
HYPERTENSION AS A CONDITION OF NON-DISEASE – THE MEANING OF CHRONICITY IN THE SUBJECTS’ PERSPECTIVE¹

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ABSTRACT: The purpose of this study was to understand the concepts underlying the health-disease-care process of subjects with systemic arterial hypertension, as well as the meaning of this disease in their lives. It consists of a qualitative descriptive study. Study participants were nine subjects with arterial hypertension, in follow-up with a family health team. The study utilized semi-structured interviews, observation and documentary analysis for data collection. Data were analyzed through thematic analysis. There was a unanimous feeling among the participants that hypertension, despite being a chronic illness, does not represent a disease condition. This is attributed to the fact that this illness does not present physical symptoms, added to the ability to stabilize pressure levels with the correct use of medication. This position was also associated with the long period of time in which they experience this chronic condition. For these reasons, these subjects define themselves as healthy people. Therefore, it is verified that these subjects have learned how to live “with” hypertension rather than “despite” it.

DESCRIPTORS: Hypertension. Chronic disease. Health-disease process. Community health nursing.

HIPERTENSÃO: CONDIÇÃO DE NÃO DOENÇA – O SIGNIFICADO DA CRONICIDADE NA PERSPECTIVA DOS SUJEITOS

RESUMO: Objetivou-se compreender as concepções do processo saúde-doença-cuidado para indivíduos portadores de Hipertensão Arterial Sistêmica, bem como o significado dessa enfermidade em suas vidas. Trata-se de pesquisa qualitativa, descritiva. Foram sujeitos da pesquisa nove indivíduos portadores de hipertensão arterial, em acompanhamento com equipe de saúde da família. Utilizou-se a entrevista semiestruturada, observação e análise documental para a coleta dos dados. Foi realizada análise temática dos dados. Foi unânime entre os participantes a concepção de que a hipertensão, mesmo sendo um agravo crônico, não representa uma condição de doença. Atribui-se isso ao fato dessa enfermidade não apresentar sintomas físicos, somado à estabilidade de seus níveis pressóricos, pelo uso correto de medicações. Associaram esse posicionamento, ainda, com o longo período de tempo em que vivenciam essa condição crônica. Por essas razões, esses sujeitos definem-se como pessoas saudáveis. Assim, constata-se que esses sujeitos aprenderam a viver “com” a hipertensão e não “apesar” dela.

DESCRIPTORIOS: Hipertensão. Doença crônica. Processo saúde-doença. Enfermagem em saúde comunitária.

HIPERTENSIÓN: CONDICIÓN DE NO ENFERMEDAD – LA IMPORTANCIA DE LA CRONICIDAD EN LA PERSPECTIVA DE LOS SUJETOS

RESUMEN: El objetivo fue comprender los conceptos del proceso de la salud-enfermedad-cuidado de los individuos con hipertensión, así como la importancia de esta enfermedad en sus vidas. Es una pesquisa cualitativa, descriptiva con nueve pacientes hipertensos, seguido con un equipo de salud de la familia. Fué utilizada entrevista semiestructurada, observación y análisis de documentos para recopilar datos. Se realizó el análisis temático de los datos. Fue unánime entre los participantes el concepto de que la hipertensión, a pesar de una lesión crónica, no es condición de enfermedad. Se atribuye al hecho que esta enfermedad no presenta síntomas físicos, combinado con la estabilidad de sus niveles de presión arterial, el uso correcto de los medicamentos, incluso con el largo período de tiempo que vivencian con esta enfermedad crónica. Por estas razones, estos individuos se definen como personas sanas. Así, personas han aprendido a vivir “con” hipertensión y no “a pesar” de ella.

DESCRIPTORIOS: Hipertensión. Enfermedad crónica. Proceso salud-enfermedad. Enfermería de salud comunitaria.

INTRODUCTION

Chronic conditions represent health problems that demand continuous management over a long period of time. They include an extremely broad group of illnesses, which have chronicity and the need for continuous care in common.¹ Among them, systemic arterial hypertension (SAH) is an illness of great epidemiological relevance, due to its high prevalence and because it represents the main risk factor for cardiovascular disease.

