DOI: 10.1590/1413-81232018247.15802017

"Pressure problems" in Guariroba/Brazil: an anthropological approach to chronic cardiovascular diseases

Soraya Fleischer (http://orcid.org/0000-0002-7614-1382) [1]

Abstract *This article, driving from Anthropology, presents ethnographic data elaborated in Guariroba, a neighborhood in the capital of Brazil. Between 2008 and 2014, dwellers, usually in their sixties, migrants and blue-collar workers, shared their perceptions on what they called high blood pressure and pressure problems, how they felt, explained and treated them. A very significant relation between pressure and nerves was clearly stated and helps clarify health professionals and also researchers in dealing with cardiovascular diseases. I suggest this relation can improve clinical and pharmaceutical practice and also the scientific results on hypertension. Knowing the perceptions from first person perspective, from those who live with long and chronic illnesses, is a relevant measure to strategically modulate actions of prevention and care.*

Key words *Pressure problem, Nerves, Brazil, Anthropology.*

[1] Departamento de Antropologia, Universidade de Brasília. Campus Darci Ribeiro, Cidade Universitária. 70910-900 Brasília DF Brasil. fleischer.soraya@gmail.com

Introduction

In 2004, Firmo et al.[1] stated that, "while on the one hand the epidemiological studies of arterial hypertension in Brazil have been increasing in number, on the other hand, anthropological studies are still rare". More recently, Fava et al.[2] perceived this identical shortage: "Despite the growing interest of research to understand the cultural construction of health/disease processes, there are few current works related to hypertension in this perspective". Canesqui[3], also in a recent article, reinforces: "National academic production on hypertension from the point of view of qualitative research in relation to the social and human sciences is relatively scarce".

Apparently, in the last decade, Anthropology is still shy to take chronicity, such as in cardiovascular diseases, as a research topic. Not even a dozen items were published up to now[4-12]. In some cases, "pressure problems" emerged collaterally. Adriana Vianna, studying the murder of young people by police forces in Rio de Janeiro/State of Rio de Janeiro, noted that pressure problems were commonly mentioned by the mothers in the search for justice and recognition (personal communication, ANPOCS, 2012). Or even Elena Calvo-Gonzalez[13] who started out curious about racial issues in Salvador/State of Bahia and ended up in clinics where "arterial hypertension" was the *lingua franca* in clinical conversations. In any case, taking "pressure" as a direct or indirect issue in the context of chronic diseases studies, this paper values the suggestion that "anthropological studies allow knowing in depth the perception that people have of hypertension, how they deal with this condition and what factors (economic, social and cultural) can influence perceptions and actions in this field"[1].

The consistent elevation of blood pressure is understood, from the biomedical perspective, as "systemic arterial hypertension" (SAH), a chronic, irreversible and incurable pathology[14]. From this point of view, "hypertension" is one of the most common and persistent health problems in our population: "Its prevalence in Brazil varies between 22% and 44% for adults (32% on average), reaching more than 50% for individuals aged 60-69 years and 75% in individuals over 70 years of age"[14]. On the other hand, from the perspective of people living with daily changes in blood pressure, there is not necessarily an understanding of illness or prolonged disturbance. Therefore, I have chosen to name the discussion that encapsulates causes, symptoms, ailments, treatments and meanings about changes in blood pressure as "pressure problems"[15].

This category was used by people I met while doing ethnographic research in Guariroba, a historic neighborhood in the city of Ceilândia, in the national capital. I was in Guariroba almost weekly, alone or in the company of different undergraduate and graduate students. I spent a lot of time observing and talking to people in the waiting rooms of one of the city's twelve public health clinics. I also observed the support groups for "hypertensive and diabetic" patients, the pharmacy daily routine and the exercise group that took place very early in the morning three times a week. When invited, I continued conversations in the homes of these patients, usually elders, migrants from the Northeast region of the country, who came to try their luck during the construction of the capital in the 1960s. Here, they married and had children, while they witnessed the city grow enormously in the last 50 years[16]. Ceilândia, founded in 1971, is the largest (with about half a million residents) of the 31 administrative regions that make up the Federal District (with a total population of about three million). Although they have been able to overcome the adversities of a stoical migration, they have remained in the poorer layers of society, although a discreet economic rise can be observed.

