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"MY BLOOD BOILS": FOLK MODELS OF HYPERTENSION AND COMPLIANCE AMONG OLDER NEW ORLEANS BLACK WOMEN

by

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DISSERTATION

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This dissertation is lovingly and gratefully dedicated to David and Nicolas.

It is also dedicated to the women of New Orleans, particularly my informants, my mother, Marguerite Anne, and my Memere, Emma Louise. Together, they taught me what all New Orleans women seem to know; how to make it through bad times. I am forever in their debt.

PREFACE

The task throughout this research has been to strike a balance between scholarly objectivity and my deep feeling for the city of New Orleans and its people. As a New Orleanian, I have no doubt suffered the same limitations as any anthropologist doing research at home.

New Orleans possesses an exceedingly strong core culture that is heavily influenced by its Black population. Although I am an outsider to Black culture, I share in New Orleans core culture enough to potentially blind me to what would be obvious to the fresh, unenculturated eye.

I have tried throughout to remain open and objective. The fact that this analysis is internally meaningful and not in opposition to previous work encourages me to believe that I was relatively successful in my efforts at objectivity. The fact remains, however, that this is the very personal analysis of an individual who was deeply involved emotionally with her subject, and it should be taken as such. I encourage further research by others.

The richness and vitality of the cultures of New Orleans have only barely been tapped in these and other anthropological writings. I urge other anthropologists to investigate these cultures particularly in relation to health and illness. Illnesses such as hypertension, heart disease, diabetes and cancers are great problems, especially in the poorer populations. These, combined with the current

economic difficulties of New Orleans and the rest of Louisiana make medical anthropology in the area more than an academic exercise. There is much practical work to be done and anthropologists can help significantly.

While I take full responsibility for the analysis and conclusions presented here, this endeavor represents the time and hard work of many whom I wish to thank.

My deepest and most heartfelt gratitude goes to Dr. Joan Ablon. She has been a guide, an inspiration and a trusted friend throughout my doctoral studies. As my dissertation chair, Dr. Ablon insisted that I aspire to excellence and humanity in my writing and analysis. Dr. Linda Mitteness has been of incalculable assistance in all aspects of this work. Most appreciated is her encouragement to recognize the legitimacy of my own thoughts, no matter how unorthodox they may have seemed at first. She has been an astute and fair critic. I extend my thanks to Professor George DeVos for his stimulating and provocative presence, urging me to go beyond easy and superficial answers. I hope that this work is worthy of their interest in my efforts.

I wish to thank Dr. Efrain Reisin of Louisiana State University Medical School who was intrumental in making this study possible. His collaboration enabled me to have access to Charity Hospital, New Orleans and its patients. I greatly value our many discussions in which he very fairly presented the biomedical point of view. He was remarkably

aware and open about the limitations of his own profession while quite justly pointing out those of mine. I have learned much from him. I am grateful to my examination committee: Frances Cohen, Bernard Rappaport, and Nancy Scheper-Hughes. They were inspiring teachers and very helpful in preparing for this research.

Dr. Zachary Gussow and Anne Gussow deserve great thanks. Their patience and compassion for an inexperienced anthropologist as myself are appreciated. I am grateful for my discussions with Dr. Gussow and the opportunity to have contact with such a great intellect. Anne Gussow's generous and experienced advice saved me many mistakes and headaches.

I wish to thank Dr. Frank Gonzalez and Sherrolyn Weed of the Section of Nephrology, L.S.U. Medical School for their support and assistance. Dr. James Storer of Charity Hospital in New Orleans is to be thanked for taking time and interest in this research during a period of crisis for his own institution.

I am deeply indebted to the staff of Medicine and Special Hypertension clinics, in particular Nurses Bland, Miles and Ayers. Without their assistance this research would literally have been impossible. Their competence and dedication under crowded, difficult conditions was nothing less than heroic, and a humbling experience for myself.

I do not know how to adequately express my thanks to David, my friend and husband. He drafted the diagrams and helped in setting up the tables. This research has caused

him numerous personal and career difficulties. I am most deeply thankful for his patience and support in the face of these difficulties. Most importantly I am grateful for his love, understanding and faith in me when I had none. He is a good friend and great human being.

Love and thanks go to my son, Nicolas Etienne, who patiently (for the most part) endured the sometimes unreasonable demands my work placed on him. His presence in my life offers me solace in the midst of a difficult world. Thanks to Claude Jacobs for advice and discussion throughout. Marian Sander is to be thanked for her generous and skillful transcription of interviews.

I wish to thank my family and friends for their patience and aid throughout this process. This includes Anne Giovingo, Rosemary Sander, Terry Arroyo, Celia Norman, Karen, Vic, Betsey, Tom, Paul, Mona, Carol, Dennie, Joe, Sue, Pam, Lee, Ellen, Lennie, Connie and Greg, and everyone else who made New Orleans such a great place to be. I am grateful to my parents for their support throughout my life, for giving me a sense of curiousity about the world, and their own examples of personal courage.

I am indebted to my classmates and colleagues, Sandra Gifford, John O'Neil and Ron Stall for commiseration, intellectual simulation, and helping to "keep my head on straight" over the past years. Thanks and affection to all of them.

Thanks go to everyone at Medical Anthropology; to Margaret Clark for helpful intervention during rough spots over the years, and to Judith Barker for help in getting the machines to work. Special thanks go to Priscilla Ednalgan and Marisa Leto for their help from afar.

I have left thanks to my informants last because, above all, they are the people who should best be remembered. I have never before met a group of people who are so deeply generous, kind, and reflective of the Christian ideal they esteem so highly. I was and still am astonished by their patience, good will, and sincere, unself-conscious spirituality. The difficulties and tragedies they experience in everyday life make their goodness-of-heart even more amazing.

We all learn from our informants and I am grateful for their cooperation which made this dissertation possible. But what I have gained as a person for knowing these women, even briefly, makes all other considerations pale in comparison. Thank you, each of you, and may God bless you.

Abstract

"My Blood Boils": Folk Models of Hypertension and Compliance Among Older New Orleans Black Women

by
Suzanne Marie Heurtin-Roberts

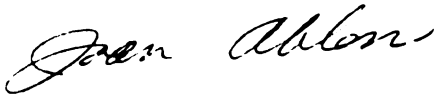
Hypertension control constitutes one of the major problems in the delivery of primary health care to the largely Black population of New Orleans. To aid in control of this serious chronic illness, this study investigated folk beliefs and affect as factors in compliance with biomedically prescribed treatment for hypertension in older New Orleans Black women. It was hypothesized that culturally influenced cognition about hypertension would be correlated with compliance with treatment.

