a nurse under section 16(iii) of the Nursing Act, 50 of 1978, as amended (South Africa 1978:5) who is working at a
community health care centre and facilitates hypertension support groups at a given clinic.

**Patient**

Patient means a person (including all ages and both sexes) as a total being, body, mind and spirit, sick or well, who needs help to complement his specific ability to accept optimal responsibility for his own health (Searle & Pera 1995:175). In this study, patient refers to persons of both sexes from the age of 19 to 82 with raised arterial blood pressure on drug and/or non-drug interventions, who attends or does not attend the hypertension support groups at seven different clinics in the Carletonville District.

**Perception**

King’s Open Systems framework defines perception as “a process of organizing, interpreting and transforming information from sensory data memory” (Chinn & Kramer 1995:180). In this study, perception refers to the way in which hypertensive patients view the strengths and weaknesses of the hypertension support groups in the Carletonville District.

**Support group**

Kurtz (1997:4) describes a support group as “a non-profit collection of persons with a common problem for the purpose of emotional support and education that is facilitated by professionals and is linked to a social agency or a larger formal
organization”. In the context of this study, a support group refers to a collective group of persons with raised levels of blood pressure who meet at the clinics on scheduled dates for moral support, sharing of experiences and ideas, health education, blood pressure level monitoring and medication therapy.

1.8 RESEARCH DESIGN AND METHODOLOGY

The research design refers to “the overall plan for addressing a research question or testing a research hypothesis, including specifications for enhancing the integrity of the study” (Polit & Hungler 1999:713). The research design for this study is quantitative descriptive and seeks to explore and describe the perceptions of hypertensive patients regarding hypertension support groups. The design assisted the researcher to develop information on the phenomena that is accurate and interpretable.

Hypertensive patients who attend clinics in the Carletonville District formed the population of this study. Stratified random sampling was used to select a total of three hundred and fifty subjects who gave informed consent to participate in the study.

Data was collected through a simple questionnaire with closed questions. Descriptive and inferential statistics were used to analyse it by computer. These statistics were useful to summarise data and draw conclusions about the perceptions of hypertensive patients on the value of support groups.
1.9 ASSUMPTIONS

Assumptions refer to “basic principles that are accepted as being true on the basis of logic or reason, without proof or verification” (Polit & Hungler 1999:695). The basic assumption for this study is that hypertension support groups are of good assistance to hypertensive patients. The specific assumptions underlying this study are as follows:

1.9.1 Ontological assumption

In this regard it is assumed that using a questionnaire with structured questions, respondents can answer in a way that reveals their perceptions regarding the hypertension support group.

1.9.2 Assumptions regarding methodology

In this regard it is assumed that using a questionnaire with structured questions, respondents can answer in a way that reveals their perceptions of hypertension support groups.

1.10 SCOPE AND LIMITATIONS OF THE STUDY

The study was done among diagnosed hypertensive patients in the Carletonville District and consisted of patients that attend the support group for hypertensive patients as well as patients who do not attend these support groups. Therefore, it might not be possible to generalize the study findings to the entire Gauteng Province as the results might only be applicable to the hypertension support groups in clinics around the Carletonville District where the study was conducted.
1.11 OUTLINE OF THE STUDY

This chapter introduced the study and discussed the problem, rationale and purpose of the study, as well as the research design and methodology.

Chapter 2 discusses the literature review conducted for the study.

Chapter 3 describes the research design and methodology.

Chapter 4 presents the findings from the data analysis and interpretation.

Chapter 5 concludes the study, briefly discusses its limitations and makes recommendations for practice, education and further research.

1.12 CONCLUSION

This chapter introduced the study, discussed the research problem, purpose and significance of the study, defined terms used in the study, and briefly described the research design and methodology.

Chapter 2 covers the literature review conducted for the study.
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is “a process of finding, reading, understanding and forming conclusion about the published research and theory by authoritative scholars on a particular topic” (Brink 1996:76). Mouton (2001:91) states that the review “should be structured around the key concepts of the research problem and the research questions that are asked”. This chapter starts with the conceptual framework that guided the study and the concepts from the framework are used to discuss and describe the key concepts of the study.

2.2 CONCEPTUAL FRAMEWORK

Homans’ (1951) interaction conceptual framework forms the basis of this study. Concepts in the framework are activity, interaction, sentiment, norms, social system, external and internal systems. These concepts are interdependent (Steyn & Uys 1998:64).

2.2.1 Activity

Steyn and Uys (1998:64) cite Homans (1950) that the deliberate formation of groups mainly occurs when, in the judgement of one or more persons, a number of
individuals are needed to execute a certain task or reach a certain goal. In order to reach a goal, a number of activities are involved. Activity refers to tasks that the members of a group do as members of that group in co-operation with other members. Toseland and Rivas (2001:22) point out activities involved in support groups such as helping members cope with stressful life events, revitalizing and enhancing members’ coping abilities so that they can effectively adapt to and cope with future stressful life events. Kurtz (1997:21) states that support groups give support, impart information, convey a sense of belonging, teach coping methods and create a platform of communicating experiential knowledge.

2.2.2 Interaction

Interaction is “a mutual or reciprocal action or influence” (Collins English Dictionary 1991:804). According to Steyn and Uys (1998:64), interaction means that one person’s activity follows or is stimulated by another person’s activity, no matter what those activities may entail. Toseland and Rivas (2001:70) cite Northern’s (1969) definition of interaction as "the dynamic interplay of forces in which contact between persons results in a modification of the behaviour and attitudes of the participants. It occurs when there is communication between persons, which can either be verbal, using words, or non-verbal, using symbols.” Kurtz (1997:99) states that most support groups prefer the round robin method where members take turns in talking because there is no direct response across the circle.
2.2.3 Sentiment

Homans (1950) (cited by Steyn & Uys 1998:64) defines sentiment as “the inner feeling that a member of a group experiences towards other members of the group and their activities”. *Collins English Dictionary* (1991:1410) defines sentiment as “susceptibility to tender, delicate, or romantic emotion; a thought, opinion, or attitude; a feeling conveyed, or intended to be conveyed, in words”. Sentiment may vary according to the number of group members who share a similar sentiment and convictions they may have in this regard.

2.2.4 Norms

*Collins English Dictionary* (1991:1065) defines norm as “an average level of achievement or performance as of a group or person; an established standard of behaviour shared by members of a social group to which each member is expected to conform”. Norms refer to rules that regulate behaviour in the group and are accepted by members of the group as valid. A norm can be in the form of a definite statement, which specifies what members, or other people must, should, or are expected to do under certain circumstances (Homans 1950 in Steyn & Uys 1998:64). Even though all members are aware of these rules, not everyone conforms to them. When norms are internalised, group members experience a need to act in accordance with the norms.
2.2.5 Social system

Homans (1950) (cited in Steyn & Uys 1998:65) states that the group “as a social system consists of the activities, interactions and sentiments of group members together with the interrelationships between these elements during the time that the group is active. Everything that is not part of the social system is counted as the environment in which the group exists as a system. The social system consists of the external and internal systems.”

2.2.5.1 External system

The external system is the group behaviour, activity, interaction and sentiment and their interrelationship. It is not the environment but the active relationship the group has with its environment.

2.2.5.2 Internal system

The internal system is the interactions, activities and sentiments above and beyond the interaction of the external system caused by expression of the sentiments by group members towards one another in the course of their life together.
2.3 SUPPORT GROUP PROCESSES

Based on Homans’ interactional conceptual framework, the processes within the hypertension support group are its activities, namely health talk, sharing experiences and supporting each other.

2.3.1 Health talk about hypertension

The nurse as the group facilitator gives the health talk because she is trained in chronic disease management. Hypertensive patients are encouraged to engage in peer education and extend their knowledge to the community. The health talk covers the definition, causes, signs and symptoms as well as the management, prevention and complications of hypertension.

2.3.1.1 Definition of hypertension, causes, signs and symptoms

Goldsmith (2000:16) states that “blood pressure relates to the amount of force blood exerts against the walls of arteries as it is pumped through them”. Hypertension occurs when the systolic pressure (force of the heart’s contraction as it pumps blood out of the left ventricle into the aorta) is 140mmHg or above and the diastolic pressure (resting force of the small arteries throughout the body) is 90mmHg or above (Hines 2000:14).

Woods (1999:41) points out that a family history of hypertension predisposes an individual to hypertension. Other risk factors include smoking, obesity, inactivity and diseases like diabetes mellitus. Daly (2000:16) states that sodium intake and alcohol
consumption contribute to hypertension. Stressful situations in which people live in also contribute to hypertension (Edwards 1997:22).

Edinburg (1995:39) points out that hypertension is asymptomatic. Most patients feel well except a few who complain of headache, which in most cases is not caused by hypertension itself. Patients can be diagnosed upon assessment by a health professional. However, in a study at Ga-Rankuwa Hospital to determine whether patients can tell if their blood pressure is high, Henbest and Tau (1995:529) found that 77% of the patients’ responses correlated positively with their actual blood pressure. This implies that patients know about symptoms like headache, sweating, feeling hot, dizziness and palpitations and are able to link them to hypertension.

In a study at the University of the Witwatersrand in 1998 on lay people’s perceptions of hypertension, Wright (1998:954) found that people had different interpretations of and myths about hypertension.

2.3.1.2 Management of hypertension

Blackwell’s Nursing Dictionary (2005:287) defines hypertension as “blood pressure readings in which either or both systolic and diastolic pressure readings are significantly higher than the mean for the population”.

Steyn (1998:917) reports that half of all hypertensive patients in a community are not known to health service professionals and half of those who are known are untreated while those who receive treatment are inadequately treated, leading to eight percent of
reported deaths in South Africa being caused by cerebrovascular accidents. Hypertension management includes non-drug measures (*lifestyle modification*) and/or drug therapy (Benjamin 1997:10).

Milne (1995:36) maintains that restricting salt intake and increasing potassium intake from fresh fruits and vegetables improve control and can enhance the effect of drugs. Exercise and increased activity may lead to a decrease in weight, which will lead to a drop in systolic blood pressure. Patients are advised to avoid alcohol intake and smoking. Sorrentino (1999:89) recommends stress management and less saturated fat intake as part of non-drug management.

Stress plays an important role in the lives of hypertensive patients. In 1999, Stewart et al (1999:16) found that Black hypertensive patients at a chronic diseases clinic in Johannesburg were always subject to worry and stress due to financial and social problems.

Drug therapy refers to patients who are taking medication to control their hypertension. According to the Executive Committee of the Southern African Hypertension Society (1995:1324), drug management is done in three steps. The first step consists of a low dose of hydrochlorothiazide (12,5mg-25mg) once a day. Sorrentino (1999:89) states that this drug is easy to use, effective and inexpensive. Benjamin (1997:10) adds that this drug has minimal lipidaemic effects and has never been shown to increase coronary heart disease risk. It also decreases the incidence of osteoporosis.
The second step is introduced if the first does not control the blood pressure. A Beta-blocker, for example Atenolol (50mg), is given only to those below the age of forty-five and Reserpine (0.125mg) for those above forty-five years of age.