A high social and financial cost is attributed to SAH and its cardiovascular comorbidities, due to the high number of hospitalizations and highly specialized procedures. As a consequence, there is an increase in absenteeism at work and early retirement and, particularly, fragility in terms of the quality of life of its carriers. Due to its epidemiological relevance, SAH represents an important public health problem.

On the other hand, in the perspective of the subjects, this illness is perceived in a unique and subjective way due to the variety of feelings, meanings and concerns that it represents in their lives. Among them, the chronic nature of SAH constitutes one of the factors having the greatest impact on the life of these people, since adaptations are imposed on the routines of the subjects and significant changes are often necessary in their life practices.

Chronicity is a biomedical concept used in the clinical classification of illnesses, meaning that cure is not possible. From a sociological point of view, it is presented as a condition of lack of health that may be generated but cannot be cured; for this reason, the health condition becomes part of the life story of the subjects. In most cases, it manifests as periodic or continuous symptoms that affect several dimensions of these subjects' lives.²

The meaning of a chronic condition is perceived differently by distinct social groups, depending on the "angle" through which it is interpreted; that is, by those who experience it or by those who care for those afflicted with it. Under this view, Kleinman³ explains the perspectives regarding the disease representation, according to the perception of different subjects, and also according to the English language. In the perspective of the patient, the term 'illness' designates the human experience in light of the disease condition. It represents the way the subject and the family members experience and respond to the symptoms and incapacities, as well as the

way their lives are modified by the repercussions originating from this condition. The perspective of the professional, on the other hand, is represented by the term 'disease' and is perceived based on the biomedical view, through both the theoretical and practical lens, with the perception of the disease as an alteration in the biological or functional structure of its carriers.³

With this understanding, the interpretation of the meanings of the disease (illness) by the professionals of the health team may contribute to the development of more humanized and comprehensive care. In order to achieve this, the nurse, as part of the multidisciplinary team, must understand the story of the disease (illness) in the voice of its carriers, built from their conception of the health-disease-care process, their illness experiences and care practices in concrete situations of their world.

In this sense, "the illness experience is understood as a subjective process, built in the sociocultural contexts and lived by the actors".^{4:90} The chronic disease cannot be reduced to physical symptoms in a general way, since it demands represents a subjective process, according to the experiences of its carriers and the type of illnesses; it is also mediated by their culture.

Consideration of the cultural dimension of the health-disease-care process is fundamental so that there is sufficient range for its total comprehension. This is justified because there is a complex relationship among the beliefs, values and habits that are developed in the daily routine of the people and the way they express themselves in situations of health and disease.⁵

Therefore, cultural factors are intrinsic to the way people behave, their perceptions and attitudes when faced with situations of health or the lack of it. However, the cultural dimension must be evaluated as a component of a complex combination of influences, which are reflected in the way people live and react to such situations.⁶ Thus, it is necessary to consider that the health-disease-care process results from multiple social determinations with the potential to strengthen or weaken a subject, group or society as a whole. For this reason, the life and care practices of the subjects are going to be guided by the combination of these elements, as well as by individual factors, such as experiences, physical and emotional conditions and personal motivation.

Hence, users must be heard in the role as subjects of their health-disease-care process, rather than the object of health interventions dictated by

scientific knowledge. Moreover, by reducing users to the role of carriers of a certain disease, requiring professional intervention in a systematized and standardized manner, they are deprived of their perceptions and beliefs, built from their sociocultural reality, creating a great divide between these two ways of viewing and executing care. Thus, the perception of the professional must contemplate the user as a complex being, having different dimensions that are integrated among each other and inserted in a complex reality.⁷

In light of this, and starting from the sociocultural reality of the studied community, the present study aimed at understanding the concept of the health-disease-care process for subjects having systemic arterial hypertension, as well as the meaning of this illness in their lives.