Health beliefs and supplementary social psychological data were elicited from a random sample of 60 Black women, aged 45-70, being treated for hypertension in the ambulatory clinics of a large public hospital. Beliefs were elicited by means of two standardized, semi-structured interviews. Compliance was followed for approximately two months for each study participant. Patient health beliefs were compared to those of 15 physicians treating these women in the ambulatory clinics.

Marked differences between patient-practitioner beliefs were found. Over half of the patients recognized the existence of two folk illnesses, "high blood" and "high-pertension", whereas physicians recognized only one illness, hypertension. Relationships between folk health beliefs

and compliance were found to be statistically significant. Culturally influenced cognitions and emotion relating to high blood and high-pertension were found to be related to the social, cultural, and psychological environment. High-pertension was found related to an anxious nervous self, while high blood was discussed within the context of status anxiety and ethnicity.

It was concluded that culturally influenced cognitions and emotions surrounding hypertension have strong implications for the adaptation of the self in the behavioral environment of hypertension. Finally, the implications for compliance, illness management, and hypertension control were discussed.



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CHAPTER 1: INTRODUCTION

> I'm told the patient population here is different from other Black populations. You know, all that voodoo; they say they're very superstitious. Ph.D. anatomist at a local medical school.
>
> High blood? Everybody knows about that. Physician who had practiced medicine in New Orleans for over 20 years.

New Orleans is popularly known as a community rich in folklore and expressive culture. This is apparent not only in expressive forms such as music, dance and language but also in the areas of religion, health and medicine. Herbalists practice in shops where, in back rooms, healers and readers cleanse, cure, predict and counsel. "Jinx" candles are sold in ordinary supermarkets, next to votive candles bearing pictures of the Blessed Virgin and the Pope. In spiritualist chapels (one is less than two blocks from the city's largest hospital) supplicants seek the aid of Blackhawk (the leader of 1812 Saux and Fox rebellions) in various matters including health (Jacobs, 1980). The Catholic chapel at St. Roch cemetery is filled to overflowing with crutches, plaster limbs, organs, and eyeballs; mementos left in gratitude for cures attributed to numerous saints, some recognized by the Catholic Church and others created locally.

Much of this cultural development is due to a particularly rich and vital efflorescence of Black culture,

which has been central in giving New Orleans its character, heart, and soul.

That this is so, however, contributes to the kind of problem reflected in the two opening quotes and that is to be adddressed in this research. Health professionals in the community are aware of a strong cultural tradition among Black patients and think they are well informed about this tradition. A sample of 15 medical residents at Charity Hospital in New Orleans who were asked to characterize the patient population said it was overwhelmingly Black, noncompliant, ignorant, and superstitious.[1] That they were compassionate enough to attribute this to poor education and poverty, which are in fact, real problems, does not change their impression of their patients as superstition ridden. Although the physicians did believe in the existence of folk beliefs in general, few were aware of the nature of any specific folk health beliefs.

Very little research on ethnomedical belief and practice has been conducted in New Orleans and the surrounding region. Knowledge of folk health culture is intuitive, unsystematic and based upon conjecture and general experience rather than objective inquiry. General professional awareness about patient folklore is an oral tradition of undocumented knowledge, and as such itself constitutes folklore.

This research project is a beginning attempt to remedy the situation by investigating ethnomedical beliefs

concerning hypertension in older New Orleans Black women. These beliefs are to be investigated as they relate to compliance with biomedical antihypertensive treatment in patients being treated at Charity Hospital in New Orleans, the key institution of Louisiana's public health care system (Storer, et al., 1986). It is also intended as a demonstration of how anthropology can contribute to a problem in primary health care delivery.

It may seem incongruous to speak of primary health care problems in an affluent society such as the United States. However, in Louisiana and especially in New Orleans, the delivery of essential health care to much of the populace is presently problematic. With a large indigent population, the state's public health care system is already over-burdened and stretched to capacity. Due to a financial crisis of mammoth proportions in state and city government, the public health care system is being threatened with massive budget cuts making the outlook for primary health care in Louisana bleak.[2]

One great strain on the system, especially at Charity Hospital, New Orleans (CHNO), is the number of patients with uncontrolled chronic illnesses, taxing inpatient as well as ambulatory services. Hypertension is particularly salient in this context since it is treatable, medically control-lable, and a particular problem at CHNO. If controlled, hypertension presents no major problems for the patient or health care system. Out of control, however, it can result

in grave consequences for the health of the individual and additional strain on an already overburdened health system.

Hypertension

In the normal vascular system, the ratio between cardiac output and total peripheral resistance of the vascular system is constantly regulated. Blood pressure in the systemic circulation is kept within certain limits both at rest and during periods of stress. When hypertension is present, this ratio is disturbed (Lund-Johansen, 1983).

Over time this can cause damage to the vessel walls and organ damage. Possible sequelae are severe and include heart disease, stroke, kidney disease, and blindness (Williams, Jagger and Braunwald, 1980). Prevention of these sequelae are dependent upon adequate blood pressure control.

According to the Joint National Committee on High Blood Pressure, the crucial missing link in hypertension control is compliance with prescribed treatment (1984). Hypertension is controllable and modern medicine provides a plethora of treatment possibilities. These include various pharmacological strategies designed to dilate vessels, reduce cardiac ouput and decrease blood volume, all with the end purpose of reducing the pressure at the which the cardiovascular system operates. Dietary restriction of sodium and weight loss are also used. (Williams, Jagger and Braunwald, 1980).

These treatments will do no good, however, if they are not well-used by the patient population. In much of the hypertensive population, they are not. A repeatedly found representation of the magnitude of non-compliance in the general population is that, of those hypertensives under biomedical treatment, about one-half adhere to their regimen (Kirscht and Rosenstock, 1977; Dressler, 1980; Taylor, et. al., 1978; Hershey et al., 1980). This is congruent with a compliance level of approximately 50% in other long-term therapies (Sackett and Snow, 1979).

This report will discuss hypertension control in New Orleans as a research problem in anthropology and primary health care, where problems in the management of hypertension in a largely Black population are related to folk illness models and health beliefs. It will be argued that problems of primary health care delivery in the U.S. are not necessarily very different from those in developing nations and that anthropology can make a significant contribution to primary health care in developed nations.