The third step is considered when a patient shows signs of end organ damage. This step consists of ACE inhibitors, such as Perindapril (2-4mg) daily. Calcium channel blockers may also be added, like Nifedipine 5mg. Sorrentino (1999:90) found that treatment with the ACE inhibitor improved the overall survival and quality of life for patients with class IV heart failure.

“The choice of a drug is determined by patient characteristics, drug efficacy, contraindications and concomitant disorders” (Sorrentino 1999:89). Health professionals should guard against side effects of drugs at all times.

2.3.1.3 Prevention of hypertension

Today people are subject to stress due to various factors like unemployment and poverty. According to Stanhope and Lancaster (1988:504), hypertension is a common major community health problem that requires lifestyle modification by every individual. Risk factors amenable to modification of lifestyle include obesity, alcohol and sodium intake, cigarette smoking, and stress. Lifestyle modification will therefore include the following:

- Regular exercise which should be increased gradually
- Regular blood pressure check ups
- Low salt intake
• Limitation in alcohol consumption
• Quit smoking
• Stress management
• Deep relaxation techniques
• Weight loss or maintenance of ideal body weight

This implies that every individual should practise the above lifestyle modification to prevent hypertension or to maintain good health.

2.3.1.4 Complications of hypertension

“Hypertension ravages vital body organs, assaults fragile tissues in the eyes and kidneys; hardens arteries and arterioles, enlarges and weakens the heart leading to congestive heart failure, produces untold disabilities and death” (Goldsmith 2000:16).

Compliance with both drug and non-drug management prevents these complications. In their study on compliance of patients with hypertension and associated factors, Kyngas and Lahdenpera (1999:832) found that compliance with the dietary restrictions was poorest while compliance with medication was best.

2.3.1.5 Sharing experiences, moral support and peer counselling

Other activities of the hypertension support group are sharing experiences, moral support and peer counselling. The nurse as the group facilitator should increase patients’ belief and confidence in the efficacy of the group mode so as to instil
positive expectations of the support group’s healing properties. In order for patients to open up and disclose their feelings and experiences, they need to see themselves as fitting into the group, and welcomed by their peers (Yalom 1995:6). According to Kurtz (1997:83), support group members should learn to help others through telling their story in a meeting, talking to a potential new member, and making other members feel free in order to open up.

Hypertensive patients who survived cerebrovascular accidents share their experiences and give motivational speeches on how to overcome the situation. Others give advice on how to prepare their diet and what to eat and not to eat, such as lowering salt and fat intake. Those who smoke and take alcohol express their difficulty in quitting and are given relevant tips and information on external rehabilitative services suitable for them. Some who have overcome the above situations share their coping strategies.

In their study on group support for couples coping with a cardiac condition in Canada, Stewart, Davidson, Meade, Hirth and Weld-Viscount (2001:194-195) found the following:

**With regard to social exchange**, participants shared information, verbalised common concerns and potential solutions, and exchanged support within the group.

**With regard to social learning**, they learned through role modelling by other members. Information about coping strategies and lifestyles management was also shared.
One of the survivors alluded that “I liked it because it wasn’t academic. It was very straightforward, and it was coming from the peer leader in a manner that, ‘this is my personal experience, and this is the way it happened to me’. And I think it had more impact than if we had somebody give a formal lecture.”

Peer facilitators and other group members were mentioned as important sources of informational support where they provided understandable and user-friendly information.

The key types of emotional support provided by the groups were listening, sharing, empathy, understanding, reassurance, companionship and concern. Everyone had an opportunity to freely express himself or herself.

### 2.3.2 Interaction in the hypertension support group

Where people are gathered together in a group, there is communication. Communication can either be verbal or non-verbal with the intention to convey a message. Verbal and non-verbal communication is therefore the component of interaction. Special attention is needed not to distort the meaning intended by the communicator. Group members who have hearing and visual impairments should be accommodated.
2.3.2.1 Patterns and factors that influence interaction

According to Toseland and Rivas (2001:74-77), interaction has patterns and factors that influence it. The maypole pattern is when the leader is the central figure and communication occurs from leader to member or from member to leader. When members take turns in talking it is referred to as round robin. The hot seat pattern relates to an extended back and forth exchange between the leader and a member as the other members watch. The last pattern is the free floating in which all members take responsibility for communicating according to what is said and not said in the group.

The factors that influence interaction include the emotional bonds that develop between group members, subgroup development in the group, the size and physical arrangement of the group. Positive bonds such as interpersonal liking and attraction increase interpersonal interaction whereas negative emotional bonds reduce solidarity between members and result in decreased interpersonal interaction.

Cartwright (1968:100) states that members gain satisfaction from contributions made by others to attainment of their common goal. Corey (2000:114) emphasises that members should be encouraged to decide what issues to explore in the group and learn how to become an integral part of the group and yet retain their individuality. This will help members to talk directly about their feelings and have meaningful interactions as they talk to and not about one another.
Toseland and Rivas (2001:74-77) go on to say that subgroups form from emotional bonds and occur naturally in all groups. They help make the group attractive to its members because individuals look forward to interacting with those to whom they are particularly close. Benefits of subgroups are more visible if the group is large and subgroups can be used to work on a specific task and then report to the whole group. However, subgroups can be a threat where the attraction of members within a subgroup becomes greater than their attraction to the group as a whole.

Size and physical arrangement are other factors that influence interaction patterns. An increase in the size of the group results in an increase in potential relationships, for example, with three people there are six potential combinations of relationships. Seating in a circular setting promotes face-to-face interaction and is always preferred to other arrangements.

2.3.3 Norms of the hypertension support group

The interaction in groups is linked to the norms of the group. Group norms are an “unwritten code of behavioural rules” (Yalom 1995:109). Norms can be a prescription for as well as proscription against certain types of behaviour as set by members themselves. Norms stabilise and regulate behaviour in groups and result from what is valued, preferred and accepted in the group (Toseland & Rivas 2001:82), and differ according to the extent that members consider them binding. Some permit a great deal of leeway in behaviour whereas some prescribe narrow and specific behaviours.
The group facilitator shapes norms by backing them with the weight of authority and experience, and by presenting the rationale behind the suggested mode of procedure (Yalom 1995:113). The group facilitator should be seen as a role model in honouring the group norms. Corey (2000:44) points out that the facilitator’s qualities can be fostered in members through demonstration, for example, if the facilitator shows respect by really listening and empathizing, members learn a direct and powerful lesson in how respect is shown behaviourally. The following norms are commonly evidenced in group activity:

Procedural norms

These norms state the basic ground rules of the interaction between members. Steyn and Uys (1998:165) cite Ridgeway (1983) who states that this includes “free talking, members waiting for their turn to talk, where and when to meet, how often and for how long”. Yalom (1995:123) adds that the group “has the power to change these norms if they hamper the development of a potent group”.

Role norms

Yalom (1995:110) concludes that every member has a role to play in nonjudgmental acceptance of others. Ridgeway (1983) cited by Steyn and Uys (1998:166) believes that norms are applicable to specific group members and define the characteristic behaviour expected of each member in particular.
Self-disclosure

Yalom (1995:119) states that patients will not benefit from therapy unless they disclose and do so fully. This should be encouraged and take place at each member’s pace. However, Corey (2000:34) emphasises that it is common to err on either extreme, disclosing too little or too much.

Members as agents of help

Group members should appreciate the valuable help they can provide to one another (Yalom 1995:125). The group facilitator may call attention to incidents demonstrating the mutual helpfulness of members. This implies that group members should be willing to assist each other in any way they can.

Support

Support refers to “providing encouragement and reinforcement to members especially when disclosing” (Corey 2000:41). Yalom (1995:126) states that members should be supportive enough to enable self-disclosure. If members feel safe and supported, they are able to express disagreement and interact actively with each other.
2.3.4 Hypertension support group members’ sentiments

When group members perceive group activities and members as good, they become attracted to the group and therefore feel positive towards members and the group as a whole. If the perception is negative, members and the group as a whole may be rejected.

Yalom (1995:67) describes the attraction that members have for their group and other members as “cohesiveness. Members of a cohesive group are accepting of one another, supportive and inclined to form meaningful relationships in the group. Cohesiveness favours self-disclosure, risk taking, constructive expression of conflict in the group, understanding and patience.”

When cohesiveness increases, attraction increases too and if it decreases, attraction also decreases. Group cohesiveness is not fixed once achieved, instead fluctuates greatly during the course of the group and result in better group attendance and greater participation (Yalom 1995:49).

2.3.4.1 Factors contributing to increased group cohesion

Corey (2000:114) points out that cohesiveness results from forces attracting members to remain in the group and refers to when members experience caring and comfort in the group.

Factors like trust, clarity of group goals, group norms, acceptance, and participation in the group contribute to increased group cohesion.
Trust

Group members go through a test period to ascertain whether it is right for them to belong and stay in the group. Corey (2000:115) states that trusting the group as a unit may increase group cohesiveness and lead to self-disclosure. Toseland and Rivas (1998:184) point out that members need to feel safe and comfortable in order to trust the group.

Clarity of group goals

When group members are clear about the group goals and how to achieve them, they are likely to be attracted to the group (Steyn & Uys 1998:194). Corey (2000: 184) emphasises that goals should be based on shared interests of group members.

Group norms

Norms of non-judgmental acceptance and inclusiveness increase members’ attraction to the group (Yalom 1995:49). According to Steyn and Uys (1998:192), the higher the conformity to norms, the stronger the cohesion of the group.

Acceptance

Steyn and Uys (1998:194) cite Dittes’ (1959) finding that those members who enjoyed a certain level of acceptance from other group members were more attracted to the group than those who were told that they were not accepted. According to
Corey (2000:118), group members who feel accepted can be who they are in the group without risking rejection.

*Participation in the group*

Participation refers to getting involved or being allowed to become involved in a decision-making process, the delivery or evaluation of a service, or even simply to become one of the people consulted on an issue or matter (Jewell 1994:434). It involves the family of members, especially for the elderly and those with a poor mental state. The group facilitator should ensure that everyone is involved in group activities so as to attract members (Toseland & Rivas 1998:184). However, Corey (2000:117) states that it is not possible to engage group members equally in activities and a few may feel isolated or distant from those members who do intensive work. This can be linked to the group size as Steyn and Uys (1998:195) emphasize that a group should be small to allow effective interaction amongst group members. Toseland and Rivas (1998:286) point out that in relatively small groups, members feel that their ideas are considered.

Waterworth and Luker (1990:971) found that some patients participate to please the nurse. This might be due to patients perceiving themselves as having less rights and sense of belonging.