This article will tackle the perceptions about pressure problems from the 70 people that I knew in the neighborhood. First, I present the terminology used to communicate the bodily sensations they experience on a daily basis. With this, I can arrive at causal explanations about the emergence of these pressure problems, especially the importance credited to "nerves". In the end, I want to show how this approach, between pressure and nerves, influences the relationship with pharmaceuticals, health services and self-care. I suggest that, by expliciting local perceptions on pressure problems, a more sensitive and successful modulation can be developed for the prevention and treatment initiatives towards cardiovascular problems.

"Pressure problem" and "high pressure"

From the beginning, I would ask for contacts of people who were living with "hypertension". I would usually hear, "No, I do not know anyone". During a conversation with Mrs. Marcela, a widow from the State of Minas Gerais, it seemed pertinent to tune up the categories. Immersed for a few months in the field, I still hadn't noticed

Ciência & Saúde Coletiva, 24(7):2617-2626, 2019

the importance of the noun "pressure". The lady promptly replied, "Oh, many have high blood pressure. My sister Camila, for example. Judith, my neighbor here. Even my husband." It seems that the nosological category "hypertension", as a disease requiring treatment, follow-up, and controlled and continuous medication, found a better correspondence to the expression "pressure problem" and not simply "high blood pressure." "Pressure problem" seems more permanent and insistent, and it was common to hear it being used with the verb "to have" in the present, "My sister has a pressure problem since she was pregnant with her last child." The second term, "high blood pressure", seems to be used as a common temporary condition, such as an unpredictable "peak". In this case, one uses the verb "to be" or "to have" flexed in the past: "I had high blood pressure last week." Thus, facing these two different terms, "pressure problem" seemed to be an older and more persistent indicator of illness and suffering.

"High pressure" and "pressure problem" are terms found also by other colleagues[1,4,5]. From what was said in Guariroba, "high pressure" is a transient situation, to which anyone could possibly be subject to. "Pressure problem" is the high pressure that became persistent, that becomes a health problem some people had. I agree with Firmo et al.[1] that "high blood pressure" is an abrupt phenomenon and that the "pressure problem" is a permanent one. The "pressure problem" seemed to be closer to "hypertension" as a disease, in biomedical terms. Fava et al.[2], in a survey on "hypertension" in the city of Alfenas/State of Minas Gerais, also noted the current use of the term "pressure problem", very much associated with the "problem of nerves". The relationship between these two types of problems reinforces my suggestion for the association of "pressure problem" with a more serious illness. Yet none of this meant that people necessarily perceived themselves as sick or, at least, sick for a long time. Let us see why.

Sensations: The basic learning about pressure problems

I met Mrs. Arabela in the health clinics' waiting room. She told me that, a few days earlier, during the Easter holiday of that year of 2011, she had been in the city of Barreiras/State of Bahia, visiting her son. He had lived there for some years now, and she would usually visit him. "I felt a great pressure in my head, a pressure on my judgment, pressing, pressing back here [and pointed to the base of the head, near the nape]. And I did not know what it was, I could not even lie down". Pain (or tightness and pressure) in the head (or on the neck, forehead, upper and lower parts of the scalp) were, without comparison, the most commonly related body sensations to high blood pressure. It was the first sensation of discomfort that motivated them to find an explanation. Other studies have indicated the same initial symptoms[1,17-19]. If this high pressure eventually became permanent, as in the case of a pressure problem, the headache was an important sign that the problem was getting worse. Thus, this nuisance passed from sensation to symptom, as experience went from high pressure to pressure problem.