Primary Health Care in An "Affluent" Society

Discussion of primary health care has traditionally taken place in the context of developing and third world nations. Recently the primary health care concept has been applied to public health programs in the fourth world and the "welfare state" (O'Neil, 1986; Hessler and Twaddle, 1986). Yet, throughout this discussion, anthropologists of western industrialized nations have shown a tendency to

focus on "them" and not "us". Certainly this is in part due to the past general tendency of anthropologists to look somewhat askance at home-based research, deeming it more appropriate for sociologists. (Cassel, 1977; Hughes, 1974). For American anthropologists, at least, it may also be related to a peculiarly American "missionary" inclination to help the "poor of the world" while remaining selectively blind to serious problems at home.

As Messerschmidt points out, "if anthropology is the study of human and social conditions broadly conceived ...then we have a definite role to play in the here and now" as well (1981:3). A concerted turn toward home has only recently become discernable in anthropology and most often emerges in the form of what Messerschmidt calls "an anthropology of issues", an applied anthropology combining theory and practice in coming to grips with social issues at home (1981). It is ironic that one of these issues should be primary health care, considering the image of affluence our society projects in the global community.

Primary health care is optimally defined as the delivery of basic health care to everyone in a community at a price the community can afford (See Gish, 1979, for a historical discussion of primary health care). That an affluent and technologically advanced nation such as the United States should fall short of this basic goal raises serious questions about our system of health care. American

affluence is not equitably distributed, nor are basic health services.

New and Donahue pointed out that primary health care problems generally are a function of the political economy at the national and international levels (1986). The American health care delivery system is, without question, in need of an overhaul. This issue, beyond the scope of the present paper, has been well defined and discussed elswhere (see, for example: Ehrenreich, 1975; Ehrenreich and Ehrenreich, 1975; Illich, 1976, Navarro, 1976). Yet, beyond political and economic phenomena at the national level, problems in primary health care in Louisiana can be also be related to local and regional economic history.

The Southern United States Compared to the Third World

A case can be made for viewing much of the United States South as a third world post-colonial nation. Marian Pearsall convincingly argued that the American South has much in common with the underdeveloped third-world (1966). According to Pearsall, much of the South historically possessed a plantation economy characterized by one-crop agriculture. It required great acreages and large amounts of unskilled labor to provide raw materials to the industrialized North. A socially small but powerful ruling class dominated the society, while a large part of the population was poor and in bondage.

After the system collapsed in the Civil War, a period of tremendous social upheaval followed with the military

occupation and suppression of the conquered region by Northern forces. This situation was comparable to the quelling of colonial rebellion and subsequent military rule in the third world by colonialist powers.

The post-war South lagged behind the rest of the country technologically, with continued emphasis on one-crop agriculture and the replacement of slavery with sharecropping. Halting attempts at diversification within the region caused the region to turn to federal agencies for relief, not unlike United States' export of foreign aid for agricultural development (Pearsall, 1966). Nevertheless, the region long remained in a state of economic depression and dependence on the rest of the nation. There was no real change until World War II when the South finally passed the 50/50 agrarian-industrial ratio, a point passed in most of the nation by the early 1900's. Not until the 1960's did the South become more urban than rural.

Pearsall also pointed out that the American South is home to a large population with the uniquely unAmerican experience of bondage (1966). American Blacks like their colonial counterparts in many areas of the world have not fully been "born free", but are still testing freedom after years of dependence and restricted participation in the larger society. To quote Pearsall "Even with change, experiences of the sort described. . .place the South closer to the rest of the world than to the rest of the U.S." (1966: 140).

Problems of Primary Health Care in Louisiana and New Orleans

Much of the contemporary South remains a single commodity economy producing raw materials whose price is controlled by the industrialized world. In Louisiana, efforts at industrialization have concentrated on oil and gas production. The recent drop of oil prices has caused this effort to all but collapse in Louisiana with catastrophic results for the state's economy, whose revenues are largely derived from taxation of the oil industry.

Faced with a possible budget deficit of $112,000,000, state government is threatening draconian budget cuts including cuts in funding to the Department of Health and Human Resources. (Times-Picayune, 1987a) Louisiana is currently only with great difficulty providing basic health care for its population. The situation is not dissimilar to that of the third world: a large population in need of primary health care with scant resources for its delivery.

This creates a situation for the delivery of primary health care different from that found in much of the nation. The region must provide health care to a large extremely poor underclass racially and culturally distinct from a now less powerful, but still formidable ruling elite. This distinctiveness not only presents problems in designing health care both suitable and acceptable to the Black underclass, (i.e.,"by the people and for the people" (Gish, 1979)), but also makes it more difficult to convince a

reluctant elite (not known in the past for their generosity toward the Black population) of the necessity to do so.

One goal of primary health care is to promote self determination, that is, to enhance indigenous forces in health care delivery, and foster use of local resources. The thrust of the effort is to provide health care from the "bottom-up" rather than the "top down" (New & Donahue, 1986) and involving full community participation. In an urban, culturally plural setting like New Orleans, where there is already a well-established health care system, indigenous forces and local resources involve both patients and healers including those of the biomedical system.

As Welsch noted, the concern for self-determination and "scientifically sound" methods and technology for health care are inherently contradictory (1986). This contradiction often takes the form of an intrinsic tension between local autonomy and external professional authority.

In a situation such as New Orleans' involving local biomedical professionals as well as patients with a strongly distinctive culture there exist two markedly different symbolic worlds in the same local system of health care. The tension between science and local autonomy described by Welsch then becomes one between two distinct symbolic worlds within one system of action. Conflict is placed then within the indigenous system itself rather than on a local/external axis. This can impede the system's functioning.

One instance in which conflict can occur is when culturally influenced health beliefs generate behaviors different from those prescribed by the health professional. The health professional considers these noncompliance, yet in the context of the patient's health beliefs and everyday life situations, these behaviors may be appropriate and reasonable efforts at illness management.

That specific beliefs influence behavior is by no means a given and for reasons to be discussed in chapter 2, can never be scientifically "proved". Rather an observed association between certain beliefs and specific behaviors can be interpreted so that the association "makes sense" or is understandable to the observer.

An Overview of the Present Work

In chapter 2 , ethnomedicine is discussed as belonging to the realm of belief, symbol and cognition. I argue that cognitive factors and affective states they generate must be addressed in understanding illness behavior and experience. The personal nature of illness experience is considered together with the role of belief, emotion and behavior in its creation.

Chapter 3 explores compliance more fully. Problems of conceptualization are discussed and I suggest that the issue be reconceptualized as illness management.

The special problem of chronic illness behavior is introduced and discussed as adaptive behavior, positive coping and health promotion. The development of a model in

which to consider efforts at chronic illness managment is introduced. The model takes into account self in its behavioral context of belief, emotion, and social interaction.

Chapters 4 and 5 discuss the methods and context in which the research problem is addressed. The local health care setting is described, and Black culture, social organization and psychology in New Orleans are discussed.

