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Arterial Hypertension as seen by the Hypertensive: The Attribution of Meanings by a Low Income Population

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Abstract

This study aims at comprehension of the meanings attributed by low income hypertensive individuals regarding arterial hypertension (AH) and its treatment. Four focus groups were organized, with 13 men and 15 women living in a community on the outskirts of Fortaleza, in the Northeast of Brazil. We perceive that the meanings expressed by the hypertensive are tied to emotions and to social and economic issues present in their life style, and that it is of fundamental importance to listen to them in order to construct strategies for educational intervention. Furthermore, the difficulties mentioned with regard to health services point to a need to also develop systemic strategies, in view of the fact that attitudinal and behavioral change on the part of those responsible for the health system also leads to changes in users' attitudes and behavior.
Keywords: Hypertension; quality of life; education.

La Hipertensión Arterial en la Visión de los Hipertensos: Atribución de Significados por Personas de Bajos Ingresos

Compendio

Este estudio objetiva comprender los significados atribuidos a la hipertensión arterial y su tratamiento por parte de individuos de bajos ingresos. Fueron realizados cuatro grupos focales de discusión, con 13 hombres y 15 mujeres, residentes en una comunidad periférica de la ciudad de Fortaleza, en el Nordeste del Brasil. Percibimos que los significados expresados por los hipertensos están relacionados a emociones, a cuestiones sociales y económicas presentes en su estilo de vida, y que es fundamental oírlos para construir estrategias de intervención educativa. Por otro lado, las dificultades apuntadas en el servicio de salud llevan a la necesidad de desarrollar cambios sistémicos, ya que el cambio de actitudes y comportamientos de los responsables por el sistema de salud también influenciarán el cambio de actitudes y comportamientos de los usuarios.
Palabras clave: Hipertensión; estilo de vida; educación.

Arterial hypertension is a pathology which, on the average, affects 20 per cent of the population in various countries of the world (Nogueira et al., 1998). Furthermore, chronic hypertension is considered the main factor in cardiovascular disease (CVD). In countries where AH is highly prevalent, the incidence of CVD in the population is great. This fact makes AH a significant public health problem (Lessa, Mendonça, & Teixeira, 1996).

The prevalence of arterial hypertension in Brazil is unknown. An incidence of 20 per cent among adults is estimated. Although studies have been done in several regions of the country, their results do not permit generalization, because different criteria have been used (Lessa, 1998; Mello Jorge, Gotlieb, & Laurenti, 2001).

Its occurrence in different populations has been found to be related to biological determinants, life style, environment, health services organization and interactions among these factors (Lessa, 1998; Lólio, 1990). Because it is a disease that frequently affects people in their productive years, causing more serious illnesses that can have physical consequences, public health institutions in several countries have been proposing educational interventions aiming at altering life styles that predispose people to the occurrence of AH and CVD. To that end, they employ strategies uniting

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community, behavioral and communication approaches (World Health Organization, 1998).

Nevertheless, a gap has still been observed between the information disseminated and its application in people's lives. Some studies of the relationship between knowledge, attitudes and practice for CVD and AH have shown that knowledge by itself does not translate into practices to reduce risk. According to this research, other factors related to people's lives influence the attitudes required for behavior change; it is necessary to take into account the relationship between the expressed behavior, attitudes and knowledge present among the individuals in order to intervene (Aubert et al., 1998; Péres, Magna, & Viana 2003; Silargy, Munir, Coulter, Thorogood, & Roe 1993; Suminski et al., 1999).

Bearing in mind the issues raised above, in this study we have investigated meanings regarding AH and its treatment among hypertensive subjects. To that end, information obtained from hypertensive men and women living in the metropolitan housing project in the municipality of Caucaia, on the outskirts of Fortaleza, Ceará, is presented and discussed, with a view to drawing up a proposal for health education among this population.

Method

The Population Studied

This study was conducted among hypertensive men and women aged 30 to 60, living in a metropolitan housing project in the municipality of Caucaia, in greater Fortaleza. All participants were hypertensive and were undergoing treatment.

There are approximately 3705 housing units in the community and about 15000 individuals, most of whom live in small dwellings built on unpaved streets with no sewage system or drainage. The community grew up in the nineties, as the result of squatter settlements on lands of the Tapebas Indian tribe; it is located alongside state highway CE 020. Because the settlements were on Indian lands that had already been marked off, the manner in which they occurred was characterized as an illegal "invasion of lands." At the present time, the basic public services provided to the population are power, running water and telephone lines. As for other services, there is only one public school. In addition, there is a police station with two military policemen on duty. There is no day care center to serve working mothers, health care post or any leisure area. The population is low income, living on the periphery of a big city and facing problems such as the absence of a sewage system, shortage of schools for the children and lack of medical care.