METHOD

This is a qualitative, descriptive study. It is seen as appropriate to the study issue because it represents a privileged approach to analyzing the reality of the subjects and understanding the different ways they interpret their life experiences.

Study participants consisted of nine people living in a community assisted by a Family Health Unit (FHU), in a municipality in the interior of Rio Grande do Sul. Inclusion criteria were: people with isolated SAH (without complications caused by hypertension – heart diseases – or any other associated chronic disease), older than 18 years of age and in follow-up* with a family health team of the FHU.

Data collection was performed through semi-structured interviews, observation and documentary analysis.⁸ Field work was developed between February and August of 2009 and took place on three different occasions in the study field. The first occasion was a meeting of the Group for Hypertensive and Diabetic Patients of the FHU where, through observation, the possible study subjects were selected. The second occasion was at the FHU, where documents were obtained to confirm the inclusion criteria of the subjects. The third occasion was at the subjects' homes, where the semi-structured interviews and observation of the routine of these users and their families were performed.

Data analysis was supported by thematic analysis, which is systematized in three chronological stages⁸: pre-analysis, when interviews were transcribed and the empirical material was organized; material exploration, when the empirical material was categorized; and treatment of the obtained results and interpretation, which consisted of the articulation between the empirical content and the theoretical referential. In the stages of pre-analysis and material exploration, Atlas Ti 5.0 (Qualitative Research and Solutions) software was used to help encode the interviews.

The study project was approved by the Research Ethics Committee of the university with which the study was associated, according to Resolution 196/96 of the National Health Council (CNS-MS), and to the Certificate of Presentation for Appreciation (CAAE): 0306.0.243.000-08.

CONCEPTIONS AND MEANINGS OF ARTERIAL HYPERTENSION AND THE HEALTH-DISEASE-CARE PROCESS

In order to understand the meaning of SAH (illness) in the life of the subjects, it is necessary to study their experiences regarding this illness, which translate the representation attributed to this disease by its carriers, considering them as part of a specific sociocultural group. This meaning and the way they experience the chronic condition in their lives is highly influenced by their concepts of health, lack of health and care. Considering that such constructs are socially produced by the subjects, having a strong relationship with their culture, this study also aimed at revealing the common knowledge regarding the health-disease-care process, using individual and collective experiences and perceptions. It is important to bear in mind that this knowledge, despite being built in a sociocultural reality, is heterogeneous among the subjects belonging to this group, full of symbolic interpretations, as well as reinterpretations of the scientific knowledge.

Conceptions of the health-disease-care process revealed by the study subjects are presented as follows, as well as the meaning of this illness in their lives.

* The authors considered "people in follow-up with a team" as those who attended the Group for Hypertensive and Diabetic Patients, developed by the FHU team, and also who kept a clinical follow-up in the unit, through medical and/or nursing visits, as indicated by the protocol of the Ministry of Health, that is, at least once a year.

Conceptions of the health-disease-care process

When requested to state their feelings regarding their concepts of health and/or lack of health, many participants presented a conception of health focused mainly on physical factors, centered on the health of the body, without considering other determinants involved in this process. In this perspective, they associated the concept of health with compliance with treatment and the access to health services: *health means not being sick! [...] it means having our health, health in a physical way, in our body. [...] the person has to take care of himself, go to the doctor, and go after it. Because we have to go after it* (S1, 54 years).

[...] health means having all your exams when you are supposed to. Taking your medication every day. Going to the doctor regularly too. [...] when people who, for instance, are hypertensive and do not take the medication correctly develop a heart disease, like ischemia, I think that it is partly due to the fact that they do not take care of themselves. (S4, 47 years).

[...] in order to improve health, there should be a specialist, a psychiatrist who could treat people. [...] who could provide physiotherapy to the patients at home [...]. People must have everything they have the right to! [...] by the time that exists, there will be less sick people, tomorrow or later on (S3, 50 years).