Informed consent, effective patient teaching, information giving, comprehensive answering of patients’ questions, and use of understandable language promote
participation (Jewell 1994:434). Cahill (1996:565) emphasises that a relationship must first exist and last, then a positive benefit should manifest.


2.3.4.2 Factors contributing to decreased group cohesion

If the group provides less satisfaction to the members, its attraction is reduced. The opposite of all the above factors that contribute to increased group cohesiveness reduces group cohesiveness.

Steyn and Uys (1998:197) cite French (1941) that the attraction of a group will be reduced if the group members disagree about the way in which group problems are solved.

When some group members dominate the group, some members become reserved (Yalom 1995:370). Corey (2000:285) states that even group facilitators can reduce the group attraction if they do not have listening skills and are preoccupied with their impact on the group.

From the factors that increase or decrease group cohesion it is clear that if a group has more of the increasing factors, attendance of members can be good and if it has more of the decreasing factors, attendance may be poor.
2.3.5 Support group as a social system

A support group, like any other group, is a social system on its own because the relationship between the group members forms an orderly whole. According to Steyn and Uys (1998:344-347), the structure of a group as a social system consists of role expectations, which refers to the “behaviour of group members in terms of what they think are the expectations”. Norms and values in a group exist to guide or regulate the group members’ behaviour. The social system has both an internal and external system.

2.3.5.1 External system

The external system is the active relationship the group has with its environment. The external system strives to adapt to its environment and achieve its intended goals. It consists of the health system, which includes the nurse as the group facilitator, and patients’ own social system, which includes their cultural beliefs, values, attitudes and personal circumstances.

2.3.5.2 Internal system

The function of the internal system is to control the tension and maintain the normative pattern of the collectivity. Therefore pattern maintenance is a function performed in the social system in order to maintain internal coherence and order. The fulfilment of this function is directly related to members’ commitment and motivation to act in accordance with the normative patterns valid for the group. The other
function of the internal system is integration, that is, the effective organisation of the members, subgroups and their roles in terms of their contributions to the whole. Homan (1950) (cited in Steyn & Uys 1998:65) maintains that “if there is a high frequency of interaction between members of a group in the external system, sentiments of respect and acceptance among group members will lead to interaction above and beyond the interaction that takes place within the external system”. Group members’ expression of sentiments towards one another in their life together constitutes the internal system.

2.3.6 Conceptual framework for hypertension support group

Homans’ (1950) interaction conceptual framework was the basis for this study. The researcher formulated a schematic diagram based on Homan’s concepts as no schematic diagram was available.
Figure 2.1 Homans' Interaction conceptual framework

Source: Steyn and Uys (1998:64)
2.3.6.1 Support group

The support group is the central point of the model because the perceptions formed result from hypertensive patients’ view. It is a structured system that has both internal and external systems. Internally, it has norms that regulate it, positions of group members, size and location where it takes place. It also has activities taking place, interaction amongst members and sentiments of group members as a social system. Externally, it has the health system from which the group facilitator comes. The hypertensive patients also come from their own social system with various cultural and religious beliefs, attitudes and personal circumstances. The support group aims to help members cope with stressful life events and revitalize existing coping abilities (Toseland & Rivas 1998:21).

2.3.6.2 Structure

There are positions, like group facilitation, in the support group to help the group perform its functions effectively to reach set goals. The support group is located at clinics where hypertensive patients receive hypertension treatment monthly. Norms, like collective active participation, confidentiality and respect for one another, regulate the support group. The size of the group is important to enable interaction in the support group. Each member should be able to participate.
2.3.6.3 Support group as a social system

As a social system, the support group has activities, like health education and sharing experiences. Group members learn to know each other better with frequent interaction and develop senses of like or dislike to one another or the group itself. Sentiments of respect and acceptance of one another develop between them as they meet regularly for sessions. According to Ashworth et al (1992:1432), there is a distribution of expertise and some individuals are taken to have a stock of knowledge at hand, which is greater in some particular realm than that of other members and this might cause conflict during group interaction. It is imperative that every group member understand the language used in the support group.

2.3.6.4 External system

The support group exists in the context of the external system, which is the health system and hypertensive patients’ own social system

- Health system

The nurse, as the support group facilitator, belongs to the health system and comes to the group with characteristics and roles to perform. This system assists the support group with the technical aspects.
Hypertensive patients’ own social system

Hypertensive patients, as members of society, come into the support group with their own diverse cultural and religious beliefs. In cases where the support group processes are in conflict with personal circumstances, negative attitudes may develop and the opposite occurs when those circumstances are in harmony with the support group processes. Some might live far from the clinic and therefore have to use their own transport to attend the support group. Some hypertensive patients might be working and therefore not have time to attend the support group.

Values are “the unconscious assumptions the members of any society make and are not proved” (Homans 1951:127). Hypertensive patients may draw conclusions about the hypertension support group based on what they value.

2.3.6.5 Perceptions formed

Hypertensive patients form various perceptions after viewing all the components of the systems involved in the support group. Some patients have a problem with the support group structure, others with the health system and still others with the activities in the support group. If patients are comfortable with all the components, then their perception will be different. However, Wallace, Robertson, Millar and Frisch (1999:1144) found that perceptions could be both negative and positive on one theme; for example, with regard to the structure, the environment can be clean but lack enough chairs for the group members. Positive or negative perceptions result from patients being satisfied or dissatisfied with the support group processes.
• Satisfaction versus dissatisfaction

Mahon (1996:1242) cites Donabedian’s (1988) view that behaviours that indirectly suggest dissatisfaction include non-compliance with treatment regime, premature self-termination of care, termination of membership in a health plan, and seeking care outside the plan. Coyle (1999:723) found that dissatisfaction is a complex social construct, which is underpinned by a range of values, beliefs, attitudes and experiences.

Satisfaction is subjective and based on expectations and perceptions and is influenced by the degree to which the expectations are fulfilled (Mahon 1996:1242). Its consequences include better patient compliance, loyalty and return business.

In a study of patients’ and relatives’ experiences of “good” and “not so good” quality care in Manchester, Attree (2001:467) found that “‘good’ quality care was characterised as individualised, patient focused and related to need, it was provided humanistically, through the presence of a caring relationship by staff who demonstrated involvement, commitment and concern. Care described as ‘not so good’ was routine, unrelated to need and delivered in an impersonal manner by staff who did not involve patients.”

2.4 GROUP DYNAMICS

Group dynamics refers to the forces that result from the interactions of group members (Toseland & Rivas 1998:66). The forces should promote the satisfaction of
members’ socio-emotional needs and accomplishment of the group tasks. Toseland and Rivas (1998:67) identify four dimensions of group dynamics:

- communication and interaction
- cohesion
- social control mechanisms, that is, norms and roles
- group culture

These dimensions were part of the conceptual framework that formed the basis for this study, except for the group culture that pertains to values, beliefs, customs and traditions inherent in a group. The implication is that the various dimensions manifest in every group of individuals.

2.5 ROLES AND CHARACTERISTICS OF THE SUPPORT GROUP FACILITATOR

The facilitator of a group (in this case, the nurse) plays an important part in the success or failure of the support group. Jooste (1996:177) acknowledges that not every group facilitator might have all the necessary characteristics to the same degree.

2.5.1 Roles

Collins English Dictionary (1991:1341) defines role as “Psychol. The part played by a person in a particular social setting, influenced by his expectation of what is appropriate”. According to Steyn and Uys (1998:255), the role of the group facilitator
is twofold, namely task-oriented relating to achievement of group goals and socio-emotional referring to the management of interpersonal relationships in the group.

- **Member orientation**

  The group facilitator has the role of orientating group members to the group processes (Corey 2000:451). Toseland and Rivas (1998:93) state that the facilitator has the expert power; in other words, the skill and knowledge of how the group should function. If group members are not well orientated to the group, they might feel as though they are not welcome into the group and become discouraged to attend the next session.

- **Group maintenance**

  The group facilitator should act to prevent member attrition resulting from unsuccessful group experience (Yalom 1995:107). Toseland and Rivas (1998:93) refer to this role as “the ability to sanction and punish the non-conformists”. According to Corey (2000:451), the atmosphere should be safe and supportive through the facilitator.

- **Give direction**

  Steyn and Uys (1998:259) refer to Bales and Slater (1969), who state that a good facilitator is one who gives the group direction. This implies that when the group goes
off the track, the facilitator steers it back to the point and is able to lead them towards achieving the goal.

- **Encourage participation**

  The group facilitator should create opportunities for the members to make decisions and plan the course of action to get everyone involved (Jooste 1996:174). According to Corey (2000:451), the group facilitator ensures participation by initiating and promoting interaction. However, the facilitating role may be relatively shared with members so that group members do not need to lean on the facilitator to initiate and direct every action within the group.

### 2.5.2 Characteristics of the support group facilitator

A characteristic is “a distinguishing quality, attribute, or trait” (*Collins English Dictionary* 1991:272). Group facilitators should possess qualities and skills of group facilitation. However, people differ as individuals and might not have same qualities to the same degree. Some group facilitators tend to push patients to disclose their feelings when they are not yet ready to do so (Weiner 1994:21). This may lead to patients dropping out of the group (Leszcz 1994:25). Zhang, Luk, Arthur and Wong (2001:458) classify the attributes into intellectual, interpersonal and technical skills.
- **Role model**

Group facilitators should lead by example so that group members can copy the good behaviour portrayed (Jooste 1996:176). Toseland and Rivas (1998:113) state that group facilitators should demonstrate behaviour in a particular situation so that others in the group can observe what to do and how to do it.

- **Resourceful**

When patients ask questions about their disease, the facilitator should be able to answer in an easy and understandable way. Jooste (1996:177) acknowledges that facilitators cannot be able to know everything but should have a database of necessary referral points. Group facilitators should, however, desire to gather as much information as possible regarding patients’ illnesses, situations and background (Zhang et al 2001:461).

- **Well-balanced personality**

Group facilitators should know themselves (Jooste 1996:176). They should be able to deal with various situations without losing their temper as group members are unique with various personalities. Zhang et al (2001:461) refer to this characteristic as “self-control”. Tolerance to stress, and ability to face challenges are crucial in group facilitation.
• **Supportive**

Group members need support in their efforts to help themselves (Toseland & Rivas 1998:110). The group facilitator supports them by encouraging them to express their thoughts and feelings. Informational support is the key to the group members so that they can understand their illness and live normal lives.

• **Accepting group members**

Group members are from different cultural backgrounds and religions, therefore, they should be respected and accepted as they are without prejudice (Jooste 1996:177). Corey (2000:127) states that with all the cultural differences in mind, the facilitator should channel the members to focus on group goal achievement.