A cross sectional study, performed in the area from which we have drawn the sample included in this study, have estimated that 22% of the population exhibit hypertension (Feijão et al., 2005).

Focus Groups

The objective of this study is to analyze the cluster of meanings attributed to the disease arterial hypertension by a small group of hipertensive patients using focus group technique. A previous study verified the relationship between knowledge, attitudes and practices related to risk factors (Lima, Bucher, & Lima, 2004).

As a means of gathering information, focus group discussions were held. Four groups were formed, with a total of 28 participants, of whom 13 were men and 15, women. Selection of individuals relied on an existing data base on this population, from which we identified the hypertensive subjects. The groups were led by the researcher, in the role of facilitator, with the assistance of a second person as an observer, and taped. A basic interview schedule was utilized, based on which we went more deeply into the questions of interest to the study.

The focus group is described of by Patton (1987, 1990) as an interview with a small number of people on a specific topic. The formation of the group obeys criteria established in advance by the researcher, in accordance with the objectives of the research.

All the material gathered from the focus groups was transcribed, read and organized into idea association maps, with the aim of understanding how the hypertensive comprehend arterial hypertension and its treatment. Next, selections were taken from the dialogue where the arguments constructed permitted better comprehension of the meanings sought after in the research. These excerpts formed the meaning figures (Spink, 1999).

The aim of idea association maps is to organize information, observing their contents and dialogic aspect, with a view to construction of meanings. Initially, we defined general categories, organizing contents on that basis, and conserving the sequence of comments. The general categories were grounded in the research objectives and the literature on the topic (Spink, 1999).

Based on the maps, we identified thematic clusters that produced the desired meaning, casting light on the association of ideas. Through the comments or the course of dialogue, we sought to understand the meanings produced by the group under study. These clusters formed the diagrams of meanings, graphic representations, which were the object of our analyses

and discussions (Spink, 1999). Through this way of organizing the data, we were able to attain greater visibility of the process of interpretation and meet the objectives set for this research.

Results and Discussion

In order to grasp the representations regarding AH, we pointed the discussion toward the following topics: discovery of the disease, the impact of hypertension on people's lives, treatment, and the seriousness of the illness. With regard to discovery of the disease, we perceived that the hypertensive subjects interviewed had discovered that they suffered from AH by chance or because of bodily sensations that led them to seek a physician and, consequently, diagnosis. In their comments, the hypertensive defined very clearly what they were feeling as a result of increased blood pressure: headaches, dizziness and a pain in the heart. Furthermore, for these subjects, to suffer from AH means to change pleasurable habits, take medicine for the rest of your life and have a serious disease.

According to their testimony, *life changed for the worse* after high blood pressure appeared (*e.g.* Figure 1). The main change was constant headaches, provoking irritation and impatience. This fact was singled out as a cause of problems in family relationships. Furthermore, the following changes were cited: increased frequency