Health was viewed by some subjects of this study as the outcome of prevention and rehabilitative actions, represented by the absence of disease and physical symptoms. This fact indicates a biological and medicalized ideal of the health-disease-care process, by viewing it as the result of biomedical actions and compliance with medical treatment. The importance and responsibility that some of the population places on these actions in facing a health condition was evident, directing less attention to the other socioenvironmental determinants involved in this process. It is perceived that the access to health services and compliance with treatment, mentioned by the subjects as “taking care of oneself”, were exemplified as determining factors of health. The concern is that, in this view, the access to health services is considered sufficient or superior to the other factors involved in the health-disease process.

Access to care was presented by these subjects as a guarantee of appropriate and equal quality service and treatment for the entire population. This argument meets a broader health view, since it elucidates a concept of “health as a right of all”, which approaches the recommendation of

the current legislation.⁹ However, the expectation of absence or improvement of diseases as a final product reiterates the medicalized view of the health-disease-care process.

In addition to this, the authors observed an intonation of responsibility attributed to the subject for his/her health condition, since, in some statements, health is presented as a result of either taking care of oneself or failing to do so. The concept of care, in this perspective, was centered on the lifestyle practices of the people, as a result of individual choices. Thus, they presented a position of making the subjects’ responsible for their own health condition. This fact may be justified by the influence that the media, and even the health services, exert on people since it is known that the notion of health transmitted by these means often attributes to people the responsibility for its maintenance¹⁰ through healthier life practices.

Another view of the health-disease-care process observed in the speeches of the subjects highlights its relationship with work. The statements showed a variation regarding the influence that work would have on this process. However, there was prevalence of the association with labor functions that involved, mainly, physical activities. The selected speeches expose this reflection: *I have always worked. I used to sew [...] I worked a lot. We were planters. I liked the job! That is why I cannot plant anything today [...] and I do not sew anymore, because of my back. My horrible back!* (S6, 78 years).

[...] I think I should have never stopped working in construction, because then it started getting worse! [...] that I could continue working, because I retired due to old age, not because of any problem with my health. So, I never wished I did not work. I am always fighting one thing or another! And I cannot stop! (S2, 80 years).

Work was pointed out by some participants as the cause of their disease, mainly due to the demands of physical effort on the body. Thus, the disease would be a physical repercussion related to the excess of work. In this context, disease, mainly hypertension, was frequently associated with heavy labor activities.¹¹

On the other hand, work was viewed by some of the subjects as a protective factor for health, with the idea that keeping physically active and continuously moving would bestow health. In this aspect, “work has a fundamental value” for the subjects, since they evaluated it as a “source of restoration and health” in their lives. Moreover, for the studied subjects, “people work to be healthy, but also get sick due to work”.^{12:46}

It was also observed that being capable of working represented evidence of health, since a person who is physically able to work cannot be ill. This argument approaches the findings of another study,¹³ in which subjects defined themselves as healthy due to their ability to perform certain activities, such as handling the housework and working.

Other points of view observed among the participants refer to a broader conception of the health-disease-care process. Health was associated with subjective feelings, such as feelings of well-being and faith, with a balance between objective and subjective factors. There was a prevalence of the concept of health associated with positive feelings, such as feeling good and being willing and able to manage in life, as observed in the following speeches: *being healthy means living well, feeling fine! [...] the person who has good health is also willing and ready! [...] and the person who is sick is resentful and frustrated, does not feel like doing anything, not even talking to people* (S9, 68 years).

[...] I think health is fundamental! [...] when the person is healthy, everything moves forward in life, in every way! And if there is no health, the person has no balance and cannot move forward! (S7, 48 years).

[...] I think I have good health. I like my life, my happiness! I help others, I have a good heart. [...] thank God, I feel fine and happy! [...] people even say: you are always in a good mood! So health is about thinking positively and realistically. Not thinking of useless things. [...] so the person must be willing to think about what is right! (S8, 65 years).

Health was perceived by a great number of the subjects of this study as something primordial, essential to the life of the human being. They complemented the health view with the idea of totality and plenitude in life, since, by achieving this, the subject would not need anything else. In this perspective, health is presented as a “necessary instrument so that the other aspects in life may occur”.^{10,248} Thus, health represents a compelling element in all aspects of the life of the subjects.