• **Interpersonal understanding**

The group facilitator should have a desire to understand members’ expressed and/or unexpressed thoughts, emotions or concerns (Zhang et al 2001:460). This will help the facilitator to predict the patients’ actions based on observation and therefore establishing effective communication amongst the patients.
2.6 ETHICAL CONSIDERATIONS FOR LITERATURE REVIEW

Researchers undertake a literature review “to familiarize themselves with the existing knowledge base” (Polit & Hungler 1999:79). All sources referred to in this study were acknowledged.

2.7 CONCLUSION

This chapter discussed the literature reviewed for the study. Homans’ conceptual framework was discussed as it formed the basis for this study. The researcher consulted literature on activities, interaction, norms, sentiments and cohesiveness in hypertension support groups. The role and characteristics of a group facilitator were also highlighted.

Chapter 3 deals with the research design and methodology.
CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter contains the basic strategies adopted “to develop information that is accurate and interpretable” (Polit & Hungler 1999:155). This study was non-experimental therefore the phenomena were described as they occurred naturally without intervening in any way. The research design used in this study, population, sampling method and research instrument as well as ethical considerations are discussed below.

3.2 RESEARCH DESIGN

The researcher chose the design that “best fitted the research purpose” (Brink 1996:100). The design was quantitative, descriptive and exploratory because it aimed to explore and describe the perceptions of hypertensive patients about the hypertension support groups in the Carletonville District.

3.2.1 Quantitative approach

Burns and Grove (1999:475) define the quantitative approach as the “formal, objective, systematic process used to describe and test relationships, and examine
cause-and-effect interactions among variables”. Polit and Hungler (1999:712) emphasise that quantitative approaches “lend themselves to precise measurement and quantification”.

The quantitative approach was chosen because it focuses on a relatively small number of concepts and uses structured procedures and formal instruments to collect information (Brink 1996:13). Therefore, it would best fit in with the purpose of the study and was compatible with the resources available, particularly time, and the researcher’s personal preference.

3.2.2 Descriptive design

A descriptive design provides “a picture of situations as they naturally happen and can identify problems in current situations” (Burns & Grove 1999:192). According to Polit and Hungler (1999:196), the research problem in descriptive studies “is cast in a non-causal way therefore there is no manipulation of variables”. The purpose of descriptive studies is to obtain “complete and accurate information about a phenomenon through observation, description and classification” (Brink 1996:11).

The strength of this design is that it has the potential to generalise to large populations if an appropriate sampling design is implemented, and high measurement reliability if a proper questionnaire is constructed (Mouton 2001:153). The weakness of this design is that the lack of depth and insider perspective sometimes leads to criticisms of “surface level” analysis (Mouton 2001:153).
The study was descriptive in that the researcher collected descriptions of the perceptions of the hypertension support group from hypertensive patients who did and did not attend the group. Descriptive statistics were used to reduce the data to manageable portions and describe the characteristics of the phenomenon under study.

### 3.2.3 Explorative design

An explorative study is one that is conducted “when little is known about the phenomenon that is being studied” (Brink 1996:208). Polit and Hungler (1999:17) state that explorative studies aim to “investigate the nature of the phenomenon, the manner in which it is manifested, and other factors related to it”.

The strength of using an explorative design is that it satisfies the researcher’s curiosity and desire for better understanding. Its weakness is that it seldom provides satisfactory answers to research questions, though it can hint at the answers and suggest which research methods could provide definite answers (Babbie 2001:93).

This study was explorative because it wanted to know factors that might prevent hypertensive patients from attending a hypertension support group.

### 3.3 RESEARCH SETTING

Carletonville District is situated in the far west of the Gauteng Province. It is a portion of Merafong City Local Municipality, which is a cross border municipality between the Gauteng and North West Provinces and also consists of other areas, namely
Wedela and Fochville. As a mining area, Merafong City Local Municipality experiences a great influx of job seekers from the neighbouring countries of Lesotho and Mozambique. Therefore the population is multicultural. Merafong City is one of the four local municipalities including the National Heritage site (Cradle of Humankind) known as the District Managed Area (DMA) that constitute the West Rand District Municipality. This study was conducted in seven clinics around Carletonville District managed by the local municipality. Mine clinics were not part of this study. Figure 3.1 presents a map of the local municipalities.

![Figure 3.1 West Rand District Municipality map](image)

### 3.4 RESEARCH POPULATION

A population is “the entire group of persons or objects that is of interest to the researcher” (Brink 1996:132; Brink & Wood 1998; Polit & Hungler 1995; Roberts & Burke 1989; Wilson 1989). De Vos (1998:190) defines a population as “individuals in the universe who possess specific characteristics in which the researcher is
interested”. According to Burns and Grove (1999:366), population refers to “the entire set of individuals who meet the sampling criteria”.

The population for this study was both diagnosed male and female hypertensive patients from the age of 19 to 82 who attend and do not attend hypertension support group sessions at clinics around Carletonville District.

### 3.5 Sampling

A sample is “a subset of the population that is selected to represent the population” (Brink 1996:214). According to Burns and Grove (1999:226), sampling refers to “the selection of a group of people, events, behaviours, or other elements with which the researcher plans to conduct a study”.

#### 3.5.1 Sampling method

This study used a stratified random sample where the population was first divided into strata (Neuman 2000:208, Brink 1996:138, Burns & Grove 1999: 235), and thereafter randomly selected. According to Burns and Grove (2001:300), stratification ensures that all levels of the identified variables are adequately represented in the sample and a high degree of representativeness is achieved. It also gives everyone a chance to be selected and avoids selection bias.

The disadvantage of the stratified random sampling method is that it needs a large population from which to select the respondents and requires extensive knowledge of
the population under study in order to stratify it (Burns & Grove 1999:237). A complete list of the study population is needed and can also quickly become complex. The population for this study was large (seven hundred) therefore the disadvantage was overcome. Polit and Hungler (1999:285) are of the opinion that random sampling “tends to be hard to establish and time consuming”.

A large sample size “accommodates the refusals and withdrawals from the study” (Brink & Wood 1998:292). Brink (1996:142) states that it is desirable to use a large sample in quantitative research as “an increase in sample size increases accuracy and the findings may be generalised to the entire population”. In a study conducted by Henbest and Tau (2000:10) to find out how people in Ga-Rankuwa Hospital understand high blood pressure, one thousand and four (1004) respondents participated in the study and the response rate was 97%.

• How sampling was done

The population was divided into subgroups or strata according to the clinics in the geographical areas and number of hypertensive patients who attended the clinics. Simple random sampling was used to ensure that every respondent had “an equal and independent chance of being selected to participate in the study” (Brink 1996:136).

Lists of names of hypertensive patients who attended all the clinics were obtained. The researcher wrote numbers on pieces of papers and put them in a basket (Brink 1996:138). The total number of respondents in each clinic was divided by two, which indicated that every second piece of paper was drawn until the proportional sample of
50% was reached. Therefore, the proportional stratified random sample was selected using the simple random sampling method, based on the number of hypertensive patients who attended the clinics.

1.1 Table 3.1 A stratified random sample according to geographic area and size

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Number of patients attending hypertension clinic</th>
<th>Proportional sample of 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Khutsong Main Clinic</td>
<td>130</td>
<td>65</td>
</tr>
<tr>
<td>2. Khutsong East Clinic</td>
<td>100</td>
<td>50</td>
</tr>
<tr>
<td>3. Khutsong West Clinic</td>
<td>120</td>
<td>60</td>
</tr>
<tr>
<td>4. Khutsong South Clinic</td>
<td>90</td>
<td>45</td>
</tr>
<tr>
<td>5. Khutsong Ext.3 Clinic</td>
<td>120</td>
<td>60</td>
</tr>
<tr>
<td>6. Carletonville Clinic</td>
<td>80</td>
<td>40</td>
</tr>
<tr>
<td>7. Blyvooruitzicht Clinic</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total = 7</strong></td>
<td><strong>700</strong></td>
<td><strong>N= 350</strong></td>
</tr>
</tbody>
</table>

3.5.2 Inclusion criteria

The respondents for this study were the male and female hypertensive patients who attended the hypertension clinic. Only those who were between the ages 19 and 82 years, who attended or did not attend the hypertensive support groups at their respective clinics around the Carletonville District were included. Hypertensive patients who do not attend the hypertension support groups were once part of the
support groups and decided not to continue therefore they were also included in this study.

In their study on patient compliance, Kyngas and Lahdenpera (1999:838) found that patients with poorest compliance did not visit health care and then frequently did not participate in studies. However, in this study those who do not attend the hypertension support group, attend the clinic on the same date with those who attend the support group. Therefore, involving them in the study was not a problem.

3.5.3 Exclusion criteria

Hypertensive patients with other chronic diseases like asthma and diabetes were not included in the study.

3.6 DATA COLLECTION

According to Polit and Hungler (1999:700), data collection is “the gathering of information needed to address a research problem”. A research instrument is “a device used to collect data in research studies” (Brink 1996:214).

3.6.1 Development of questionnaire

For this study a simple questionnaire with closed questions was developed. Mouton (2001:102) states that most of the existing questionnaires, scales and tests were developed in the highly industrialised countries of Europe and North America
therefore cannot be implemented in multicultural and multi-ethnic studies of South Africa. The larger the sample, the more structured the questions need to be and the fewer the number of unstructured questions allowable (Brink & Wood 1998:297). In a study on determinants of support group attendance and satisfaction of adolescents with sickle cell disease, Telfair and Gardner (2000:45) used a questionnaire with structured questions and one open-ended question to gather “reasons for not attending” the support group.

According to Brink (1996:53), the advantages of a questionnaire are that it is a quick way of obtaining data from a large group of people, and less expensive. This research instrument is the easiest to test for reliability and validity and respondents feel a great sense of anonymity. Disadvantages are that respondents may provide socially acceptable answers and fail to answer some of the questions. Babbie (2001:240) states that closed questions provide a “greater uniformity of responses and are more easily processed”. However, some issues that were important might be omitted. In this study, a well-trained research assistant assisted respondents who were unable to read and write.

3.6.2 Reliability of the questionnaire

Reliability refers to “the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over a period of time on the same person or by different researchers” (Brink 1996:171; Bouma 2000:86). The questions in the questionnaire were structured on a Likert scale, which implies that the subject may respond in the same way if retested by another researcher using the same scale.
Polit and Hungler (1999:411) define reliability of an instrument as “the degree of consistency with which it measures the attribute it is supposed to measure”. Test-retest was done. The research instrument for this study was reliable as the researcher administered the same test to a sample of hypertensive patients on two occasions and then compared the scores obtained.

### 3.6.3 Validity of the questionnaire

The validity of a research instrument refers to how accurately it measures what it is supposed to measure (Brink 1996:167; Polit & Hungler 1999:418; Burns & Grove 1999:260).

Content validity – This research is about the hypertension patients’ perceptions of the hypertension support group. Therefore questions about the support group attendance were asked. To validate whether the items on the instrument adequately covered the content area being measured as well as the relevance of the items, two experts working at the clinic and the academic supervisors checked the questions. According to Polit and Hungler (1999:419), it is common to use experts to verify the content validity of new instruments. No rectifications were necessary.