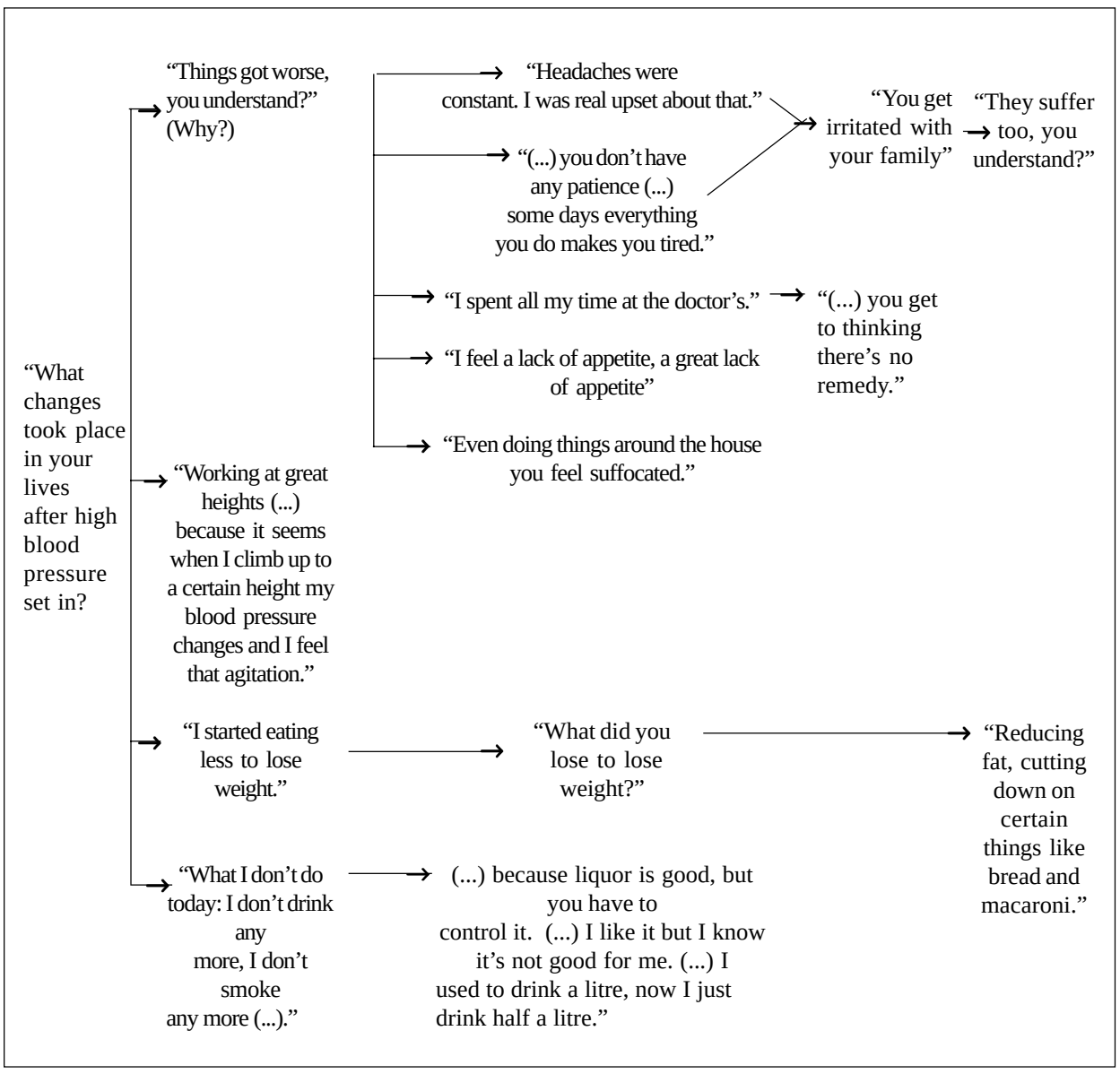

Figure 1. What has changed since AH

of visits to the doctor, lack of appetite, a sensation of suffocation, and changes in diet and in smoking and drinking habits. From the women's point of view, high blood pressure disease interferes in family life, marriage and one's sex life. Work was one point that was greatly stressed by the men. For them, their professional activities are prejudiced by the presence of the disease; and, likewise, the type of work performed and working conditions impedes the routine adoption of the behaviors prescribed for treatment of arterial hypertension.

As for treatment, we identified certain important points. Being treated for arterial hypertension means a *struggle* - taking medicine, walking and dieting. In our view, the use of the word *struggle* is related to the difficulties encountered in facing the disease. When we are struggling, we are simultaneously facing an adversary and seeking results. To that end, we require favorable conditions for the confrontation with the *enemy*. As we are dealing with people living with very limited financial resources, who have very low levels of schooling and who face a wide variety of problems imposed by the social and economic characteristics of the country, we wish to stress that just living is itself a difficult struggle. So, what is it like to suffer from a disease that can be controlled but not cured, and to be dependant on medication? One of the testimonies reinforces this idea: "*(…) You've got to realize that you have that problem and that it's practically an incurable disease, and you worry about that, you understand?*" (Male focus group on AH treatment).

The literature indicates that socioeconomic factors may be associated with occurrence of arterial hypertension. With regard to income and education, it may be affirmed that groups with low incomes and low levels of schooling have high levels of blood pressure (Fuchs, Moreira, Moraes, Bredemeier, & Cardoso, 1995; Lólio, 1990).

As for the relationship between occupation and arterial hypertension, a review of the literature in Brazil, covering the period from 1967 to 1986 (Cordeiro, Frischer, Lima Filho, & Moreira Filho, 1993), reported that in all the studies reviewed a relationship was found between type of occupation and arterial hypertension. The lower the professional level in the hierarchy, the greater the prevalence of AH.

An exploratory study by Duarte et al. (2002, p. 93) analyzes health inequalities in Brazil and suggests that the country has indicators resembling those of the developed countries, with the occurrence of ailments derived from this phenomenon, including cardiovascular disease. At the same time, it also presents indicators characteristic of underdeveloped countries – a case of "the phenomenon of juxtaposition between the 'diseases of backwardness' and the 'diseases of development.'"