The same participants highlighted emotional factors as relevant, in the sense that harboring positive feelings – optimism, joy and happiness – is a condition of total health. Thus, a strategy pointed out as important was to focus on the positive aspects of life, which is understood as representing a form of health care in and of itself.

On the contrary, the lack of health (or disease) was perceived by the participants as lack of willingness; that is, a limiting factor in the life

of people. In this sense, the disease was associated with negative feelings, whose repercussions would affect people individually and in their relationships with other people. The representations of disease and health are similar as both are illustrated by feelings and emotions.¹⁴ In other words, these constructs present similarities in the way they are perceived and explained by the subjects, but with opposite repercussions in their lives. Thus, having health means being well and happy, whereas having a disease would be associated with feelings such as sorrow and sadness.

Another aspect observed in the speeches of these subjects was the relationship between the concept of health and the readiness to embrace life, in the sense of assuming a position of encouragement for the execution of activities, such as work, leisure and even the choice to relate to other people: *a happy person, a person who wants to communicate with others. A person who likes going out, going shopping. It is all of it! [...] I like working, cooking, walking... and when I walk a lot, I know I am fine. I feel fine! Physically. Everything! I even feel lighter, much better! [...] that is having health* (S9, 68 years).

[...] [health] is having balance, to be willing to talk, to go out, to work, to do anything! Then you have health! (S7, 48 years).

In this understanding, health would be connected to the concept of movement, associated with the ability to take part in daily practices, permeated by the sensation of wellbeing. In this conception, health would be articulated both to the perception of physical ability to handle such activities and to the subject’s willingness to do them.¹⁴

Still, from a broad perspective regarding the health-disease-care process, other participants conceptualized health as a balance among objective factors, such as employment, income and life conditions, together with subjective factors, such as feelings of peace and tranquility: *[...] our life is the most important thing for our own life! If you are well spiritually, at peace with your family, with your life [...]. It does not matter if you have a job and you are not healthy. It does not matter if you have money in your pocket and you do not have peace. Health means you have to be working, with money, and also be in harmony with your partner, with your children, with God! [...] you must have self-esteem! You have to like yourself! [...] so, one thing leads to another. We need it all!* (S7, 48 years).

It is understood that the view of health of these subjects approaches the concept proposed by health promotion, which is ruled by a positive

and broad perspective involving personal/social resources and physical capabilities, going beyond a healthy lifestyle towards global wellbeing.¹⁵ Hence, elements of subjectivity with sociocultural organization were integrated into the health-disease-care process.

This explanation elicits a comprehension of health based on a perspective of comprehensiveness, and also on subjective and broad perceptions. The interviewees suggest a representation of health as something positive, centered on the concept of wellbeing and living well. In order to do so, they pointed out various health strategies, prioritizing their own life and valuing feelings such as spiritual peace, harmony, autonomy, self-esteem, and self-love. Under this subjective perspective, health is characterized by wellbeing as a state of harmony with oneself, which is articulated with feelings of spiritual peace and self-esteem.¹⁶

Meaning of SAH (illness) in face of the health-disease-care process

Based on their understanding regarding the health-disease-care process, the participants were asked to reflect on the meaning of SAH in their lives. There was a unanimous conception revealed in the statements of the participants that hypertension does not represent a disease condition: *it started with a burning sensation here [thoracic region], then I went to the doctor, and my pressure rose, and I had to start treating it, taking care of myself. My pressure is normal now. It has been normal for years. I take the medication correctly [...]. But, other than that, I am not sick, except for my back that hurts; I have good health, thank God! (S6, 78 years).*

[...] my worst disease is bronchitis! My blood pressure, thank God, is controlled. I take the medication correctly [...] I feel fine (S3, 50 years).

[...] I can say I have health because I am not a sick person who has problems. [...] because my pressure is always good. I feel fine! (S1, 54 years).