Chapter 6 describes the health beliefs found in the research and their relationship to illness behavior and compliance. Chapter 7 represents an effort to interpret and understand the experience of hypertension in New Orleans Black women. Self, belief, and emotion within the behavioral environment are considered.

In the following discussion, I will argue that illness can be better managed when patients are viewed as thinking, rational, discriminating persons rather than black boxes compelled to action by external stimuli, whimsical creatures at the mercy of emotional flux or cultural clones whose thought and actions are determined by "personality writ large".

This is not to say that an individual's actions are all coherent or that belief, motivation, and action, taken together, make up a logically integrated whole. Rather, an individual, if viewed with insight into his/her cognitive and emotional world, will emerge as a purposeful, sentient person whose actions make sense.

This study is intended as a context in which these issues can be addressed. It is hypothesized that folk beliefs about hypertension will be found to be correlated with compliance. It is further proposed (although this is not subject to hypothesis testing) that illness behavior will be better understood in the context of ethnomedical belief about hypertension.

Black New Orleanians have a strong cultural tradition. This aspect of their behavioral environment cannot be ignored, but must be considered in association with the social milieu, individual affect, everyday contingencies and the biomedical system in order to understand the experience of hypertension and efforts at its management. Only then can the biomedical problem of noncompliance be addressed and positive efforts at illness managment be encouraged. Without this there can not be an effective primary health care program.

NOTES

[1] None of the medical residents interviewed were themselves Black. During the period this research was conducted I saw only two Black residents in medicine clinic, one of whom only came occasionally as a substitute. The other was not staffing the clinic at the time the residents were interviewed.

I did speak with a Black representative of a pharmaceutical company who was a native New Orleanian. He was aware of the health beliefs discussed in this research but shrugged it off as belonging to the "old people". It is uncertain how much of this folk knowledge is held by younger generations. I have since met younger Blacks who were familiar with this, yet they have all been well-educated health professionals, and as such not representative of the population discussed.

[2] The state of Louisiana and the metropolitan area of New Orleans are presently undergoing a grave financial crisis brought on by plummeting oil prices world-wide, an overly oil-dependent economy, and a singular lack of foresight and leadership by past elected officials. (Times-Picayune, 1986)

CHAPTER 2: ETHNOMEDICINE: BELIEF, UNDERSTANDING, AND ILLNESS BEHAVIOR

An Ethnomedical Approach to the Study of Medical Systems

Health beliefs, while the product of individual cognition and social interaction, take shape within ethnomedical traditions. Ethnomedicine will be discussed as the framework in which individual health beliefs are constructed and illness behavior is organized and generated.

Virtually all studies of medical systems[1] contrast what has been variously called `Western,' `scientific,' or `modern' medicine with all other medical traditions (Kleinman, 1975). There can be discerned a real reluctance to view `Western' medicine as just another medical system. Kleinman attributes this largely to what he characterizes as an ethnocentric biomedical profession (1975). Yet this dichotomy is seen not only in the works of early medical anthropologists such as Clements or Rivers, but also in much more recent discussions (Hughes, 1968; Lieban, 1974; Chrisman, 1977) which contrast "biomedicine" or "scientific" medicine from ethnomedicine or lay medicine.

Any medical system, however, including biomedicine, is integrally a part of its sociocultural context. No medical system reflects an absolute physical reality but one which is culturally perceived and constructed. An ethnomedical perspective implies investigating the emic view of a system's beliefs and practices within their sociocultural context (Fabrega, 1975). The position taken in this study

is that all medicines are ethnomedicines when considered as part of a sociocultural system. Thus biomedicine can be compared legitimately to any other ethnomedicine according to the same parameters.

An Ethnomedical Approach to Medical Traditions in New Orleans

The present study investigates a situation involving two medical traditions, which can be characterized as a folk medicine on the one hand, in contact with biomedicine on the other. Both traditions will be viewed ethnomedically, with the focus of attention and actual object of study being the folk medicine. This is not a holistic study of Black folk medicine in its entirety, nor of biomedicine, much less of their respective organizational institutions. The study focuses on beliefs and behavior surrounding what has been biomedically diagnosed as hypertension, and the illness constructed in response to it by the patient sample.

The Black patient's medical beliefs and practices can be characterized as a folk medicine following the definition of a folk medicine as one of the people existing in opposition to a dominant professional system (Press, 1980; Leslie, 1978). Besides folk and professional medicine, Kleinman includes popular medicine in his formulation of medical systems (1980). It is a nonprofessional realm of health care arising from the social interaction and problem solving of individuals regardless of whether they share a common ethnomedical tradition. This is the health area

where family and friends offer diagnoses and care. Although it may overlap with the folk sector it is more a lay medicine since no shared cultural tradition is assumed. If a shared health culture were present, it would be folk medicine. Since there is ample evidence of a shared cultural tradition, nonprofessional Black medicine in New Orleans will be called a folk medicine.

The dominant medical orientation in New Orleans will be termed biomedicine rather than professional medicine, although this would be the logical contrast term for folk. One reason for using "biomedicine" is that there exist a numerous healers and herbalists in south Louisiana who, in exhibiting expertise at their craft and earning their living accordingly, could conceivably be called "professional" (Press, 1980). Reserving the term professional for biomedically trained and licensed physicians fails to do justice to the plural nature of health culture in the region. (Hurston, 1931; Webb, 1971; Jacobs, 1984) In addition the term "professional" only refers to a dimension of social organization.

Using the term `biomedicine' allows the reader to readily recognize the medicine being discussed. As used here, `biomedicine' refers to the ideological substance and content of the system. This is an explicity ethnomedical usage referring to the beliefs and perspectives which, emically, are fundamental to the system.

This does not imply that other medical systems are not biological but that biomedicine is overwhelmingly and insistently so. Biomedicine is a product of the Western cultural tradition of rationalism, empiricism, and the separation of the mind and body. Contemporary biomedicine strongly emphasizes body-ness while paying little attention to mind-ness or spirit-ness, unlike many other medicines. It is often said that contemporary biomedicine treats a disease and not a human. Adjustments are made in the realm of biology broken down into biochemical, neurochemical bits, leaving mind, spirit and the rest of the cosmos out. For this reason, the professional medicine addressed in this work will be called biomedicine.

Ethnomedicine: Belief, Emotion and Action

A contemporary approach to the study of ethnomedicine considers it part of a people's symbolic world. The research task becomes the observation and analysis of culture; the explanation of belief systems, of symbols and meaning and related practice.[2,3] How to approach the task is problematic.