### 3.6.4 Pilot study and pre-test

The pre-testing of a measuring instrument refers to the application of the measuring instrument to a small number of persons with characteristics similar to those of the target group of respondents (De Vos 1998:179). A pilot study refers to conducting the
study on a small scale using subjects who met the inclusion criteria in the main study. It is done to check the time spent completing the questionnaire and whether the respondents understand the questions clearly. No rectifications were made to the questionnaire during the pilot study for this study.

3.6.5 Administration of the questionnaire

Hypertensive patients who attend or do not attend hypertension support groups are given specific dates to attend the clinic therefore this implies that data was collected over a period of seven days at the various clinics. The researcher and the research assistant went to the clinics for data collection. The research assistant was fully informed about the process of data collection.

Hypertensive patients who do not attend the hypertension support groups were once part of the support groups and decided not to continue with it, therefore they were given the very same questionnaire, as they are aware of activities taking place within the support group. Moreover they attend clinic on the dates scheduled for hypertensive patients but not grouped with those who belong to the hypertension support groups.

Advantages of a questionnaire

Using a questionnaire had the following advantages:

- They are a quick way of obtaining data (Brink 1996:153).
• The subjects felt a greater sense of anonymity, as their identities were not revealed on the questionnaires unlike interviews where respondents would have been expected to respond in front of the interviewer.

• Questionnaires were not expensive compared to focus groups where tapes and research field notes have to be organised.

• It was easy to record, score and quantify the results (Bless & Higson-Smith 1995:122).

• The questionnaire format was standardised for all respondents and was not dependent on the mood of the researcher (Brink 1996:153).

Disadvantages of a questionnaire

The questionnaire had the following disadvantages:

• The questionnaire was written in English and some respondents could not understand it. Through the help of research assistant this disadvantage was overcome.

• The disadvantage of respondents responding to the same question in different ways was overcame by going through the questions with them before they completed the questionnaire (Hogstel & Sayner 1986:81).

• The respondents had no excuse for not returning the completed questionnaire as the researcher was within reach.

• To avoid boredom and exhaustion, questions were short, clear and simple (Hogstel & Sayner 1986:82).
**Format of the questionnaire**

The questionnaire consisted of the following sections:

Section A: biographical data of the hypertensive patients, which helped the researcher to interpret the study findings.

Section B: their healthy or unhealthy lifestyle

Section C: perceptions of the hypertensive patients with regard to the strengths of the hypertension support groups

Section D: perceptions of the hypertensive patients of the weakness of the hypertension support group.

Section E: perceptions of hypertensive patients about reasons why some of the hypertensive patients do not attend the hypertension support groups.

Section F: perceptions of hypertensive patients of the roles and attributes of the nurse who facilitates the hypertension support group.

**3.6.6 The research question**

The following question guided the study:

What are the hypertensive patients’ perceptions of the hypertension support groups?

**3.7 ETHICAL CONSIDERATIONS**

When human beings are used as study participants in research, their rights should be protected (Polit & Hungler 1999:131). De Vos (1998:24) defines ethics as “a set of moral principles which are suggested by an individual or group, subsequently widely
accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students”. The basic ethical principles of respect for persons, beneficence, justice and informed consent guide researchers (Brink 1996:39; Polit & Hungler 1999:140).

A letter of permission to conduct the research from Carletonville Town Council is attached as annexure A.

3.7.1 Informed consent

Informed consent means that participants have adequate information about the research, are capable of understanding and have a choice of participating or not participating in the study (Polit & Hungler 1999:140, De Vos 1998:25, Brink 1996:42)

- Adequate information

The study participants were verbally informed about the study purpose, data to be collected, study duration, selection criteria, data-collection procedure and how to contact the researcher (Polit & Hungler 1999:140).
• **Understanding information given**

The researcher explained everything mentioned above in simple language that was understood by the study participants (Brink 1996:43). Questions were asked to ascertain the level of understanding (Burns & Grove 1999:170, Brink 1996:43, Polit & Hungler 1999:143).

• **Free choice**

Study participants were not forced to participate in the study and were informed that they had a right to decline participation (Brink 1996:44). Those who agreed to participate in the study signed a consent form (Polit & Hungler 1999:141). The return of the completed forms also reflected their voluntary consent to participate.

**3.7.2 Principles of beneficence**

This principle emphasises that the researcher do good and no harm (Polit & Hungler 1999:134). Brink (1996:40) states that discomfort and harm could be “physical, emotional, spiritual, economic, social or legal” The researcher ensured that the study participants were not subjected to any form of harm or discomfort.
• **Freedom from harm**

No form of harm was incurred in this study. Questions were simple and understandable so as not to inflict psychological harm during data collection (Polit & Hungler 1999:134).

• **Freedom from exploitation**

Exploitation refers to taking advantage of study respondents in any way to obtain information from them (Polit & Hungler 1999:134). The respondents were assured that the information they gave in the questionnaires would in no way be used against them or affect their relationship with the clinic team. They were informed that the information obtained would be used to strengthen or restructure the hypertension support groups, and were therefore encouraged to feel free to comment freely without fear of victimization.

3.7.3 **Principle of respect for human dignity**

Human beings are unique and autonomous. Protection should be ensured to those with diminished autonomy like the mentally impaired (Brink 1996:39).
• **Right to self-determination**

Polit and Hungler (1999:136) define this principle as the right of the study respondents “to decide voluntarily whether to participate in a study, without the risk of prejudice”. The respondents in this study were not coerced to take part and were made aware of their right to withdraw from the study at any time without fear of endangering their relationship with the clinic team concerned.

• **Right to full disclosure**

Full disclosure means that the researcher has fully described the nature of the study (Polit & Hungler 1999:137). In this study the researcher did explain the nature of the study to the respondents.

3.7.4 **Principle of justice**

Justice should be done to the research respondents with regard to their rights to selection and treatment, and privacy (Brink 1996:40).

• **Right to fair treatment and selection**

The research respondents for this study were selected using stratified random sampling, which gave each member of the population a chance to be selected.
• **Right to privacy**

Study respondents have the right to expect that any information collected during the course of the study will be kept in strictest confidence (Polit & Hungler 1999:139). They were assured of anonymity and confidentiality in this study. Completed questionnaires were not attached to their names and no one had access to them except the researcher and the research assistant who was well trained in confidentiality. Questions on the questionnaire were not invasive of the respondents’ private affairs.

### 3.8 DATA ANALYSIS

Data analysis is “the systematic organization and synthesis of research data, and the testing of research hypothesis using those data” (Polit & Hungler 1999:699). In this study data was analysed by means of the Statistical Package for the Social Science (SPSS) because it contains programs to handle a broad variety of statistical analyses. Descriptive statistics were presented in tables and diagrams. The researcher consulted a statistician to assist with data analysis.

### 3.9 LIMITATIONS OF THE STUDY

The study cannot be generalized to other regions within Gauteng as the findings might only apply to the context of Carletonville District. It can also not apply to support groups of other conditions or diseases.
3.10 CONCLUSION

This chapter described the research design chosen for the study. According to Polit and Hungler (1999:169), the decision about a research design affects the ability to interpret the data.

Chapter 4 discusses the data analysis, interpretation and findings.
CHAPTER 4

DATA ANALYSIS, INTERPRETATION AND FINDINGS

3.1 INTRODUCTION

Chapter 3 discussed the data-collection methods. This chapter discusses the data analysis and interpretation, using tables and graphs. The research sample was 350 and the response rate was 100% (n = 350).

Data will be presented according to the sections in the questionnaire. Table 4.1 shows the sections of the questionnaire.

<table>
<thead>
<tr>
<th>Section</th>
<th>Function covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A</td>
<td>Biographical data</td>
</tr>
<tr>
<td>Section B</td>
<td>Health education</td>
</tr>
<tr>
<td>Section C</td>
<td>Strengths of the hypertension support group</td>
</tr>
<tr>
<td>Section D</td>
<td>Weaknesses of the hypertension support group</td>
</tr>
<tr>
<td>Section E</td>
<td>Why some hypertensive patients do not attend hypertension support group</td>
</tr>
<tr>
<td>Section F</td>
<td>Attributes of the nurse as the support group facilitator.</td>
</tr>
</tbody>
</table>
The purpose of this study was to explore and describe the perceptions of the hypertensive patients regarding hypertension support groups in Carletonville District.

The research questions were:

- What are the strengths of the hypertension support groups perceived by hypertensive patients in Carletonville District?
- What are the weaknesses of the hypertension support groups perceived by hypertensive patients in Carletonville District?
- Why do some of the hypertensive patients in Carletonville District not attend the hypertension support group?

Questionnaires were administered to the respondents and assigned numbers on return. Anonymity was ensured in that numbers did not identify respondents but enabled the researcher to recheck the questionnaires if the need arose. The data obtained was analysed by computer.

A four-point Likert scale was used in sections B, C, D, E and F: Always, Often, Seldom, Never and Strongly agree, Agree, Disagree and Strongly disagree. The respondents were expected to indicate the extent to which they agreed or disagreed with the statements by marking their responses with an “X”.

Summation of responses was done where “agree” and “strongly agree” were summed as “agree” indicating positiveness towards the statements. “Disagree” and “strongly disagree” were summed as disagree indicating negativeness towards the statements. Summation of “always and “often” was also done indicating that an action mentioned
in the statements was taken. “Seldom” and “never” indicated that the action was not taken.

Graphs and tables are used in the data presentation. Polit and Beck (2004:609) point out that tables are an important way to economise on space and avoid repetitious statements. According to Knapp (1998) (cited in Lekhuleni 2002:68), tables are generally more useful in summarizing most of the data and are easily understood and interpreted by the reader.

4.2 SECTION A: BIOGRAPHICAL DATA

4.2.1 Clinics where hypertensive patients receive their hypertension management (N=350)

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Hypertensive patients (N = 350)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
</tr>
<tr>
<td>Khutsong Main Clinic</td>
<td>65</td>
</tr>
<tr>
<td>Khutsong Extension 3</td>
<td>59</td>
</tr>
<tr>
<td>Khutsong West Clinic</td>
<td>61</td>
</tr>
<tr>
<td>Khutsong East Clinic</td>
<td>50</td>
</tr>
<tr>
<td>Khutsong South Clinic</td>
<td>45</td>
</tr>
<tr>
<td>Carletonville Clinic</td>
<td>40</td>
</tr>
<tr>
<td>Blyvooruitzicht Clinic</td>
<td>30</td>
</tr>
<tr>
<td>TOTAL</td>
<td>N=350</td>
</tr>
</tbody>
</table>
Table 4.2 indicates that most of the respondents (18.6%) were from Khutsong Main clinic while the smallest sample (8.6%) was from Blyvooruitzhict clinic. The proportional sample of 50% was selected in each clinic based on the total number of hypertensive patients attending that clinic.