It is understood that hypertension, despite being a chronic condition, did not represent a disease to the participants of this study. It is observed that, since it does not present physical symptoms or restrict any activity, SAH was not considered a condition of lack of health.

The studied group did not consider themselves to be ill since SAH does not present any sign of suffering or incapacity. On the contrary, they evaluated themselves as healthy people, mainly due to the stability of their pressure levels,

reassured by their compliance with the treatment which consisted of medication used properly and continuously and the execution of other care procedures: *treating and taking care of myself*. In this aspect, it is known that the primary meaning of disease (illness) is the symptom attributed to that particular illness, as it represents a conventional sign of incapacity or anxiety resulting and expected from the disease condition.³ Justifying this view of SAH as a condition of non-disease, the interviewees highlight other illnesses, such as back problems and bronchitis, since they present symptoms and limitations, representing elements that threaten their position as healthy people.

Confirming the perception of SAH as a condition of non-disease in the life of its carriers, some participants associated this position with the long period of time in which they had experienced this chronic condition, as may be observed in the following speeches: *since my first pregnancy, 29 years ago, when I discovered I was hypertensive. [...] and, since then, I have been taking the medication. [...] exams, there are times I do not take them. I am a little negligent in this part, I am! Ah, it is really negligence. There is nothing else to say. I take my medication. But I take the treatment and go on, as God wants me to! And my pressure is a little high [...]. I do not worry about it! I am used to it. I have already learned to live with it, you know? (S7, 48 years).*

I started the treatment 35 years ago, at the former INANPS [...] and then I kept going, treating and taking care of myself [...] it has been so many years since I started the treatment and now, after all these years and treatments, I already know how to deal with my blood pressure (S6, 78 years).

The fact that SAH occurs in the life of these subjects for a long period of time without resulting in repercussions to their health, creates a situation that releases them from greater care measures and/or concerns, justified by the fact that they have *learned to live with it*. Chronic diseases demand from carriers the ability to learn how to live "with and despite of the disease",^{2,20} since it follows them everywhere, for a long period of time.

Therefore, as time goes by, the experience of hypertension is incorporated into the routine of the subjects, especially when there are no serious events or limitations.¹¹ The course of the disease (illness) becomes so close to the life story of its carriers that they become inseparable, and it is impossible to think of one without the other. Moreover, the absence of physical symptoms that denotes the presence of SAH in the life of these

subjects becomes a factor that contributes to this experience, since it does not represent a condition that demands greater concern.

Other participants, in reflecting on their condition as SAH carriers, pointed out the causes they believed to be directly responsible for the development of hypertension in their lives. They mainly highlight life practices, and also relationships with others as factors that influence the disease process, as observed in the statements: *I became hypertensive. I can tell you why: I smoked for 36 years in my life and drank. [...] and then I became hypertensive because of the drinking and the smoking. I blame it on them!* (S3, 50 years).

[...] I have been through a lot of problems, because the father of my son used to drink and fight with everyone. I think that I became hypertensive because of all the stress (S4, 47 years).

In these arguments it is possible to observe the influence of lifestyle choices on the development of the chronic disease, both in relation to individual factors and to external ones. In this sense, they confirm the premise that the disease process is built socially, so that the predisposing individual and external elements (exemplified in this situation, respectively, as the decision to smoke and interpersonal relationships) resonate in relation to their influence on this process.²

The view of life practices as individual determinants of the disease process elicits a position of blaming the participants, by taking the responsibility for the development of SAH and attributing it to unhealthy choices. It is obvious that the meaning of SAH (illness) for these subjects is highly influenced by the collective construction of this condition, since the sociocultural context itself labels them as responsible for their disease due to their unhealthy lifestyle choices.