Lefévre[20] recalls that the disease of "hypertension" is a sensation. It is no wonder that many people, when describing a list of these pains and annoyances, conclude by saying, "That is how I feel the pressure." It was from the domain of feeling that came the closest and most concrete experiences with high blood pressure and also with pressure problem. Mrs. Rebecca told me, "Oh, when I feel a headache, I know I need to measure it." Mrs. Camila explained, "When it's the ear that throbs, I know it's high blood pressure. Headaches, dizziness too". While waiting for his consultation, Mr. Ivan said, "The forehead gets hot and the eyes get heavy. I know my body. I know when it's different." They learned to notice which sensations were specifically related to the pressure problem, especially when the blood pressure was rising. The goal was to perceive any changes quick enough to act and normalize their pressure level. All these people related the sudden rise of blood pressure to critical events such as stroke, aneurysm, infarction, and stroke[17]. These sensations were reported in two ways: first, symptomatic "crises" or "pressure peaks" that should find immediate hospital attention or, second, silent and unnoticed rises that were only discovered in a routine consultation, also found by Santos and Silva[21], Péres et al.[19] and Castro and Car[18]. It became a problem much more frequently when related to evident symptoms than to silent ones.

There were clinical and laboratory exams to discover and define a pressure problem. But at home, these people also performed "tests," as they called them, to find out if a headache was related to a pressure problem. One of the tests was to consume forbidden foods. Mrs. Carolina recalled, "Today, if I eat any salty food for lunch, then I'll immediately feel sick." When they were already taking some kind of blood pressure med-

ication, another kind of test was to skip the pill for one or more days[17]. A strong headache and/or a high number displayed on the sphygmomanometer screen were ways to verify that the test had worked. The measurement, in this sense, was understood as a proof of what had been perceived at the sensation level.

These assessments gained an important role in the interpretation of bodily sensations of illness. Most people I met over the years had sphygmomanometers at home and measured their blood pressure several times a day and for different reasons[6]. The equipment and its numbers continued to help make sense of what was not felt, especially to the so-called asymptomatic people. More available and accessible than medical authorities, devices became popular as an explanatory source for different malaises, disturbances, jitters, not only of pressure problems[6]. However, over time and with the insistence of pressure problems, people became autonomous from the numbers, devices and technical opinions. They were progressively attentive to symptoms and sensations, as if the body were little by little transformed into a sort of "natural sphygmomanometer". When they felt bad, they might not be able to tell if they were "15 by 10" or "16 by 10", but they knew their pressure was high or was on the dangerous rise. One woman, who took care of her both parents with "pressure problems" and now lived with her brother in the same situation, explained, "When my brother has high blood pressure, he does not even have to look at the device. He's all red, itchy and becomes nervous, he needs to take a cold shower, have some calming tea." I suggest that the pressure problem, as a sensation, a numerical index, and, as I will show in the next section, as an explanation, is part of the list of "physical-moral disturbances", so well discussed by Duarte[22].

Explanations for the pressure problem

As already mentioned, the first mild or the critical bodily sensation led to the discovery of a pressure problem. That is to say, the crises, more or less intense, were read and translated in several spaces, starting in the house, involving the extended family and sometimes even the neighborhood, all the way to the routine visits to the clinic (gynecologist, pre or postnatal clinician, nutritionist, nurse etc.) or to the 911 ambulances and hospital emergency wards. But people went further, explaining to me the reasons for these sensations and crises. In this section, I would like to discuss these explanations that help advance the understanding of pressure problems and, more than that, the biographical trajectories within which these problems take place.

To begin with, several women associated the onset of their pressure problem with reproductive events such as pregnancy, abortion, puerperal leave or menopause. Other accounts have also found this explanation[4]. Another explanation were family ties. Two of Mr. Felipe's brothers were "hypertensive", as he told me. And then he concluded: "If you have someone in the family, you have to take care of yourself. If you do not take care of yourself, you will also develop the problem." In the city of Salvador/State of Bahia, Trad et al.[23] noted among their interviewees that "SAH is recognized in this group as an *illness of the family*, due to its number of members, and to have affected different generations" (: 800, emphasis mine). The expression "of the family" rather than "of a family" is very eloquent because it clarifies, in my view, that this problem is perceived as a specific and pronounced pathology in *that* family, not any family nor even all families. This kinship reasoning was extended, in Guariroba, to the female line as responsible for defining the form (capacity, duration, moment in life) of becoming and continuing pregnant, miscarriage, birth, postnatal quarantine, menopause and, eventually, the effect of all these reproductive phases on blood pressure. On the other hand, it is worth noting that the familiar recurrence of the problem can contribute to trivializing causality and also treatment. For example, one of Castro and Car's[18] interviewees from the city of São Paulo, recalled: "The diagnosis of hypertension was known four years ago, and the treatment was started two years ago. Because my family has all this, I did not care that much". Finally, it seems that aging was a phenomenon considered to produce weakness, to the point of explaining the emergence of several problems, including pressure[3-5,11,23]. In general, I heard the following logic, when Mrs. Julieta from Guariroba reported to have high blood pressure, gout, nervousness: "Old age comes, and, you know, disease arrives."