Fig 4.1 – Clinics frequencies (N=7)
4.2.2 Gender of the respondents

Of the respondents, 71,1% (N=249) were females while only 28,9% (N=101) were males. According to Goldsmith (2000:16), females are predisposed to hypertension by several factors including pregnancy and oral contraceptives. Another contributing factor might be that women use health care services more than men (Davidson et al 2000:206).

4.2.3 Age of the respondents

The respondents’ ages ranged from 19 to 82 years. At 19 years one is probably out of school, studying at tertiary institution or working therefore is subjected to stressors that might lead to hypertension.
Figure 4.2 depicts the respondents’ age distribution and reveals that 28.3% (N=99) were between 41 and 50, 26% (N=91) were between 51 and 60, 21.7% (N=76) were 60 and above; 18.3% (N=64) were between 31 and 40 and only 5.7% (N=20) were between 19 and 30. The prevalence of hypertension increases with aging and for women the prevalence exceeds that of men (Prisant & Moser 2000:283). According to Davidson et al (2000:206), elderly people utilise health care centres more than young people.
4.2.4 Employment status of the respondents

Of the respondents, 48.6% (N=170) were unemployed, 22.8% employed (N=80), 20.6% pensioners (N=72), 6.3% self-employed (N=22) and 1.7% were students (N=6).

4.2.5 Type of hypertension management

Figure 4.4 Employment status of the respondents (N=350)

Figure 4.5 Type of hypertension management (N=350)
Figure 4.4 reveals that 90.3% (N=316) of the respondents were on drug management and only 9.7% (N=34) were on non-drug management.

### 4.2.6 Taking hypertension medication

![Figure 4.6 Taking hypertension medication (N=350)]

Of the respondents, 93.7% (N=328) said that they took their medication as prescribed; 4.0% (N=14) said they took their medication when they felt like it and 2.3% (N=8) said they were not on anti-hypertensives. The percentage of those not on medication was expected to correlate with that of those on non-drug management (see section 4.2.5), but 26 respondents appear to have given incorrect information on their hypertension management and how they took their medication.
4.2.7 Duration of hypertension support group attendance by respondents

![Chart showing duration of hypertension support group attendance]

*Figure 4.7 - Duration of hypertension support group attendance (N=350)*

Of the respondents, 29.0% (N=100) had attended the hypertension support group for less than a year while 71.0% (N=250) had attended for more than a year.
4.2.8 Attendance of hypertension support group

![Pie chart showing attendance categories of hypertension support group (N=350)]

Of the respondents, 88.3% (N=309) said that they attended the hypertension support group regularly, 8.6% (N=30) said they were non-regular attendees and 3.1% (N=11) said that they had terminated their attendance. The majority of the respondents (90.3%) were on drug management which is amazing as to what do they learn in the support groups.

4.3 SECTION B: HEALTH EDUCATION

Section B consisted of five items aimed at discovering the respondents’ perceptions of the health education given on lifestyles. Daly (2000:15) stresses that hypertension can be prevented by lifestyle interventions. The lifestyle modification should be recommended before starting drug management.
Table 4.3 Respondents’ perceptions of lifestyle health education in the hypertension support group (N=350)

<table>
<thead>
<tr>
<th>Questionnaire items</th>
<th>Hypertensive patients (N=350)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always/Often</td>
</tr>
<tr>
<td></td>
<td>f</td>
</tr>
<tr>
<td>We are advised on low salt intake</td>
<td>342</td>
</tr>
<tr>
<td>We are advised to limit alcohol intake</td>
<td>331</td>
</tr>
<tr>
<td>We are advised to quit smoking</td>
<td>328</td>
</tr>
<tr>
<td>We are advised to do exercise</td>
<td>283</td>
</tr>
<tr>
<td>We are taught about stress management</td>
<td>255</td>
</tr>
</tbody>
</table>

From table 4.3 it is clear that the respondents’ overall perceptions of the lifestyle health education given in the support group were positive. However, in spite of these findings, the dependence on drugs is still high compared to non-drug management of hypertension. Healthy lifestyles are related to proper eating habits, such as low sodium and alcohol intake, which has a bearing on the status of hypertension.

According to Searle and Pera (1995:178), the nurse “prevents diseases and promotes health by teaching and counselling individuals, families, groups of persons and the community”. Stanhope and Lancaster (2004:995) state that the nurse “identifies groups at risk within the community and implements health education interventions”. Nurses should take the lead in implementing lifestyle changes to help patients with the hypertension condition (Cresswell 1999:9).
4.3.1 Section B item 1: Advised on low salt intake

Of the respondents, 97.7% indicated that they were taught about low salt intake while only 2.3% stated they were not. There may be a discrepancy between the knowledge gained at the support groups and the actual compliance at home with the lifestyle modification. This lifestyle modification benefits hypertensive patients as it improves control and enhances the effect of drugs (Benjamin 1997:10).

4.3.2 Section B item 2: Advised to limit alcohol intake

Of the respondents, 94.6% stated that they were advised to limit alcohol intake while 5.4% disagreed. Edinburgh (1995:42) emphasises that patients should avoid alcohol as it puts them at high risk of hypertension complications.

4.3.3 Section B item 3: Advised to quit smoking

Of the respondents, 93.7% reported that they were advised to quit smoking whereas 6.3% said they were not. Like alcohol, smoking puts patients at high risk of hypertension complications.

4.3.4 Section B item 4: Advised to do exercise

Of the respondents, 80.9% indicated that they were advised to do exercise whereas 19.1% said they were not. Edinburgh (1995:42) points out that “exercise leads to weight loss, which reduces blood levels on average by 7mmHg (systolic) and 4mmHg (diastolic)”. Therefore exercises seem to be good for hypertensive patients’ health.
4.3.5 Section B item 5: Advised about stress management

Of the respondents, 72.9% stated that they were taught about stress management while 27.1% said they were not.

4.4 SECTION C: STRENGTHS OF THE HYPERTENSION SUPPORT GROUP

Section C consisted of eleven items on the strengths of the hypertension support group.
The overall perceptions of the hypertensive patients regarding the strengths of the support group were positive.

### 4.4.1 Section C item 1: Support group session has objectives

The majority of the respondents (77,4%) agreed that each session of the support group had its own objectives and 22,6% disagreed.

#### Table 4.4 Respondents’ perceptions of strengths of the hypertension support group (N=350)

<table>
<thead>
<tr>
<th>Questionnaire items</th>
<th>Hypertensive patients (N=350)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td></td>
<td>f</td>
</tr>
<tr>
<td>1. Each support group session has its own objectives</td>
<td>271</td>
</tr>
<tr>
<td>2. There are rules that regulate our support group</td>
<td>319</td>
</tr>
<tr>
<td>3. We feel welcome in the support group</td>
<td>321</td>
</tr>
<tr>
<td>4. We accept one another as members in the group</td>
<td>312</td>
</tr>
<tr>
<td>5. We have moral support in the support group</td>
<td>328</td>
</tr>
<tr>
<td>6. We share life experiences in the support group</td>
<td>318</td>
</tr>
<tr>
<td>7. We receive peer counselling in the support group</td>
<td>281</td>
</tr>
<tr>
<td>8. We are taught about the side effects of different hypertension tablets</td>
<td>318</td>
</tr>
<tr>
<td>9. We are advised to take our medication daily</td>
<td>345</td>
</tr>
<tr>
<td>10. We are issued with our medication after blood pressure level measuring</td>
<td>342</td>
</tr>
<tr>
<td>11. Appointment cards are issued to remind us of the date of the next meeting</td>
<td>303</td>
</tr>
</tbody>
</table>
4.4.2 Section C item 2: Rules that regulate our support group

Of the respondents, 91,1% agreed that there were rules that regulated the support group and 8,9% disagreed. Stanhope and Lancaster (2004:544) assert that all groups “have norms and mechanisms whereby conformity is accomplished and are meant to maintain the group, influence members’ perceptions and interpretation of reality, and to ensure movement towards the group’s purpose”.

4.4.3 Section C item 3: Feel welcomed into the support group

Of the respondents, 91,7% felt welcome in the support group whereas 8,3% disagreed.

4.4.4 Section C item 4: Acceptance of one another as members in the support group

Of the respondents, 89,1% agreed that they accepted one another in the group while 10,9% disagreed. According to Steyn and Uys (1998:194), members who enjoy a level of acceptance from other group members are attracted to the group. It may be a contributory factor to a reasonably high level of attendance at support groups.

4.4.5 Section C item 5: Moral support within the support group

The majority of the respondents (93,7%) indicated that they had moral support in the support group whereas a small group (6,3%) disagreed.
4.4.6 Section C item 6: Sharing life experiences within the support group

Of the respondents, 90,9% agreed that they shared life experiences in the support group while only 9,1% disagreed. Davidson et al (2000:206) are of the opinion that “collective wisdom is born through the shared experiences of participants rather than the leader”.

4.4.7 Section C item 7: Receiving peer counselling within the support group

Of the respondents, 80,3% agreed that they received peer counselling in the support group whereas 19,7% disagreed. The 19,7% might be the irregular or terminated attendants.

4.4.8 Section C item 8: Information on side effects of different hypertension tablets

Almost all the respondents (90,9%) agreed that they were taught about side effects of different hypertension tablets whereas 9,1% disagreed. An understanding of pathology, nature of the disease and medication enhances compliance with medication (Stewart et al 1999:14). This is confirmed by 93,7% of the respondents who said they were taking their medication as prescribed.
4.4.9 Section C item 9: Advised to take medication daily

Of the respondents, 98.6% agreed that they were advised to take their medication daily and only 1.4% disagreed. According to Benjamin (1997:10), compliance could be improved if patients understood the advantages and objectives of the treatment.

4.4.10 Section C item 10: Medication after blood pressure levels measuring

Of the respondents, 97.7% agreed that they received their medication after blood levels were measured while 2.3% disagreed. Some respondents appear to have given false information as 9.7% reported to be on non-drug management in item 4.2.5.

4.4.11 Section C item 11: Appointment cards issued

Of the respondents, 86.6% agreed that they were given appointment cards to remind them of the date of the next meeting while 13.4% disagreed. Most of them may be attending the clinic to fetch the medication and not necessarily to attend the support group.

4.5 SECTION D: WEAKNESSES OF THE HYPERTENSION SUPPORT GROUP

Section D consisted of fourteen items on weaknesses of the hypertension support group.
Table 4.4 shows that some respondents agreed that there were weaknesses in the hypertension support group.

4.5.1 Section D item 1: Distance of the clinic

Although most of the respondents (62,0%) agreed that the clinic was within walking distance, 38,0% disagreed. This implies that the clinic was not accessible to all
hypertensive patients and therefore could be regarded as a weakness of the hypertension support group held at the clinic.