However, the external elements exemplified in the speeches, such as conflict in relationships between members of the family, were thought by some participants to predispose to the development of hypertension. In this view, the development of SAH is also perceived by the subjects to be fallout from the suffering and misfortunes experienced throughout their lives, which they could not avoid.¹¹ Using this logic, emotions are sociocultural constructs that must be considered in the experience of becoming ill, as they represent communicative fields that unite the subjects to macro and microsocioal spaces.⁴

It is understood that external events, represented in this case by family conflicts, act as

triggers for internal factors, such as the emotions resulting from these conflicts, as an explanation for the hypertension developing, according to the subjects in this study.

Other meanings of SAH observed in the statements of some participants refer to the need for continuous treatment. Hence, after the hypertension diagnosis, a care plan became part of the routine of these subjects, including the daily use of medications and adaptations in their lifestyle practices. This fact may be evidenced in the following speech: *I started controlling it [the pressure] with medication. Nobody likes taking medications. But you have to! And I just have to take them now. I have never been sick! [...] I have good health. I just have to take care of myself and control this. Taking care of my diet and walking, which is good. So I think I am a healthy person* (S9, 68 years).

It is evidenced that the burden associated with SAH (illness) as a chronic disease in the life of these subjects is minimized by compliance with the plan of necessary care. Thus, even when it generates some discomfort, the daily use of medications, as well as the other care measures pertinent to SAH, decrease the meaning of this condition, whose most concerning characteristic for these subjects is the fact that there is no cure.

In this aspect, most chronic diseases demand “body re-learning”,^{2,27} which involves preventive and protective measures, as well as compliance with medical technologies and regimes. These actions may influence the identity of the subject.

Therefore, it is understood that the meaning of SAH (illness) is closely associated with the perception of the carrier regarding his/her identity as a sick or healthy person. Even when considering themselves as not being sick, a fact that would exempt the subject from the use of medications, this practice is necessary for the effective control of blood pressure. Besides removing the label of ‘sick person’, despite being the carrier of a chronic condition, this action allows the subject to consider himself healthy.

FINAL CONSIDERATIONS

In reflecting on the experience of this study, it is perceived that in order to achieve the necessary knowledge regarding the meaning that SAH represents in the life of these people, it was necessary to submerge ourselves in the “life story with hypertension” of each subject in this study. Focusing on life, and consequently on the experience of

chronic illness of these people, the authors aimed at understanding the individual perspectives as part of their stories, the events comprising them and the sociocultural context in which they took place. The subjectivity and individuality of each story stands out in the statements of these subjects, since the elements that give meaning (illness) to the life of each one were captured in their memories.

The interviews performed in the home environment represented a privileged tool to achieve the necessary range to comprehend the conditions of life and the daily dynamics of these people. Furthermore, it provided a moment of reflection, allowing them to re-evaluate these elements and, therefore, to reconsider their views on the meaning of health and how to manage their lives in face of a chronic disease. It is observed that this reflection was affected by the way they perceived and experienced the health-disease-care process, outlined in their life experiences and in the sociocultural context to which they belong.

Regarding the meaning (illness) of SAH, its relationship to the perceptions of the subjects regarding their identities as sick or healthy people was evident. In this context, there was a unanimous concept revealed in the statements that hypertension, despite being a chronic condition, does not represent a disease. This evaluation by the interviewees is attributed to the fact that this illness does not present physical symptoms, added to the stability of their blood pressure levels due to the proper use of medications. For these reasons, these subjects define themselves as healthy people.

Another intrinsic element in this analysis refers to the fact that SAH is a part of the carriers' lives for a long time (forever for some). The hypertension story is often confused with the life story of the subject himself. In this sense, it is confirmed that these subjects learned how to live *with* SAH rather than *despite* it.

The findings of this study reveal elements that must be considered by health teams, especially by the nurse, so that the planning of health practices results in comprehensive and resolute actions. Therefore, it is recommended that care practices be brought closer to the reality of the subjects and exercised in the perspective of the complexity of the human being undergoing treatment.

Furthermore, the authors did not pretend to exhaust the theme of this study, considering the perception of new views as important. Hence, there is the need for new studies to analyze the influence existing between the meaning (illness)

of chronicity, in the way people live and direct their care practices in the interface with the health-disease process.

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