Furthermore, those same researchers also suggest that health inequality in Brazil is polarized in the different regions of the country. Thus, the southern and southeastern regions, with better socioeconomic levels, generally have better mortality readings for poverty-

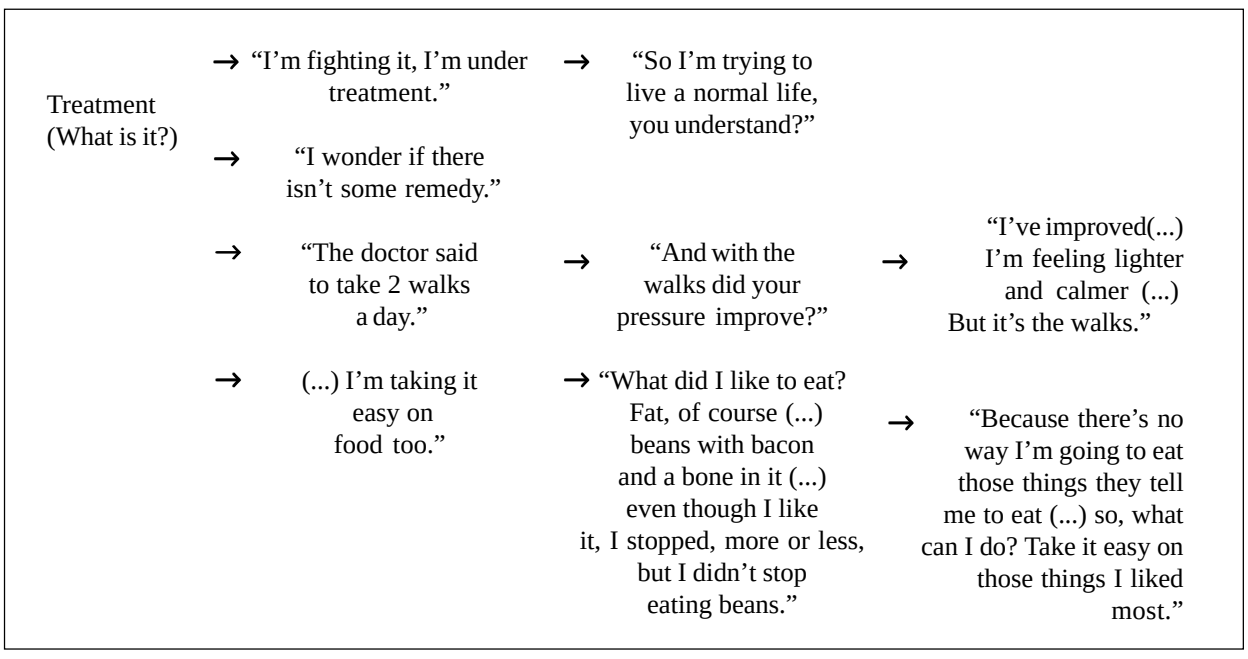

Figure 2. Meanings of hypertension treatment

related diseases than the northern and northeastern regions. As for cardiovascular disease, the highest mortality rates are associated with lower levels of poverty. Thus, in the North and Northeast, lower rates of mortality from cardiovascular disease are observed.

Besides defining what AH treatment means, these subjects also expressed their dissatisfaction with the treatment. One of the points mentioned is the idea of having to buy the medicine. We understand that this dissatisfaction results from the fact that they are living on very little income. Thus, taking money out of the small family budget to acquire medication means there won't be enough for food and other household expenses. For these people, living with arterial hypertension means, first of all, *having to take medicine the rest of your life*. We found meanings that demonstrate that knowledge does exist of the need to take medicine. However, besides this, we found emotion-laden representations. For some people it's *horrible*, an obligation, it's always seeing yourself as a sick person. However, in spite of the manifest dissatisfaction, the medication was also referred to as what gives you back your life, because without it, the sensations of discomfort provoked by increased blood pressure would make life worse.

Carvalho, Telarolli Junior, and Machado (1998), based on a study of hipertensive elderly in Araraquara city, São Paulo, found that the necessity to treat arterial hypertension is not, generally understood. In this sense, the researchers considered that the chronic nature of the disease, that persists for long periods of time without presenting symptoms, is a factor which under mines individual's attitude towards treatment.

On the other hand, we also find that *having to abandon things you like to do* is a source of dissatisfaction. In the first place, we perceive that dieting requires *an effort*. We understand that the need to make an effort exists, on the one hand, because of the dislike of refraining from eating a lot and eating what one likes, and also because of the lack of means to buy food. Also, the subjects pointed out the difficulty involved in giving up the habits of eating salty food and smoking: *"(...) the hardest thing is giving up cigarettes, and even today I haven't been able to do it."; "I just can't seem to do it, I know it isn't good for me, but I'm just not going to eat bland food*."

Also in this regard, from the point of view of these subjects, a behavior that is good for your health may p rovoke a personal feeling of displeasure (*e.g*. Figure 3). This way of seeing the disease presents us with a conflict faced by these individuals: the confrontation between awareness that it is important to change one's habits to have more health, but also that this change may mean giving up some pleasure. Pleasure is an emotion tied to an agreeable sensation or the satisfaction of a tendency. Like pain, it has the effect of orienting an individual's activities on the pathway of adaptation. It is inseparable from desire, just as pain is inseparable from aversion. It is characteristic of human beings to seek pleasure and flee from pain (Sillamy, 1995).