In addition, there was a whole set of explanations that referred to the effects that emotions - usually caused by situations of conflict - exerted on blood pressure. When I visited Mrs. Janete, she brought out a shoe box where all her medication was stored. I noticed that several boxes were only partially consumed. Her son, across the room, was surprised with all this, "But Mom, why don't you take it as the doctor prescribed?". She shrugged and kept talking to me, "I'm like

Ciência & Saúde Coletiva, 24(7):2617-2626, 2019

this, I take it when I need it, when I'm kind of in this way." I wanted to understand what she meant by "way" and she went on: "Oh, my dear, sometimes I'm here watching television and I see so many ugly things, so much trouble around the world. Then I'm kind of like this, in this way. And I take one more pill to see if I get a bit better." Mr. Tadeu, one morning in the waiting room of the health clinic, followed the same reasoning of Mrs. Janete. He told me what made his pressure go up, "Oh, I think it's a moment thing. You're fine, but if you get nervous, then the pressure rises. Then, you take the pill, and in an hour, it already works, and your pressure is good again. But if you get agitated with something, it'll go back up again." I ask him for a concrete example, he thinks a bit and says, "Oh, bad news that you receive, for example. It upsets you and the pressure goes up." Mrs. Rafaela, who was sitting right next to us that day, disagreed with Mr. Tadeu: "Oh no, my [pressure] type is different. My kind of high blood pressure is emotional. That's my type. The pressure is agony. It's the emotional state that changes and affects the blood, the blood pressure." She explained that major events in life and in the family made the pressure "start to rise" and, over time, it became a persistent problem: "My father died at age 95, he died of cancer. I took care of him and everything. But it was very difficult for me. This was when my pressure began to rise. It was a very emotional thing. But what really helps me is walking and also the exercising we do here at the clinic. When I walk and everything, I feel very well, without this emotional thing affecting me that much."

Worldwide problems that arrived through Mrs. Janete's television and also local problems, faced within her family, had a great influence on her pressure problems[1,23]. Later, however, these authors recalled that "the family as the primary source of support in all areas, plays a key role in times of illness. This could explain why any problem with the family constitutes such an ominous event". In Guariroba, the family could be the generator of, but it was also expected to be the main caretaker of pressure problems. The same can be said in relation to health services, initially imagined as a source of care, but, in fact, also found as a source of conflict. Mr. Olavo told me how biomedical iatrogeny could alter his health: "At Ceilândia's Regional Hospital this takes place. Doctors are all like horses. They treat people like animals. Why does the person come to the doctor after all, right? The person comes looking for a solution. Comes to see if he can find a better medication that lowers his blood pressure, right? But then, he is treated really badly, and this puts him into a state of anger. All this, in fact, increases his pressure!".

It seems that the "moment thing", explained by Mr. Tadeu, Mrs. Janete and Mr. Olavo, was something transitory. And the "emotional thing", as Mrs. Rafaela illustrated, had a lasting effect, leaving her disturbed for a much longer period. These people helped me understand that "moment things" might relate to fluctuations in high blood pressure; while the "emotional things", produced by tragic, dramatic and enduring difficult events, left lasting marks, transforming itself, indeed, into a pressure problem. The "moment thing" also affected those who had a pressure problem already installed, causing, for example, pressure peaks or crises. These accounts seem to communicate that older bodies presented themselves as more fragile, more susceptible to the effects of what they defined as agony, anger, worry, stress, and nervousness. They were more likely to develop a high pressure to the point of becoming a pressure problem.

Canesqui[4] mapped the causal range that several other studies also found: "Explanations of high blood pressure by informants involve multiple domains: physical, emotional, relational, familial, moral, nutritional, hereditary". This range also echoes back in Guariroba but were not put into practice necessarily in isolation. The high blood pressure was momentary and could be altered by worrisome. On the other hand, constant and insistent suffering or worrisome had the potential to maintain pressure high and, in fact, transform it into a complicated health problem.