4.5.2 Section D item 2: Length of queues

Of the respondents, 70,6% said that they stood in long queues whereas 29,4% said they did not. This is yet another weakness of the support group. Stewart and Eales (2002:14) emphasise that inaccessible clinics and long waiting time impact negatively on patients.

4.5.3 Section D item 3: Understanding language used

Almost all the respondents (90,3%) agreed that they could understand the language used in the support group while 9,7% disagreed. South Sotho and Xhosa are the predominant languages in Carletonville District.

4.5.4 Section D item 4: Meaningfulness of health education

Of the respondents, 94,6% agreed that the health education given in the support group was meaningful and 5,4% disagreed. This correlates with the above statement where 90,3% of the respondents reported they understood the language used in the support group.
4.5.5 Section D item 5: Experiences are not discussed out of the support group

Of the respondents, 70.6% were satisfied that their experiences were not discussed out of the support group with non-members while 29.4% were not satisfied. Most of the respondents (90.9%) reported they felt free to share experiences in the support group. This might be encouraged by the trust they have in one another to talk.

4.5.6 Section D item 6: Unresolved conflicts within the support group

More than half of the respondents (51.7%) reported that they had unresolved conflicts in the support group. Less than half (48.3%) said that they did not have unresolved conflicts in the support group. Although conflicts help groups work towards their purpose, resolving these conflicts depends on open communication among all parties, diffusion of negative feelings and perceptions, focusing on the issues and structured approach to process (Stanhope & Lancaster 2004:550). The unresolved conflicts serve as a weakness of the support group. It may also reflect negatively on the role of the facilitator.

4.5.7 Section D item 7: Domination within the support group

Almost half of the respondents (49.1%) stated that some members dominated the support group whereas 50.9% said no member dominated the support group.
4.5.8 Section D item 8: Information on signs and symptoms of hypertension is enough

Of the respondents, 91.7% agreed that the information they received on the signs and symptoms of hypertension was enough while 8.3% disagreed.

4.5.9 Section D item 9: Information on how to manage hypertension at home is enough

Of the respondents 90.9% agreed that the information they received on how to manage hypertension at home was enough while only 9.1% disagreed.

4.5.10 Section D item 10: Information on what to do should complications occur

Of the respondents, 82.9% agreed that they received sufficient information on what to do should complications occur while 17.1% disagreed.

4.5.11 Section D item 11: Taking responsibility for our own health

Of the respondents, 90.9% agreed that they were encouraged to take responsibility for their own health while 9.1% disagreed.
4.5.12 Section D item 12: Sharing our experiences, fears and ideas with support group members

Of the respondents, 90,9% agreed that they shared their experiences, fears and ideas with support group members whereas 9,1% disagreed. This supported the findings in section C item 6 where 90,9% of the respondents agreed that they shared life experiences, fears and ideas in the support group.

4.5.13 Section D item 13: Sense of belonging to support group

Of the respondents, 94,6% reported that they felt a sense of belonging in their support group while 5,4% disagreed.

4.5.14 Section D item 14: Atmosphere within the support group is empathetic

Of the respondents, 81,7% agreed that the atmosphere in the support group could be described as empathetic while 18,3% disagreed.

4.6 SECTION E: CLINIC AS A MEETING POINT FOR THE SUPPORT GROUP

Section E consisted of thirteen items on the clinic as a meeting point. Some inconveniences were identified which could be regarded as reasons why some hypertensive patients did not attend the hypertension support group.
<table>
<thead>
<tr>
<th>Questionnaire items</th>
<th>Hypertensive patients (N=350)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td></td>
<td>f</td>
</tr>
<tr>
<td>1. Those of us who are employed find it easy to abstain from work on the planned dates</td>
<td>172</td>
</tr>
<tr>
<td>2. The time scheduled for the support sessions is suitable for us</td>
<td>225</td>
</tr>
<tr>
<td>3. We do not experience transport problems when attending the support group</td>
<td>152</td>
</tr>
<tr>
<td>4. The venue for the support group at the clinic is user-friendly</td>
<td>316</td>
</tr>
<tr>
<td>5. There are enough chairs for everyone</td>
<td>213</td>
</tr>
<tr>
<td>6. The length for the support group session is sufficient</td>
<td>181</td>
</tr>
<tr>
<td>7. We find it easy to attend support group sessions</td>
<td>191</td>
</tr>
<tr>
<td>8. We have good relationships with one another</td>
<td>331</td>
</tr>
<tr>
<td>9. We do learn from one another as support group members</td>
<td>331</td>
</tr>
<tr>
<td>10. We do receive support from our family members</td>
<td>316</td>
</tr>
<tr>
<td>11. There are enough members in the support group making it possible for all members to participate</td>
<td>290</td>
</tr>
<tr>
<td>12. Support group members respect other members’ feelings and opinions</td>
<td>264</td>
</tr>
<tr>
<td>13. I like all of the members in the support group</td>
<td>255</td>
</tr>
</tbody>
</table>
4.6.1 Section E item 1: Abstain from work on the planned dates

Of the respondents, 50.9% stated that they did not find it easy to abstain from work on planned dates and 49.1% said they found it easy to abstain from work on planned dates. In section A, nearly half of the respondents said they were unemployed. This finding could be identified as the first reason why some hypertensive patients did not attend the hypertension support group. In a study in Johannesburg, Stewart et al (1999:15) found that employed respondents raised the concern of being at the clinic a long time for their “check-up” and felt that their employers had difficulty giving them the time off work needed. Loss of work time with the resultant of loss of earnings makes adherence for hypertensive patients difficult (Stewart & Eales 2002:15).

4.6.2 Section E item 2: Suitability of scheduled times

Of the respondents, 64.3% said that the time scheduled for the support group session was suitable for them whereas 35.7% disagreed. The group that disagreed could have been the working group. However, of the respondents, 48.6% were unemployed (see figure 4.4). They might have other responsibilities, such as child care, home chores or community activities. It is not clear why so many seemed to be satisfied with the time of the support group sessions, but more than half seemed to experience work related problems with the scheduled time.
4.6.3 Section E item 3: Transport problems

Of the respondents, 56,6% said that they did experience transport problem when attending the support group while 43,4% did not. This corresponds with 38,0% of the respondents who indicated that the clinic was not within walking distance. With 48,6% indicating that they were unemployed, it was clear that hypertensive patients could not afford transport fees. This could serve as another reason why some hypertensive patients did not attend hypertension support groups. Stewart and Eales (2002:14) point out that poor finances and transport have an effect on patients attending the clinics.

4.6.4 Section E item 4: User-friendliness of the clinic venue

Of the respondents, 90,3% were satisfied with the clinic as the venue for the support group whereas 9,7% were dissatisfied.

4.6.5 Section E item 5: Chairs in the clinic

Of the respondents, 60,9% said that there were enough chairs for everyone while 39,1% felt that there were not enough chairs. According to figure 4.2, 28,3% of the respondents were aged between 41 and 50, and 26,0% between 51 and 60. Most of the respondents are aging and easily grow tired of standing for long.
4.6.6 Section E item 6: Length of the support group sessions

Of the respondents, 48,3% were not happy about the length of the support group sessions while 51,7% were happy. This could also be linked to section D item 2 where 70,6% said that they stood in long queues. The time scheduled for the support group at Carletonville District was 45 minutes, excluding the time for vital signs checking. However, Benjamin (1997:10) emphasises that it is important to spend quality time explaining hypertension to patients.

4.6.7 Section E item 7: Attendance of the support group

Of the respondents, 45,4% said that they did not find it easy to attend the support group. This could be linked to transport problem and employment as indicated in section E item 1 and 3. Most of the respondents, namely 54,6%, indicated that they found it easy to attend the support group sessions. This could be the reason why some hypertensive patients did not attend the hypertension support group.

4.6.8 Section E item 8: Good relationships with one another

Despite some inconveniences identified, 94,6% said that they had a good relationship with one another and only 5,4% disagreed.
4.6.9 Section E item 9: Learning from each other as support group members

Of the respondents, 94.6% said that they learnt from each other as support group members and only 5.4% said they did not. Davidson et al (2000:205) point out that “support groups often go unnoticed because of a bias towards professionalism”. This implies that patients could indeed learn from each other as ordinary members of the support group. Davidson et al (2000:205) emphasise further that wisdom is born through the shared experiences of participants rather than through the professional training or style of the facilitator.

4.6.10 Section E item 10: Family support

Of the respondents, 90.3% received support from their family members whereas 9.7% did not. Wang and Abbot (1998:408) found that most hypertensive patients receive family support on taking medication but less support on exercise and diet. Pennix, Kriegsman, van Eijk, Boeke and Deeg (1996:229) revealed that family support led to higher medication adherence. Schoenberg (1998:290) found that family provide more reliable and extensive support to hypertensive patients.

4.6.11 Section E item 11: Participation of members

Of the respondents, 82.9% indicated that there were enough members in the support group, which made it possible for all members to participate while 17.1% disagreed.
4.6.12 Section E item 12: Respecting other members’ feelings and opinions

Of the respondents, 75.4% said that the group members respected other members’ feelings and opinions while 24.6% did not agree with the statement. This finding contradicts section D item 7 where 49.1% of the respondents reported that some members dominated the support group.

4.6.13 Section E item 13: Liking members in the support group

Of the respondents, 72.9% stated that they liked all of the members in the support group whereas 27.1% disagreed. The elderly, who are of a common age group, represented a high percentage of those who agreed. They may be identifying with one another easily in terms of life experiences and value systems. According to Stanhope and Lancaster (2004:542), attraction increases when members feel accepted and liked by others, see similar qualities in one another, and share similar attitudes and values.