In an exploratory study of 32 hypertensive patients is the connty of Ribeirão Preto, São Paulo, researchers revealed the existence of a lacuna between what patients know about arterial hipertension and what they actually do. In reaction to adapted behaviors, the valuing of medical assistance and medication ewer other recommended practices was encountered. On the other hand, the same individuals, when questioned about what they coned do to control their pressure penpaisted changes in lifestyle (Peres et al., 2003).

In other study, which investigated knowledge and practices related to arterial hypertension it was found that individuals have their own system of beliefs and disease, its causes, riskes and complications. These feet can also generate control practices that are also distorted, making difficult compliance with correct treatment (Lima, Bucher, & Lima, 2004).

Regarding the seriousness of arterial hypertension, there are different opinions. Some consider the disease a serious problem because it can cause death or a permanent state of physical deficiency. Others expressed the opinion that it is not worth worrying about. For this group of women, death would come anyway,

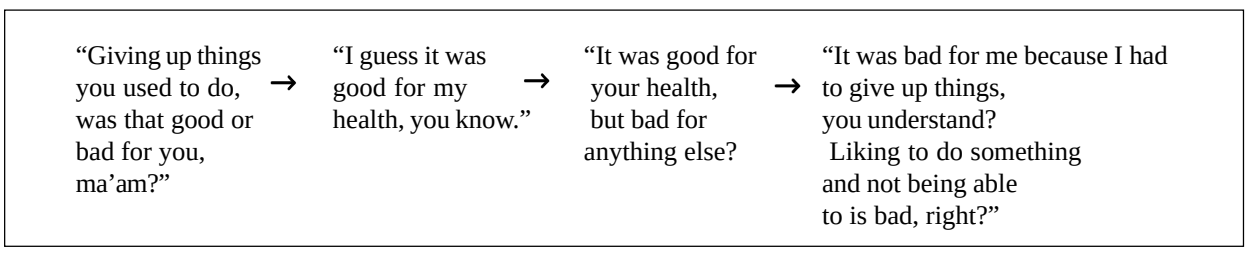

Figure 3. Meanings of behavior change.