Nervousness, medications and curability

Nervousness was such a frequent category within this explanatory logic of the pressure problems, that I found, associated to it, a wide circulation of psychotropics. Some people said they had started taking a "controlled medication" at a time their high blood pressure became a pressure problem.

The morning I met Mrs. Lina at the health clinic, she seemed apprehensive. Back then, she was taking several pills and showed me each of the prescriptions she kept in a plastic binder. That morning, she was expecting to convince the clinician to give her one medication in particular: "Yes, I take several medicines, but the most important thing is the controlled one, the sleeping pill. Tonight, for example, I slept almost nothing.

I think I woke up about three in the morning and I'm up since then. I cannot sleep at night, I cannot sleep during the day. This is like torture. So, I want to ask the doctor to return with Ametril [amitriptilin]. That's what I most want today, you know. This medicine is for relaxation, to be able to sleep. It is important to me. I get a lot better with them." A previous doctor had interrupted Ametril, claiming it was unnecessary. Mrs. Lina wanted to convince this second doctor that without sleep, it was impossible to relax and, as a direct consequence, it was impossible to control her high pressure and diabetes. Mrs. Ivia explained accordingly:

I take the pressure medication because my pressure is an emotional pressure, it gets out of control when the nervous system rises. It's not that I have high blood pressure, no. My pressure is 12 by 8, it is normal. Now, any little thing, any little emotion that I feel, anything, then the pressure quickly goes up. It is controlled only by Lexotan [*bromazepam]*. If I only take the pressure pill, my pressure problem does not go under control. I take the pressure medicine every day, but for me, when I'm in this uncontrolled emotional state, my pressure only gets better if I take the controlled medicine, Lexotan. You should try it, it's very good!

Fava et al.[2], in a survey in the southern part of the State of Minas Gerais, looked at one more aspect, which seemed to have important implications in the living and caring of pressure problems. They noticed that "for interviewees, a peculiar aspect are the meanings attributed to the treatment goals for SAH. The perception they have of the problem is that it is due to the nervousness (a symptomatic and curable state), and therefore *the treatment, according to its criterion, will also be for a temporary time*" (my emphasis). I agree that a symptomatic problem (nerves) will affect the solution of another problem (pressure), mostly asymptomatic. I suggest that this resolvability logic is associated with the consumption of medication, especially of psychotropic drugs.

In this way, it is difficult to sustain the idea that pressure problems are a chronic disease, as Biomedicine insists to affirm. By the significant association of pressure problems to the nervous system and its associated pharmaceuticals, arises the premise of curability. Fava et al.[2] also recall that their interviewees "firmly support the belief in the cure of the problem, however, relapses are foreseen, because the external factors that trigger the nervous system cannot be avoided, they are part of life". Thus, cure may have taken place for one high pressure episode, but the nerves could be destabilized and, therefore, pressure would rise again, and the problem would begin once more. Although people I talked to took care of their pressure problem, given associated malign consequences, it was only possible to control certain variables that they knew affected their pressure, such as food or medicine. But bad news, interpersonal conflict and other events that impacted their emotional state were hard to avoid. When speaking of the impact of worries and conflicts, they were confirming how "external factors as part of life" became "triggers to the nervous system"[2].

Reproduction, family, old age, work, the city, health services and professionals and the various "moment things" generated discomfort to the point of being in a certain "way", as Mrs. Janete told me pages ago, and their pressure would rise so frequently as to become a constant problem. In accordance to other authors, these patients took "hypertension" as a "consequence of an emotional state, which translates as *being very nervous*"[17]. A third of Péres et al.[19] interviewees mentioned the need to "control emotion [to] avoid being nervous, staying calm and living in peace; getting out of stressful situations, like leaving the house to take a walk, talking to other people, reading and completing crossword puzzles". This nervousness was associated to the "street [with] a lot of clutter and quarrelsome, night and day"[2]; "to modern lifestress"[17]; "to living and working in a great ('agitated') metropolis"[18]; to "life afflictions, repressed emotions, conflicts and domestic and familiar preoccupations and to the overload of domestic chores"[24]. Gender issues were intensely associated with pressure problems. And Péres et al.[19] also found that "nervousness and irritation (60%), worrisome (31%) and anxiety (9%) among the "hypertensive" interviewees in the city of Ribeirão Preto, State of São Paulo.