For explanations of illness behavior, formalist symbolic analyses of ethnomedicines are woefully inadequate. Turner and Geertz have both argued for a dynamic rather than formalist perspective in the study of symbols, especially in relation to social action (Turner, 1975; Geertz, 1973). Turner said it was necessary to view symbolic forms in terms of the purposive actions of individuals negotiating social

meaning. Geertz questioned the existence of a coherent system of beliefs, values and norms divorced from human action and will (1973). He called such perspectives "hermetical" and divorced from reality. The symbolic study of ethnomedicine without reference to human purpose is useless for the elucidation of behavior.

In discussing ethnomedicine as a system of belief and practice, the term `system' surely must be used loosely. The successful quest for order and cognitive coherence in the study of ethnomedicines as belief systems is doubtful.

Certainly, there is a rationality to belief systems, that is there is a meaningful relationship between its elements. Each element however, may not be logically related to each other, and some are more closely tied and tightly embedded in the system while others may be looser and more peripheral. (See Kiefer, 1977; Douglas, 1970; Peacock, 1975 and Hall, 1976 for discussions of embeddedness and coherence in symbol or belief systems).

Kunstadter considers it a mistake to rely, as an explanatory hypothesis of behavior, on the tendency of humans to bring their thoughts and behavior patterns into strict consonance or orthodoxy (1975). He questions to what extent people really are disturbed by cognitive dissonance (as represented by multiple and perhaps inconsistent medical theories).

DeVos criticized Festinger's theory of cognitive dissonance as inadequate to explain behavior (1975a, 1975b).

Rather, he said the explanation lay in the experience of affects dissonant or discordant with other affects valued and important to the individual. The attempt to resolve this dissonance is the impetus to action.

This criticism points up a significant failing of purely cognitive explanations of behavior. These discussions frequently neglect to question how people feel about a given cognition. Westin characterizes emotions as the missing link between cognition and behavior (Westin, 1985). Goldschmidt proposed that the need for positive affect, which he equated with the quest for increased self-esteem, is the basic motivating force in humans (1959, 1974).

Decisions to take action are made not only in terms of one's cognitive appraisal of a phenomena but also in terms of one's feelings about it. Feeling gives us a reason for doing something about what we think. To understand and explain behavior, it is necessary to understand the individual's cognitive environment and his feeling about it.

On Understanding and Interpreting Behavior

In his eloquent discussion of empiricism and understand-ing, Vendler notes that the human as a physical entity is readily observable empirically (1984). When we move into the realm of the human as person however, such thorough empiricism is no longer possible, for we are dealing with subjective states. These states can not be

directly perceived, but must be inferred on the basis of certain observable manifestations.

This inference must be based on our own experience, our feelings and thoughts in what we perceive to be similar situations. We imagine what we might do or feel if we were in a similar situation, or in interactionist terms, we "take the role of the other". Thus the connection between the other's subjective state and his overt behavior is to be found in our experience alone and not directly. Action is not "caused", but performed by an actor for a reason which we can seek to understand in terms of our own experience (Vendler 1984: 207).

Experience is recountable and interpetable but not directly observable and thus, necessarily falls outside the realm of science. Yet without interpetations invoking experience and imagination we are left with the "black box" of behavioral psychology where the only admissible data are observable stimulus and response. Eliminating this link of experience and imagination leaves us with only the human automaton as the subject of study.

Since one must try to take the role of the other to explain action, it is necessary either to possess experience similar to the other's or to gain information about the other's experience. This is the task of the social sciences. To quote Geertz ,"The trick is not to get yourself into some inner correspondence of spirit with your

informants....[But rather] the trick is to figure out what the devil they think they are up to (1974)."

The study of the human person's behavior (as opposed to the human organism), then implies the task of understanding culture, belief and feeling. To understand behavior it is necessary to apprehend the world in which the actor makes his choices.

In the realm of health and illness, part of that world is ethnomedicine -- the health beliefs, the symbolic and meaningful elements of a society's medical system. Efforts at explanation of health and illness behaviors must involve the individuals' beliefs and feelings about health related matters. These include culturally shared beliefs as well as more personal, idiosyncratic ideas.

The Uses of Ethnomedicine

Ethnomedical belief communicates information about other elements of the sociocultural and psychological milieu. To illustrate what can be learned from ethnomedicine, the uses of ethnomedicine, it is helpful if we view ethnomedicine as belonging in the realm of folklore.

Edmondson pointed out there were two aspects to folklore, metaphor and hypothesis, both relational statements (1971). Hypothesis is a denotative statement where an element of one category is also given membership in another category. Metaphor is a connotative statement where one goes beyond the surface statement of categorical membership to see what is also or "really" being stated.

This sub-surface meaning may not at all involve the same categories as the "surface" statement, but be an analogous to it. Metaphor, unlike hypothesis is changeable and may carry many meanings which change in use.

As folklore then, ethnomedicine (belief and practice), consists of both types of statements. It communicates information about many elements of the world. In ethnomedicine, hypothetical statements convey simple, logical messages at the surface level. Ethnomedical statements, as metaphor, can also convey analogical messages about matters not addressed at the surface level.

Sickness can perform an ontological role, communicating and confirming ideas about the real world (Young, 1976). Folk illness can function to sustain dominant cultural values (Rubel,1960). Kleinman says medical systems give meaning to illness episodes by giving name and cause, they are made understandable in terms of the "natural order" (1980). Looking at Kleinman's statement inversely, medical systems (including ethnomedicines) are symbolic systems constructed by human groups which reflect world view, expressing the nature of world and one's relation to it. Thus, ethnomedal beliefs can be studied not only for what they tell us at the hypothetical level, for information about health illness and illness behavior, but for what is communicated metaphorical ly. Ethnomedical phenomena insofar as they are metaphorical statements can be considered expressive forms.

The idea that health and illness carry with them metaphorical meaning is certainly not new. Much early work in psychosomatics and psychoanalysis focussing on the conversion of psychic excitation and disorder into somatic symptoms can be recognized as the interpretation of illness as a metaphorical statement of psychic disorder and conflict. Susan Sontag perceptively examined two key metaphors inherent in illnesses in Western culture (1977).

What is noteworthy is the interest given to metaphors in ethnomedicine as they express facts of the broader sociocul-tural milieu and also the individual's relationship to that milieu. Examples of such works include Ohnuki-Tierney (1984), Good (1977), Nichter (1981), Ito (1982). These diverse analyses of illness all have in common an attempt to delve beneath the hypothetical level of illness statment into the level of metaphorical expression. Illness is treated as an expressive form.