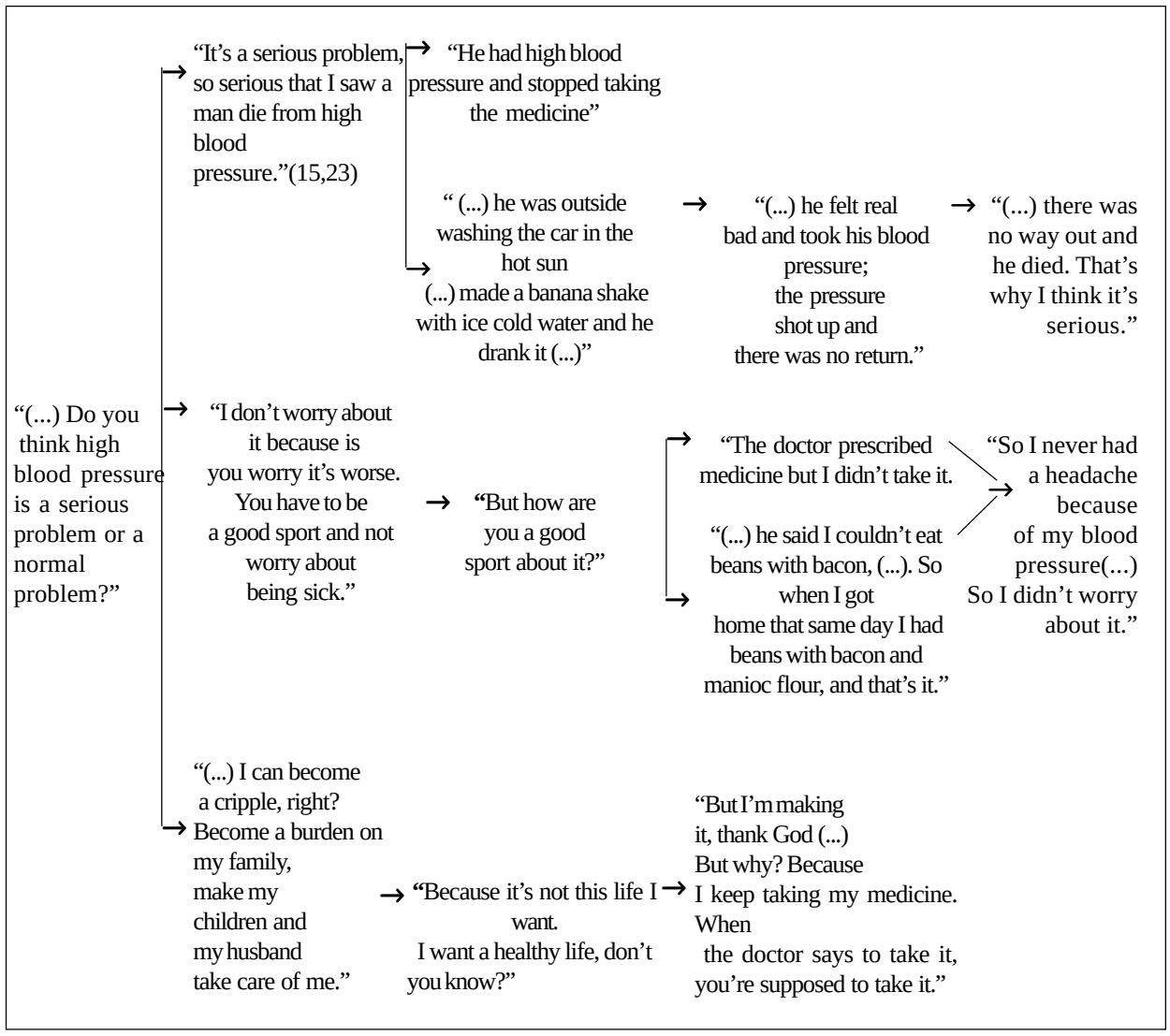

Figure 4. Meanings regarding the seriousness of hypertension.

independently of arterial hypertension. Discussing her lack of concern with being hypertensive, one of the women interviewed stated that she doesn't worry about it *because if you worry it's worse*; she defines lack of concern as *being a good sport*. Thus, she does not take the prescribed medicine nor does she diet. That same person justifies her behavior saying that she never had a headache because of high blood pressure. When we analyze her comments per se, as well as the way they were expressed, we note the presence of a feeling of revolt. Thus, we understand that *if you worry it's worse*, because the means required for solving the problem are not easily accessible and the only way to live with AH is not to worry. Within this perspective, we may say that the medical prescriptions may be coming up against the difficult conditions experienced by this population in their everyday lives. The medicine may be provided by the health service, but not the food. As one of the female participants stated in the discussion of treatment of AH, "*so the only thing to do is to suffer pain anyway and put your hope in God. He's the only solution for us, isn't that right?*" Poor living conditions reduce these individuals' availability for treatment. Faced with this situation, the response is religiosity - the sentiment of faith as something that may solve their problems and as a hope for improved living conditions.

Another important point highlighted by the comments cited in Figure 4 is that besides an awareness of the need for medication, people have their own explanations of how the disease occurs. Regarding this question, we find in the literature that people construct and reproduce medical knowledge in accordance with the sociocultural world in which they live and with the meaning they attribute to bodily sensations. From this viewpoint, disease, as an interpretation and judgement,

is a process of construction of a sociocultural nature. Furthermore, the subjects defend the idea that disease has both a physical dimension, as studied in the universities and experienced in the clinic, and an experiential dimension, which refers to the patient and his way of perceiving and experiencing suffering and pain (Alves & Rabelo, 1995; Caprara, 1998; Uchoa & Vidal, 1994).

Another important aspect of the investigation is the relationship established between AH and emotional aspects. To go more deeply into the topic of the causes of AH in the focus groups we raised the following question: *Why do you think you have high blood pressure* ? Among the responses there was reference to heredity, worries, and problems in life and in marriage.

Hunt, Enslie, and Watt (2001), in a study seeking to investigate individual attitudes and behavior, relating perceptions regarding family history to heart disease, found that heredity was mentioned spontaneously as a cause of heart disease by more than two thirds of those interviewed; almost all agreed that it is an important factor when asked specifically about it. Although aware of heredity as a cause of cardiovascular disease, the interviewees did not consider that occurrence of a heart attack in the family put them at greater risk of having the disease. Besides family history, they posit other aspects, such as differences between their own life styles and those of affected family members, the ages of those relatives or the degree of relationship; or they attribute the heritage to the other side of the family. Thus, the interviewees make a distinction between general risk and personal risk.

According to Hunt et al. (2001), the perception of heredity in the occurrence of heart disease is much more complex than a dichotomous variable. People need to be aware that incidence of a determined disease in the family predisposes them to the risk of getting that disease.

We observe that besides heredity (classified in the literature as a constitutional risk factor), the comments point out and go more deeply into the meanings of factors related to life style. We also find reference to drugs in the family, violence, disease and chronic marital maladjustment, generating unhappiness, unresolved dissatisfaction and, therefore, inadequate conditions of life. There is no doubt that in these individuals' system of meanings, the disease has an hereditary origin, and is likewise determined by the characteristics of the family and social milieu in which they live.