Thus, literature points out the nervous and the emotional, in their different manifestations, as "the main causes of high blood pressure"[1]. Still, despite the centrality of the nervous explanation (acting before, during and after high pressure), some authors still persist in devaluing this logic of how pressure problems come to be. Peres et al.[19] believe that among their interviewees there was "an ignorance of the etiology of arterial hypertension and a concentration of responses, attributing the causes of the disease to the emotional aspects". Later, these authors, representing, in my opinion, a possible common sense in the academy and health services, also indicate a "dis-

Ciência & Saúde Coletiva, 24(7):2617-2626, 2019

tortion" in patients' understanding and a "lack of understanding of the multifactorial nature of hypertension". It impresses me how a recurring finding among different social and biomedical researches around the country can be so ignored, especially by those studies (as Perez et al.[19], for example) which held, as their main goal, the enhancement of patient involvement in better adherence to treatments.

More appropriately, in my view, Fava et al.[2] seem to solve the riddle: "It is perceived that the ways of thinking and acting of people with 'SAH', which can be translated by the experience with the disease, are little valued and understood by health professionals". And, I add, also by academics. In a bold and interesting way, Fava's team recognizes that misunderstanding is, in fact, among those who prescribe and study, that is, health professionals and researchers, in proposing a self-critical and reverse perspective on pressure problems.

Final considerations: Pressure, nerves and medications

Antihypertensive drugs not only had to lower blood pressure, especially those stubborn and dangerously quiet types, but also to counteract this pressure with the effects of the nervous system. In the eyes of these Guariroba interlocutors, if it was a medication prescribed by "my doctor" (instead of a general practitioner), personalized (instead of a generic drug), effective (instead of a medication taken for many years and, with which the body had already become accustomed to, as indicated by Firmo et al.[1]), purchased (instead of dispensed free of charge by the public pharmacy), from a specific drugstore (instead of any other drugstore around the city), to a high price (instead of subsidized prices), this pill would have much more chances of positively effecting pressure and also nervousness. My interviewees from the Guariroba neighborhood were calling my attention to the "charm" of certain medications[25]. However, these people only got the chance to access public clinics, quick consultations, free pills. There was a strong distrust on these local pharmaceuticals, believed to be "made out of flour" and to be "weak". So, it made all the sense to move to another set of drugs, which were considered to, at the same time, solve pressure and nerve problems. The controlled drug, coming from a special drugstore, dependent on rare prescription was widely recognized and valued, and, most importantly, respected and consumed. Due to its potency, the purchase of few items would be efficient, confirming its cost-effectiveness.

People like Mrs. Lina and Mrs. Ivia had found in the psychiatric drugs an outlet to control their bodily indexes and maintain, for a longer time, the daily well-being. As reported about Ametril, Mrs. Lina went back to sleep, which seemed to determine her mood, her disposition throughout the day, and her good blood pressure. With Lexotan, Mrs. Ivia shielded herself from the "moment things" or even from the emotional weight that family conflicts or TV programs had on her. The increasingly liberalized prescription of these drugs was strategic to both of them, guaranteeing access and self-medication in times of pressure and nervous crisis.

Thus, on the one hand, the hypertension program, proposed by the Ministry of Health, opened up the possibility of gaining access to consultations, support group, medicines. It was an issue, as these people well perceived, based on an established nation-wide public policy (called Hiperdia[14]). This translated, in practice, as these patients having priority in queues, reception rooms, offices, pharmacies, laboratories, fitness groups etc. Experiencing the pressure problem intensively was therefore a legitimate and strategic way to alleviate a whole range of problems, commonplace and persistent, such as insomnia, nervousness, anxiety, impatience with neighbors, relatives and work colleagues, panic and urban fear, for example. For this reason, these patients took advantage of the consultations of the "group of hypertensive patients"[7] to associate the nerve problems with pressure problems and soon leave the clinic with prescriptions for tranquilizers, sleeping pills, calming tablets etc.[8]. They clearly understood how pressure problems, by the efficient term "hypertension", counted with an ample apparatus of policies, services, professionals and rights. This apparatus was well used to try to control the stubborn blood pressure, but also all the other problems that affected them. In finding the policies for chronic diseases, in the figure of "hypertension" (and also "diabetes"), people would have the chance to be minimally attended to a range of nervous problems, since these appeared as the main explanation for problem pressure.