3.7 SECTION F: ATTRIBUTES OF THE NURSE AS A GROUP FACILITATOR

Section F consisted of thirteen items pertaining to the nurse as the support group facilitator. Nurses are urged to take the lead in hypertension support group by virtue of their experience and knowledge on caring for patients with hypertension (Cresswell 1999:9).
Table 4.7 Respondents’ perceptions on attributes of the nurse as the support group facilitator (N=350)

<table>
<thead>
<tr>
<th>Questionnaire items</th>
<th>Hypertensive patients (N=350)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td></td>
<td>f</td>
</tr>
<tr>
<td>1. The nurse who facilitates the group is approachable</td>
<td>312</td>
</tr>
<tr>
<td>2. The nurse is supportive to all of us</td>
<td>331</td>
</tr>
<tr>
<td>3. The nurse orientates new members to the support group process</td>
<td>283</td>
</tr>
<tr>
<td>4. The nurse helps us to overcome the hypertension stigma</td>
<td>316</td>
</tr>
<tr>
<td>5. The nurse motivates us to attend the support group</td>
<td>335</td>
</tr>
<tr>
<td>6. The nurse answers all our questions</td>
<td>281</td>
</tr>
<tr>
<td>7. The nurse respects our various cultures and beliefs</td>
<td>225</td>
</tr>
<tr>
<td>8. The nurse guides the support group interaction</td>
<td>331</td>
</tr>
<tr>
<td>9. The nurse deals with barriers to communicate within the support group</td>
<td>225</td>
</tr>
<tr>
<td>10. The nurse stresses the issue of confidentiality throughout the session</td>
<td>347</td>
</tr>
<tr>
<td>11. The nurse encourages active participation of group members</td>
<td>342</td>
</tr>
<tr>
<td>12. The nurse promotes patients empowerment and autonomy</td>
<td>321</td>
</tr>
<tr>
<td>13. The nurse assists the patients to increase their knowledge</td>
<td>328</td>
</tr>
</tbody>
</table>

Table 4.7 indicates that almost all the respondents’ perceptions of the nurse’s attributes were positive.
4.7.1 Section F item 1: Approachability of the nurse

Of the respondents, 89,1% felt that the nurse as the group facilitator was approachable while only 10,9 % disagreed. The findings linked with section E item 8, which also confirmed good relationships with one another within the support group. Stewart et al (1999:15) found that nurses are friendly and could be asked questions at any given time as they could be from similar cultural backgrounds and there was a possibility of speaking the same language or being bilingual.

4.7.2 Section F item 2: Nurse’s support

Of the respondents, 94,6% agreed that the nurse was supportive to all of them while 5,4% felt that the nurse was not supportive. This linked with Section D item 14 where 81,7% of the respondents said the atmosphere was empathetic.

4.7.3 Section F item 3: New members orientation

Of the respondents, 80,9% agreed that they were orientated as new members into the support group while 19,1% disagreed. Corey (2000:451) emphasises that the nurse has the skills and knowledge of how a group should function.

4.7.4 Section F item 4: Overcoming the hypertension stigma

Most of the respondents (90,3%) indicated that the nurse helped them to overcome the hypertension stigma while only 9,7% disagreed. Those who disagreed may be
respondents under 30 years. Hypertension is known as a chronic disease and affects old people. This notion may contribute to it being a stigma, especially to the younger generation. There is a need to educate young people about health problems so that the risks of being affected are reduced (Stanhope & Lancaster 2004:1051).

4.7.5 Section F item 5: Motivation to attend the support group

Of the respondents, 95,7% agreed that the nurse motivated them to attend the support group while 4,3% disagreed. This linked with section A item 8, where 88,3% of the respondents indicated that they were attending the support group regularly.

4.7.6 Section F item 6: Answering all questions

Of the respondents, 80,3% agreed that their questions were answered whereas 19,7% disagreed. This finding supports Jewell’s (1994:434) finding that comprehensive answering of patients’ questions and use of understandable language promote participation. Goldsmith (2000:16) states that nurses are primary educators of the patients and their families because they are knowledgeable.

4.7.7 Section F item 7: Respect for various cultures and beliefs

Although 64,3% of the respondents agreed that their cultures and beliefs were respected, 35,7% felt that the nurse did not respect their various cultures and beliefs.
Carletonville District as a mining area has people from nearby countries with various cultural beliefs, values and traditions. It was clear that some respondents were not happy about this issue. This may be a challenge to the facilitators to familiarise themselves with the cultures, attitudes and values of the patients who attend the clinics. Compliance is also affected by how people’s beliefs and values are respected or disrespected by the nurses. Facilitators should consider cultural relativism where people view other people’s cultures from the perspective of their culture and understand other cultures rather than dismissing them as “strange” (Monareng 2003:183; Schaefer & Lamm 1992:186).

4.7.8 Section F item 8: Support group interaction guidance

Of the respondents, 94,6% agreed that the nurse as the support group facilitator guided the group interaction while only 5,4% disagreed. One of the roles of the nurse is to give direction on how the group should interact (see chapter 2, section 2.5.1).

4.7.9 Section F item 9: Dealing with barriers to communication

Of the respondents, 64,3% indicated that the nurse dealt with barriers to communication in the group while 35,7% disagreed and this percentage was of concern. It can be linked with section D item 7 where 49,1% of the respondents were of the opinion that some members dominated the group. It may also be due to language barriers because the patients around the mines come from different language backgrounds.
4.7.10 Section F item 10: Confidentiality within the support group

Of the respondents, 99,1% agreed that confidentiality was maintained within the group while 0,9% disagreed.

3.7.11 Section F item 11: Active participation of group members

Of the respondents, 97,7% reported that the nurse encouraged the active participation of group members and only 2,3% disagreed. The findings could be linked with section D item 12 where 90,9% of the respondents agreed that they shared experiences, fears and ideas in the support group. Toseland and Rivas (1998:184) stress that the group facilitator ensures that everyone is involved in group activities so as to attract members.

3.7.12 Section F item 12: Promoting patients’ empowerment and autonomy

Of the respondents, 91,7% agreed that the nurse promoted patients’ empowerment and autonomy while 8,3 % disagreed. Stewart and Eales (2002:13) state that patients are empowered if they convert knowledge gained into meaningful action to change their health behaviour.

4.7.13 Section F item 13: Increasing patients’ knowledge.

Of the respondents, 93,7% agreed that the nurse assisted them to increase their knowledge while only 6,3% disagreed.
4.8 GENERAL PICTURE OF ALL THE SECTIONS

The lowest mean for all sections was in section E ($M = 2.9567114$) which dealt with the reasons why some hypertension support group members did not attend the hypertension support group sessions. Inaccessible and lack of transport seemed to have had a negative impact on the hypertension support groups.

![Figure 4.9 Combined means for different sections](image)

The above figure revealed that the respondents rated section B on health education positively.

4.8.1 Means split for gender by different sections

The lowest mean in female respondents was found in section D ($M = 2.9839934$) which dealt with the weaknesses of the hypertension support group. Weaknesses picked up in section were that some support group members dominated the group, unresolved conflicts within the support group, and long queues.
The lowest mean in males respondents was found in section E ($M=2.8545714$) which dealt with reasons why some hypertensive patients did not attend hypertension support group. Some respondents were employed or self-employed and therefore found it difficult to abstain from work on scheduled dates.

![Figure 4.10 Means split for gender by different sections](image)

**Figure 4.10 Means split for gender by different sections**

### 4.9 CONCLUSION

This chapter discussed the data analysis and interpretation, using tables and graphs. The overall findings of the study were positive though weaknesses, which need attention, were also identified.

Chapter 5 concludes the study, discusses its limitations, and makes recommendations.
CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter concludes the study, discusses its limitations and makes recommendations for practice and further study. The purpose of this study was to explore and describe the perceptions of hypertensive patients regarding hypertension support groups in the Carletonville District in order to make recommendations that could improve the quality of management of hypertensive patients.

5.2 CONCLUSIONS

The following conclusions were drawn from the data analysis and are discussed according the research questions.

The study revealed that the hypertension support group should be sustained, as the perceptions of the hypertensive patients were positive. The strengths of the hypertension support group outweighed the weaknesses. However, some weaknesses were identified that need to be attended to in order to improve the quality of hypertensive patients’ management.

What are the strengths of the hypertension support groups perceived by hypertensive patients in Carletonville District?
Section C of the questionnaire consisted of items considered to be the strengths of the support group. Almost all the respondents rated the items positively. It was clear from this section that hypertensive patients had moral support and peer counselling in the support group. They also shared life experiences and felt welcome in the support group.

The highest rated strength was that of adherence to treatment. Almost all the respondents (99,0%) mentioned that they were encouraged to take their medication daily. In addition, the patients were also taught about the side effects of the treatment.

The respondents stated that their knowledge about hypertension had increased and they felt a sense of belonging to the support group. It can therefore be concluded that the support groups are helpful in hypertension management and should be strengthened and sustained.

*What are the weaknesses of the hypertension support group perceived by hypertensive patients in Carletonville District?*

Of the fourteen items in section D considered weaknesses of the hypertension support group, the respondents only identified the following as weaknesses:

- unresolved conflicts (51,7%)
- domination (49,1%) by other group members in the support group
- inaccessibility of the clinics that serve as the meeting point for the support group (38,0%)
- the long waiting period at the clinics (70,6%)
• although not part of this investigation, it would be of interest to know why many of the respondents complained about long queues
• difficult to abstain from work on planned dates (50,9%)

Although there were only a few weaknesses, they might impact negatively on support group attendance. It can thus be concluded that the support groups are not user-friendly enough for most of the hypertensive patients.

**Why do some of the hypertensive patients in Carletonville District not attend the hypertension support group?**

Sections E and F, which dealt with the clinic as a meeting point and the attributes of the nurse as the support group facilitator, indicated the following reasons for not attending the hypertension support groups:

• transport problems (56,6%)
• not easy to attend the support group sessions because of employment (50,9%)
• length of support group sessions and considering that they still had to wait in long queues before being attended to, too much time was needed to attend the support group (70,6%)
• some nurses were not culture sensitive (35,7%)
According to Monareng (2003:182), cultural conflict might occur in a group without the facilitator noticing and most sources of conflict in a multicultural group might be based on different values, cultural backgrounds and experiences. With regard to accessibility and distance, it can be concluded that hypertensive patients cannot attend the support group sessions because they cannot walk to the clinic as the majority of them are elderly.

5.3 LIMITATIONS

The researcher identified the following limitations:

- The researcher had to wait for the specific dates scheduled for the support group in each clinic and that prolonged the data-collection period.
- Patients with other chronic diseases like asthma and diabetes mellitus who were also support group members were excluded.
- The study focused only on local municipality clinics and excluded clinics managed by mining houses which also had hypertensive patients.

5.4 RECOMMENDATIONS

The following recommendations are made for improving the hypertension support group and for further study.
5.4.1 Improving the hypertension support group

- Support group sessions should be separated from follow-up check-ups.
- Patients who are working should have their own support group and meet at a time suitable for them.
- The support group sessions should be shortened.
- A venue other than the clinic should be considered, as the clinic was not accessible to some of the respondents.
- Long queues should be eliminated.
- The nurse should consider cultural diversity and sensitivity.
- The nurse should guard against group domination by other group members.
- Conflicts should be resolved to members’ satisfaction within the support group.
- The nurse should deal with barriers to communication.

5.4.2 Further study

Further study should be conducted on the following:

- Factors contributing to long queues at the clinics
- How hypertension support groups can be sustained
- Nurses’ perceptions of the hypertension support groups
- Whether support group attendance is linked to collecting medication.
5.5 CONCLUSION

This chapter evaluated whether the research questions were answered, presented the conclusions, identified the limitations of the study and made recommendations for support group improvement and further study. Hypertension, as a silent killer, remains a threat to our community therefore patients need to be regularly updated about it. Goldsmith (2000:16) emphasises that hypertension cannot be cured but for many patients can be managed.
LIST OF SOURCES