Backett and Davison (1995) discuss the concept of lifestyle from the point of view of the layman and of the social sciences, as well as its utilization in the health area. Their study shows that the meanings attributed to health, disease and related behaviors were grouped by

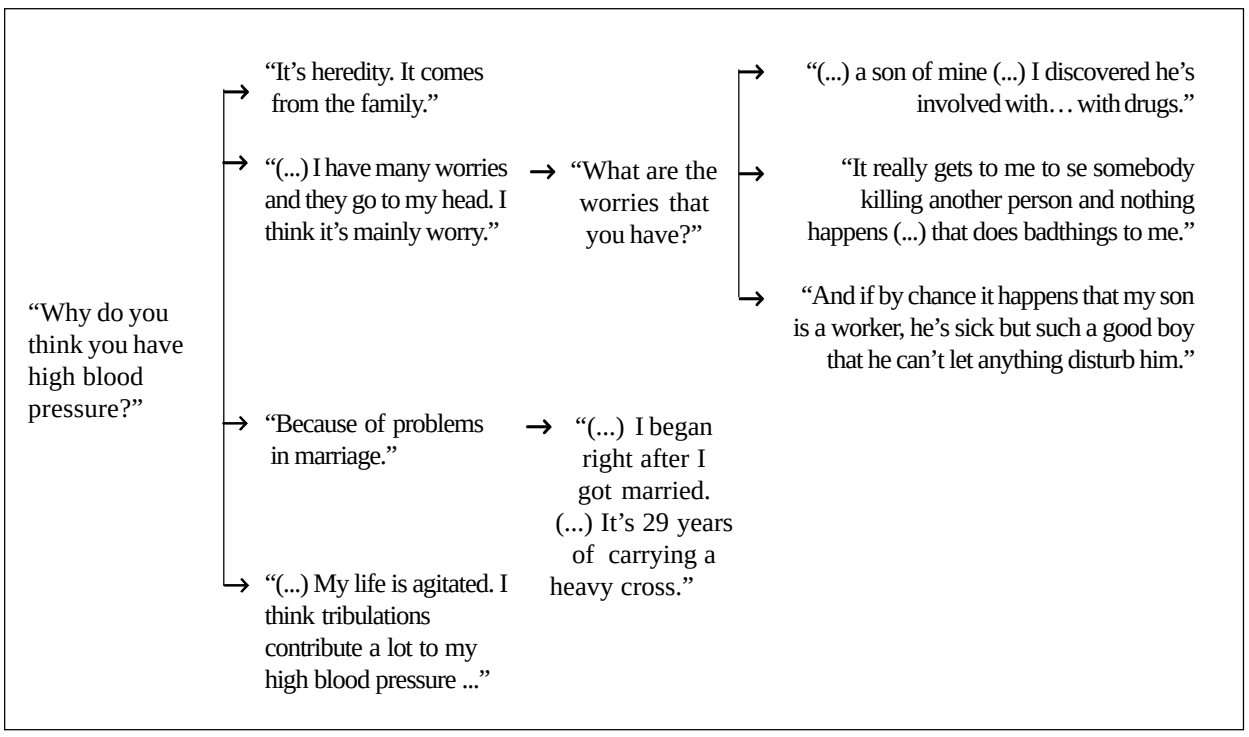

Figure 5. Meanings regarding the causes of hypertension.

period of life. Thus, evaluation of the positive or negative influence of the behavior occurs within the cultural context that establishes life style by age, demographic position and personal biography.

With regard to its utilization in the health area, these authors point out that the concept of lifestyle has been essential in the development of theories of health promotion. However, they criticize the psychological approaches which predominate in research on health behaviors for focusing almost exclusively on the responsibility of the individual, ignoring the influence of psychological factors and social and environmental conditions.

Besides what was discussed above, we would like to point out that according to what was expressed in the groups, access to health services is a bottleneck in treatment practice. At this time, we have identified two determining factors for the practice of treatment. The first is a deficiency in the capacity for local health care provision; the participants reported that it is necessary to arrive in the wee hours of the morning at the health posts and stand in long lines to be cared for. The second factor is the lack of preparation of health care professionals to serve the low income population, which leads to prescriptions that are inconsistent with the kind of life this population leads and the people's lack of confidence in the efficiency of the service:

> "Because what the doctor told me to do, the first time I went to the doctor he told me to eat two spoonfuls of rice, a little bit of beans and a beefsteak. Right! A green vegetable. So that day… that day I did what he said, you know. But the next day, where were the six reals for a kilo of beef?" "Yeah, the doctor thinks we live the way he does." "That's why it's so hard." (Dialogue taken from the women's focus group on AH treatment.).