On the other hand, however, keeping oneself under the cardiovascular umbrella often meant that these people had lesser chances of counting on specialists and psychotherapies for mental health problems. Some of the health-care pro-

fessionals I met in Guariroba acknowledged that "domestic problems" had eventually raised blood pressure around the neighborhood, but this recognition did not include nervousness within the care offered by the hypertensive program in that clinic. No other activity was offered besides consultations, pressure level measurements, information about food, medication and an exercise group (carried out by patients and quite ignored by local managers and doctors[26]). Thus, the tendency to "hypertensivize" mental and moral problems, in a clear encapsulating effect, contributed to the invisibility or even trivialization of nervous problems.

Those suffering with emotions, nerves and even the mind tended to be classified as noted by Canesqui[4]: "It is observed in the investigations made with cardiac patients attended in an emergency service in the city of São Paulo that, to those classified by health professionals as 'multi-complainers', are to impute 'imaginary' or 'psychological' pains and the frequent search of the various health services". Many professionals and also researchers mock nerve problems and disregarded the effects of these problems on pressure problems. In the end, I observe, neither the nerve problems nor, much less, the pressure problems were well understood and clinically referred to. Ignored by the health teams, nerves were likely to maintain pressure problem within high, troublesome and dangerous levels among these pioneering dwellers of Guariroba.

In this article, I have tried to consider two sets of interlocutors, those who live and care, and those who research and tend to pressure problems. Given the number of studies on hypertensive disease in Brazil, here represented by a small but eloquent set, it is possible to think that they are an important source consulted by primary health care managers and professionals. What worries me, therefore, is that the perceptions on pressure problems were perceived very differently by people who lived them on a daily basis and by the professionals who treated them. Therefore, disregarding the relationship between nerves and blood pressure can have very negative consequences. These patients tended to find distant, authoritarian and misguided dialogues in the health clinics, since much of the mainstream SAH research probably are guiding the way management, consultations and pharmaceutical care is being conducted in the country.

Acknowledgements

Many thanks to the students who accompanied me in getting to know Guariroba, the sweet elders who showed interest into talking to me, the Anthropology Department, the University of Brasília, in the form of institutional space, scholarships and opportunities for research. I thank the comments received by colleagues at the Department of Medicine (Unicamp) and in Mandacaru - Gender, Health and Human Rights. This project was approved.