Simple expression of conflict or distress is not the sole purpose of illness statemnt, however, for meaning has its uses. DeVos, in his analyses of interpersonal behavior and the uses of ethnic identity, distinguished between instrumental and expressive uses (1982). This distinction can fruitfully be applied to health and illness metaphor. Thus statements, verbal or behavioral, of health and illness can be intended expressively, as ends in themselves to satisfy some prior emotional need.

They may also be used instrumentally, as goal oriented behavior, a means to an end. Instrumental behavior occurs when illness behavior is performed for secondary gain, for example, effecting of changes in the social milieu, coercion, or acquisition of goods or favors. Expressions of illness readily lend themselves to this use.

Ethnomedicine and Personal Experience

Foster distinguished between personalistic and naturalistic views of illness in the analysis of ethnomedical systems, but to a certain extent all illness is personal (1976). It can have exceedingly strong meanings and messages to the individual about himself and his environment. Insofar as illness is used expressively and instrumentally, illness experience becomes deeply personal, relating to the individual's emotional and social needs, which of course depend upon each individuals situation, as it is appraised and interpreted by the individual (Lazarus, 1974).

Hallowell argued over 40 years ago that belief and symbol provide the basis for human cognitive orientation toward the world outside the self (1942). He said "The native belief system...defines the...environment in thich they live, and no purely objective account would be sufficient to account for their behavior in relation to this physical environment" (quoted in Black, 1973: 519). This is true of ethnomedicine.

Lakoff and Johnson argued that experience of the world rests upon choice of metaphor (1980). Experience of illness can thus be said to rest in part on the metaphors employed in health belief and practice as directed by an ethnomedical tradition. As Mechanic noted, two persons may have the same disease yet perceive and experience their symptoms differently so that illness experiences differ. Consequently, illness behavior differs which differentially influences further experience. Fabrega remarked on the personal nature of disease, that it means deviation from individual as well as group norms concerning a bodily condition (1981).

It is also a basic tenet of the medical social sciences that illness is social phenomenon. Parsons in his discussion of the sick role made explicit the social nature of illness; that illness resulting in changes in role behavior is threatening to the social order (1972). This only points up the the reflexive nature of illness experience, that it is both personal and social, and constructed in the intercommunication of both realms. Kirkpatrick and White point out that the person is the link between the subjective and the social (1985).

The study of illness and illness behavior then implies study of culturally influenced beliefs. Moreover it implies inquiry into the individual's emotional and cognitive interpretation of them in a social context. Since illness is so very personal, there is no escaping the necessity of addressing individual beliefs and motivations in investigat-

ing illness and illness behavior. We are compelled to try to get inside the "black box" to relate what seems to be on its mind to its behavior. We are forced back to the realm of understanding and interpretation, of addressing the individual person.

NOTES

[1] In this work, `medicine' will describe the cultural realm of belief and practice, while `medical institution' will refer to the social organization which supports the cultural area. `Medical system' will refer to the systemic whole of sociocultural phenomena dealing with health and illness.

[2] It will be understood that terms such as belief, cognition symbol and metaphor while certainly not interchangeable are of the same domain and can be used in general discussion to refer to the broad realm of cognitive phenomena. As the discussion becomes more specific, so will these terms' usage.

[3] By illness is meant the total subjective experience of being unwell. This is to be distinguished from a disease which is taken to mean a biomedically detectable and recognized physical state of pathology.

CHAPTER 3: COMPLIANCE, ILLNESS MANAGEMENT, AND ILLNESS BEHAVIOR: THE SELF IN THE BEHAVIORAL ENVIRONMENT OF CHRONIC ILLNESS

Noncompliance with medically prescribed treatment has been widely recognized as a significant problem in contemporary health care (Leventhal, Zimmerman, Gutman, 1984; Eraker, Kirscht and Becker, 1984). Although supported by the awesome resources of modern biomedical technology, the practitioner is frequently frustrated in his/her efforts by apparent patient reluctance to utilize this technology.

While this dilemma is present in any illness, in chronic illness the problem is compounded by its long-term character and its pervasive influence on the experiences of everyday life. I will argue that there are special social psychological processes present in chronic illness that are not found to such a degree in acute illness. Further, I argue that in chronic illness changes in self and social organization may occur which are strong forces in motivating and directing all illness behavior, especially in relation to that characterized by the biomedical profession as proper compliance with treatment.

Before addressing these issues I will briefly examine previous medical and behavioral research on compliance with special attention given to compliance in hypertension. I will explore the concept of compliance and propose an anthropological perspective on this issue. Then a provisional model acknowledging some of the social, cultural

and psychological aspects of the chronic illness experience will be proposed.

Compliance Research

Medical and Behavioral Approaches to Compliance

Medical & behavioral efforts at investigating compliance have met with only limited success, and outright failure, in some cases, due to overly simplistic formulations of compliance. Instead efforts have focused on refining and developing ever more sophisticated methods of measurement and testing. The increasing complexity and refinement of methods and measures may in fact signal the necessity for a reformulation of the problem. The issue of compliance is a complex one. Failure to address this complexity dooms the research from its origin, sophisticated methodologies notwithstanding.

A herculean effort to determine why so few persons fully avail themselves of existing biomedical treatment for hypertension and other diseases has been undertaken under the rubric of compliance research. This research effort has continued for approximately three decades. The literature is vast and spans several disciplines (See Leventhal, Zimmerman and Gutman 1984 for an excellent presentation of the literature). The single most notable characteristic of this effort is the copious and wide array of factors found not to be associated with compliance. Indeed compliance research may be unsurpassed for its abundance of null findings (Stunkard, 1979).

Medical investigations of compliance have largely taken an external, individual trait approach, comparing compliers and noncompliers in terms of variables presumed to influence compliance (Marston, 1970; Mitchell, 1974). Patient and disease characteristics, the patient-practitioner relationship, and organization of the health care system have been investigated and found to inadequately predict compliance (Haynes 1979, see Haynes, Taylor and Sackett, 1979 for a comprehensive statement of the medical approach to compliance).

Features of the treatment regimen fared better although only slightly more so (Haynes, 1979). Side effects, popularly invoked as the cause of noncompliance, were not significant factors. Negative correlations were found, however, between duration and complexity of treatment regimen and compliance.

The medical approach to compliance research, almost completely atheoretical, was largely hit-or-miss in choice of variables (Sackett and Haynes, 1976). The behavioral approach to compliance, in an effort to remedy this situation, is based on a stimulus-response paradigm (Leventhal, Zimmerman and Gutman, 1984).