Besides these factors, we also identified in the comments a lack of time due to housework, dissatisfaction with having to go to the doctor and take medicine every day, lack of knowledge of the consequences of the illness, absence of symptoms, physical difficulties characteristic of the environment where they live, difficulties they face at the workplace, and the fear of going to the doctor and discovering they are ill. From the viewpoint of these individuals, willpower appears as a factor in behavior modification. This is related to popular sayings like *to want to is to be able to* and to explanations that ascribe to the individual the responsibility to follow the prescriptions of the health professionals, without regard to the lack of adequate conditions for putting them into practice.

The group with which we did this study consists of humble people who are often blamed for practically everything that doesn't work out the way it was supposed to. They are the scapegoats of the system. An example of this phenomenon may be seen in the following dialogue: "*What are the difficulties you encounter in getting to where the doctor is?" "I guess we're the ones who create the difficulties, ain't that right*?" (Dialogue taken from the women's focus group on AH treatment.)

On the other hand, we also identified factors that have a positive influence on attitudes toward treatment. Factors that mobilize people to put into practice these behaviors include considering health important, recognizing the importance for good health of the behavior, the occurrence of acute symptoms that cause pain and discomfort, difficult experiences with the illness in the past, pleasure in behaving in the prescribed manner, the prior existence of the habit of behaving in the manner that is being required of them, the will to live longer, fear of dying, favorable working conditions, the support of the family, and awareness of habits that exacerbate the problem of high blood pressure.

As for the mobilizing factors cited above, we perceive among these people a recognition of health as something important, and to be healthy as a latent desire. Health is seen as a precious possession, and is often compared with good appearance. This feeling was expressed by one focus group participant: "*But it's very good to have health. It's very good to have a good, healthy appearance*."

Conclusion

From the discourse of the hypertensives, we perceive that they do have knowledge of what is indicated for treatment of AH. This is due to the fact that we were dealing with hypertensive individuals who had already received medical orientation regarding treatment. From the discussion groups with hypertensives there emerged categories ranging from cultural, social and economic issues to individual reasons that represent personal dissatisfaction. It should be noted that the meanings expounded upon in this article are just the tip of the iceberg, and that it is necessary to go more deeply into the questions that are seen to be emerging.

The information extracted from the interviews in the focus group discussions clearly showed the relevance of utterance as free expression of opinions and emotions. In this study, we found that the focus group

technique, facilitating as it did group interaction, helped to stimulate ideas and overcome whatever resistance might have occurred in an individual interview process. The interaction among the members of the group encouraged them to talk more among themselves than with the moderator; thus, in practice, there were more moments of exchange of ideas within the members of the group than responses to outside questions. Even though the groups were not interacting in a natural environment, as in an observation situation, the interaction among the participants did produce important information, on the basis of which we were able to conduct our analysis.

The method of analysis of results employed in this study made it possible for the information to be interpreted with greater assurance. Ordering the dialogues in idea association maps made possible better comprehension of the meanings expressed in the utterances. We also perceived that the meanings expressed by the study participants took on form and significance as we progressively identified their insertion into the life style of the group under study. Subsequently, relating the method of analysis, with all its organization and transparency, to the socioeconomic characteristics of the interviewees, we were able to uncover and to comprehend at a deeper level the meanings we were seeking.

The results of this study reinforce the implications of the existing social and economic inequalities in Brazil, which call for adoption and expansion of public policies on infrastructure, redistribution of wealth, and broader access to public services and household consumption items, as well as implementation of anti-violence policies to promote healthy lifestyles, and point to a need for greater awareness on the part of health professionals in prescribing behavior change.

The problems cited in the preceding paragraph are difficulties faced by low income populations. Imposing as they do a style of life lacking in both public and private goods, they may stimulate behaviors harmful to health, such as smoking, sedentary lifestyles, and drinking during pleasurable experiences. Moffatt (1981, p. 74) refers to the “struggle for pleasure”: the feeling of pleasure that is organized around whatever provides immediate satisfaction to marginalized people.

In this study, we found that in addition to the confrontation with social aspects, prescriptions for treatment of arterial hypertension may conflict with pleasure mechanisms created by individuals as instruments of defense against life’s difficulties. These questions may provoke difficulties in mutual understanding between the health professional and the patient, creating obstacles to the behavioral change indicated for treatment.

Any proposed intervention with this group should take into account, besides what is already known about the patterns of the disease, the representations manifested by those who suffer from it. To do that, it is of fundamental importance to listen to people and to penetrate their imaginations, teasing out their knowledge, beliefs and perceptions. On that basis, we may be able to construct a discourse to be transmitted by the health area, facilitating the dialogue between professionals and the population and avoiding the imposition of prescriptions related to life styles.

Thus, we posit that strategies implemented for prevention and treatment of AH must act on the individual, considering his or her own perceptions, and that they must observe the individual’s social milieu and the forms taken by relationships within this milieu, whether in the family or the community.

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