References

1. Firmo JOA, Lima-Costa MF, Uchoa E. Projeto Bambuí: maneiras de pensar e agir de idosos hipertensos. *Cad Saude Publica* 2004 20(4):1029-1040.
2. Fava SMCL, Zago MMF, Nogueira MS, Dazio EMR. "Experiência da doença e do tratamento para a pessoa com hipertensão arterial sistêmica: um estudo etnográfico". *Rev. Lat-Am Enferm.* 2013; 21(5):1022-1029.
3. Canesqui AM. Estudo de caso sobre a experiência com a *pressão alta*. *Physis* 2013; 23(3):903-924.
4. Canesqui AM. *Pressão alta no cotidiano: representações e experiências*. Rio de Janeiro: Editora Fiocruz; 2015.
5. Nations M, Firmo JOA, Lima-Costa MF, Uchoa E. Balking blood pressure control by older persons of Bambuí, Minas Gerais State, Brazilian ethno-epidemiological inquiry. *Cad Saúde Publica* 2011; 27(Supl. 3):s378-s389.
6. Fleischer S, Almeida N. A popularização de esfigmomanômetros e glicosímetros no bairro da Guariroba, Ceilândia/DF. *Soc. e Cultura* 2013 16(1):183-193.
7. Fleischer S. O "grupo da pressão": notas sobre as lógicas do "controle" de doenças crônicas na Guariroba, Ceilândia/DF. *Amazônica Rev. de Antropologia* 2013; 5(2):452-477.
8. Fleischer S. Uso e circulação de medicamentos em um bairro popular urbano na Ceilândia, DF. *Saúde Soc.* 2012; 21(2):410-423.
9. Souza MLP, Garnelo L. É muito dificultoso!: Etnografia dos cuidados a pacientes com hipertensão e/ou diabetes na atenção básica, em Manaus, Amazonas, Brasil. *Cad Saude Publica* 2008; 24(Supl. 1):s91-s99.
10. Canesqui AM. Estudos socioantropológicos sobre os adoecidos crônicos. In: Canesqui AM. *Olhares socioantropológicos sobre os adoecidos crônicos*. São Paulo: Hucitec, FAPESP; 2007. p. 19-51.
11. Leibing A, Groisman D. Tão alto quanto o morro - Identidades localizadas de mulheres hipertensas na favela da Mangueira. In: Leibing A, organizadora. *Tecnologias do corpo: Uma antropologia das medicinas no Brasil*. Rio de Janeiro: Nau Editora; 2004. p. 277-299.
12. Maciel CLC. *Hipertensão essencial: Emoção, doença e cultura* [dissertação]. Recife: Departamento de Antropologia Social; 1988.
13. Calvo-Gonzalez E. Construindo corpos nas consultas médicas: uma etnografia sobre hipertensão arterial em Salvador, Bahia. *Cad CRH* 2011; 24(61):81-96.
14. Brasil. Ministério da Saúde (MS). *Estratégias para o cuidado da pessoa com doença crônica: hipertensão arterial sistêmica*. Brasília: MS; 2013.
15. Fleischer S. *Descontrolada: Uma etnografia sobre os problemas de pressão na Guariroba, Ceilândia/DF*. São Carlos, EdUFSCar; 2018.
16. Fleischer S, Batista M. O tempo da falta e o tempo da bonança: Notas sobre experiências de cronicidade na Guariroba, Ceilândia/DF. *Anu Antropológico* 2013; 2012:195-224.
17. Carvalho F, Telarolli Júnior R, Machado JCMS. Uma investigação antropológica na terceira idade: concepções sobre a hipertensão arterial. *Cad Saude Publica* 1998; 14(3):617-621.
18. Castro V, Car MR. O cotidiano da vida de hipertensos: mudanças, restrições e reações. *Rev. Esc. Enferm.* 2000; 34(2):145-153.

19. Péres DS, Magna JM, Viana LA. Portador de hipertensão arterial: Atitudes, crenças, percepções, pensamentos e práticas. *Rev Saude Publica* 2003; 37(5):635-642.
20. Lefèvre F. *O medicamento como mercadoria simbólica*. São Paulo: Cortez; 1991.
21. Santos ZMSA, Silva RM. Prática do autocuidado vivenciada pela mulher hipertensa: uma análise no âmbito da educação em saúde. *Rev. Bras. Enferm.* 2006; 59(2):206-211.
22. Duarte LFD. *Da vida nervosa (nas classes trabalhadoras urbanas)*. Rio de Janeiro: Jorge Zahar, CNPq; 1986.
23. Trad LAB, Tavares JSC, Soares CS, Ripardo RC. Itinerários terapêuticos face à hipertensão arterial em famílias de classe popular. *Cad Saude Publica* 2010; 26(4):797-806.
24. Silva MEDC, Barbosa LDCS, Oliveira ADS, Gouveia MTO, Benevina MVTN, Moreira ELMA. As representações sociais de mulheres portadoras de Hipertensão Arterial. *Rev Bras Enferm* 2008; 61(4):500-507.
25. Geest SVD, Whyte SR. O encanto dos medicamentos: Metáforas e metonímias. *Soc. e cult.* 2011; 14(2):457-472.
26. Fleischer S, Batista M. "Isso aqui é a minha valência": Notas etnográficas sobre um grupo de ginástica na Guariroba, Ceilândia, DF. In: Ferreira J, Fleischer S, organizadores. *Etnografias em serviços de saúde*. Rio de Janeiro: Garamond; 2014. p. 209-242.

Article submitted 02/07/2017
Approved 19/09/2017
Final version submitted 21/09/2017