Behavioral studies have met with notable success in areas such as weight control and smoking, improving behavior by 60-90% (Leventhal and Cleary, 1980). In the area of hypertension the strategy was to enhance motivation by

increasing the patient's understanding of the illness and its risks (Taylor, Sackett and Haynes, 1978).

While the behavioral approach has been succesful, it has effected temporary changes which deteriorate over time rather than achieving long term adherence (Hunt and Bespalec, 1974). This is particularly problematic in chronic illnesses like hypertension where treatment is required throughout the course of the illness. Behaviorists have seen this as a failure of method and technology (Zifferblatt, 1975). Leventhal and Cleary, however, view this as a failure of behaviorist theory which neglects to view the patient as goal oriented within the context of his or her long-term life patterns (1980).

Both the behavioral and medical approaches pay little attention to the patient's perspective, thus offering little insight into motivations influencing behavior. Consequently, medical and behavioral research have produced an inadequate understanding of the problem of noncompliance and what to do about it.

Attempted Solutions: Cognitive and Experiential Approaches

Cognitive Approaches

A considerable body of research investigating the influence of cognition on illness behavior has accumulated. Much of this research has been based on the Health Beliefs Model, derived from cognitive psychology and relating

patient beliefs, attitudes and perceptions to illness behavior (Maiman and Becker, 1974).

First used to predict preventive health behavior, the model's use has been extended to research on compliance with antihypertensive treatment (Hershey, J. et al., 1980; Nelson, et al., 1978; Kirscht and Rosenstock, 1977). Nelson and associates (1978) and Kirscht and Rosenstock (1977) found perceived severity of illness and perceived efficacy of treatment to best predict compliance. Hershey and associates, however found perceived locus of control to be the most important factor (1980). This disagreement is puzzling in light of the fact that the studies used very similar methods and sample populations. In these studies, approximately 15% of the variance was explained.

In addition to Health Belief Model research, other behavioral models have been developed which recognize the importance of cognition on health and illness behavior. They have been developed by social psychologists attempting to delineate the use and evaluation of information in decision making (Montano,1986; Triandis, 1980; Ajzen and Fishbein, 1980; Bandura, 1977). These are intended as improvements on the Health Belief Model which does not address the evaluation of beliefs and attitudes.

While cognitive models do improve on simplistic formulations of compliance, they have an important limitation. These models have been deductively derived from theory in cognitive psychology, generating research on

beliefs that are theoretically significant (Maiman and Becker, 1974). However, the study population may actually emphasize a different set of beliefs, which would be missed by research based on these models. The cognitive models discussed are not sensitive to possible cultural and social differences in health-related cognition.

Blumhagen made this point in his discussion of Health Belief Model applications to compliance in hypertension (1982). He expressed it as the fallacy of depending too much on theroetical concerns and not on what the "people" think is important. Blumhagen blamed this deductive "blind spot" for the inconsistencies mentioned earlier in Health Belief Model Research on hypertension. A more empirically grounded, inductive approach is surely appropriate for the study of health beliefs (Glaser and Strauss, 1967).

Sole reliance on deductive theory in research can mean that entire realms of belief may not be tapped, beliefs that may be crucial to the understanding of compliance and other illness behaviors. The use of inductive, exploratory research on health beliefs, as in the present study can provide a sociocultural context for deductively derived models and facilitate deeper insights into compliance behavior.

Experiential Approaches

A serious failing of previous cognitive research is that the patient's experience and perspective are not taken into account, (Blumhagen, 1982). This is being addresssed

in contemporary inquiries into compliance which Leventhal, Zimmerman and Guttman characterize as the "self-regulating approach" (1984). I would prefer to call them, more simply, experiential approaches since the patient's perceptions and experience are emphasized.

The experiential approach does not represent a consciously assembled body of cohesive research but a number of inquiries with common a common perspective. The perspective views patients as active agents choosing, responding to, and evaluating their own goals as determined by their individual formulations of illness and treatment (Schulman, 1979).

The point has been well made that the emic or patient's view of his or her own illness is important in the choices of treatment and, therefore compliance, (Hayes-Bautista, 1976, Chrisman, 1977, Kleinman, 1980.) Furthermore, differences between patient/practitioner models of health and illness can be the source of numerous problems in complying with treatment, (Garrity, 1980).

Insofar as the emic, patient's view is given importance, an anthropological perspective is indispensible for understanding cognition and illness behavior and is the keystone of an experiential approach. As Dressler noted, the "question of beliefs and attitudes as factors in compliance converges with one of the more interesting

theoretical issues in medical anthropology, the relationship of ethnomedical beliefs to health-related behaviors" (1980: 88).

Snow (1974: 94), reviewing health-beliefs of American Blacks remarked that the presence of an alternate medical system that's different at best, and at worst in direct conflict with the Western biomedical system can only complicate matters. These beliefs can greatly color the doctor/patient relationship and influence the decision to follow or not the doctor's orders. Harwood (1971) and Logan (1973) made similar points regarding Hispanics. Blumhagen, working with a primarily middle-class Anglo-American sample, similarly concluded that ethnomedical beliefs were important influences on compliance (1982). Anthropological input can significantly benefit compliance research.

Reformulation of Compliance as Illness Management

Difficulties in compliance research lie not only in the approach taken to independent variables such as health beliefs, but also in the manner in which the entire problem is formulated. Indeed, it is necessary to rethink the concept of compliance. Trostle and his associates demonstrated that behavior often labelled "noncompliant" by the medical profession can be seen as reasonable efforts at illness management (Trostle, Hauser, and Susser, 1983). The meaning of any illness behavior depends upon personal interpretation of the elements constituting one's own

illness experience. Strict adherence to the traditional conceptualization of compliance focuses attention on a narrowly defined behavior which ultimately addresses only the issue of obedience to medical authority.

This formulation is an inadequate expression of the real question involved. The more effective question is "What is a person doing about his/her health and why?" This broad question is of greater importance because it addresses the numerous behaviors and contingencies which come to bear upon a person's health status. Research motivated by this question broadens our perspective and addresses the cognizant, feeling human as person. Only by asking this question can we gain insight and understanding into the motivations and dynamics of illness behavior. The focus on compliance can then be reconceptualized as a problem in illness management, efforts at treating one's illness and promoting health in the context of everyday life. This conceptualization allows a shift from issues of obedience/disobedience, to the contextual and personal phenomena coming to bear on an individual's actions. It not only allows the patient to be viewed as a cognizant, rational person making choices, but allows a deeper understanding of these choices.

It has been suggested that other terms be substituted for compliance, the most frequently used one is `adherence'. This is only avoiding the issue. Although the use of terms such as adherence does soften the tone, it does not change

the relationship of patient to practitioner nor does it resolve what biomedicine considers an urgent problem (Haynes, 1979). The authoritarian connotations of compliance keep in the forefront ethical questions which might be "soft-pedaled" by other terminology (1979).

`Compliance' accurately reflects the reality of contemporary biomedicine which does view the physician as a figure of authority and of biomedicine's commitment to the efficacy of its treatments. It is a part of biomedicine's symbolic world as encountered by the patient. If the major issue is whether a patient does what the doctor has said to do then the preferable term is compliance. Nevertheless, compliance must be recognized as only one of the behaviors which comprise an individual's total effort at illness management.

Illness Behavior, Illness Management, and Personal Adaptation

Alland has recently reaffirmed his position that medical anthropology is uniquely useful to the parent discipline in that it addresses broad questions of biocultural adaptation and the human species (1987). It has been argued that medical systems should be seen as culturally instituted adaptive resources (Kleinman, 1975; Kunstadter, 1975; Alland, 1987). Medical systems are a part of a population's efforts at adaptation.

In biology, adaptation is defined as the reproductive success of a population. Yet, adaptation is often a

compromise between long range benefits to the population and the immediate requirements of the individual. Success of a population is most commonly favored by the individual's adaptation to his environment (Hamburg, Coelho and Adams, 1974). A population which does not provide for the well-being of its individual members is doomed to adaptive failure. Although we may speak of adaptation in terms of human groups, ultimately what's under consideration is the health and well-being of individuals[1].

If a group's medical system is an adaptive resource, then illness behavior (including compliance) directed toward illness management represents a use of that adaptive resource. Individual efforts at illness management can be seen as personal adaptation. Illness behavior can be adaptive or maladaptive, depending upon the general outcome in well-being of the individual.

On the surface, compliance with treatment appears to be adaptive. In the broader context of illness management and general well-being, however, the adaptive worth of compliance can not be assumed. As as been noted, illness management involves weighing the cost-benefits of any action in the context of contingencies as perceived by the individual (Hayes-Bautista, 1976 Kleinman, 1980; Trostle et al., 1983; Chrisman, 1977). Since there is always an element of the unknown regarding contingencies and outcome, the adaptive worth of any given illness behavior can not be known with certainty but evaluated in terms of probability.

Compliance does not necessarily equal adaptation, but may promote it.

Hallowell argued that the human psyche as well as the behavior it generates are products of evolution and a peculiarly human adaptive resource. According to Hallowell symbolic behavior and self-awareness are part of the psychological restructuralization in hominid evolution

adaptation. As the human psyche is capable of symbolic action so is the human able to manipulate, change and recreate the environment through symbolic means. The manipulation of symbols and therefore meaning is humanity's most ubiquitous and conspicuous way of coping and adapting (1955, 1960, 1961).

The Behavioral Context of Chronic Illness

The Self in the Behavioral Enviornment of Chronic Illness

The adaptive effort of illness management involves the symbolic manipulation of the environment including the self as object. Since the self is reflexive, change in self-as-object results in change in self-as-subject. Thus illness can be expected to influence the self. When one views one's self as sick, one's self becomes sick. This is never more so than in the case of chronic illness.

For the sick individual, chronic illness is a long-term, constant aspect of daily life. It can be expected that this will have a profound influence on the self in its social and symbolic environment. Illness becomes an object

imbued with meaning for the self and its social milieu, potentially requiring major reorganization of previous lifeways (Gussow, 1964). This experience, mediated by cultural beliefs and expectations, can be expected to strongly influence the self.

According to Fabrega, "normal" or "sick" can be seen as designations of a person's self by himself (his self-image) or imputed by others (his identity) 1974). When a person is denoted ill or, in the case of the present study, hypertensive, the self as actor and object as well as social identity are also thus designated and a hypertensive self and identity are constructed. Self and social identity are, according to Fabrega, the bases for a role that is a "set of expectations mobilized by an identity in a situation. Thus a sick role is designated.

As formulated by Parsons the concept of the sick role involves changes in role behavior resulting from physical limitations brought about by illness (Parsons, 1972). Changes in role behavior involve changes in social organization. To the extent that these changes are meaningful or prolonged, sickness presents a serious threat to the social order. In acute illness this is a passing threat, one which can be excused as temporary social adjustments are made. In chronic illness this is not the case.

In a chronic illness such as hypertension, the role extends through time, pervading multiple aspects of daily life and similarly influencing the self. Role behavior and

self become to some degree hypertensive, accruing the characteristics culturally associated with the illness. The degree to which this occurs depends on a number of contingencies and influences which are part of daily experience.

The social construction of self and identity in chronic illness, indeed the experience of chronic illness occur in the context of the phenomenal environment in which a person functions. Hallowell called this the "behavioral environment" or, the culturally constituted world of objects in which the individual self is motivated to act (Hallowell, 1955).

Hallowell's intent in proposing the behavioral environment as a frame of reference, one which I share, was to develop a means by which "...it may be possible to view the individual in another society in terms of the psychological perspective which his culture constitutes for him and which is the integral focus of his activities" rather than to take the perspective of an outside objective observer. I propose that this framework can be productvely applied to the experience of chronic illness, which has the potential for pervasively coloring the behavioral environment and deeply influencing the self as well as providing an idiom for the self's expression. Use of the self in the behavioral environment as the unit of analysis provides a broad yet personal perspective in which to

understand the experience of chronic illness as well as the motivations and contingencies which influence and organize the self's illness behavior and efforts at chronic illness managment.

A Proposed Model for the Anthropological Study of Illness Behavior in Chronic Illness

The following discussion is an initial exploration of how various aspects of the behavioral environment in chronic illness might be usefully perceived. A fully developed model for application is not proposed; this should be regarded as a beginning discussion toward that end. The present research was not intended as a test of these ideas nor has it produced data applicable to all areas of the discussion. Rather it is intended as a general theoretical framework in which the present research will be discussed and in which future research efforts towards the development of a formal model can be undertaken.

The human behavioral environment is not to be construed as phenomena "external" to the individual; rather it is a behavioral field taking into account the properties and adaptational needs of the organism in interaction with the external world (Hallowell, 1955). Hallowell cited G.H. Mead who insisted that the organism "determines the environment...the organism is in a sense responsible for its environment' (Hallowell, 1955: 86). Inasmuch as human self-awareness results in a reflexive self, then the self is also a part of the behavioral environment.

This view differs slightly from simply taking an emic perspective or understanding "from the native's point of view" (Geertz, 1984) which imply a broader, culture-wide perspective. Rather, as was discussed in Chapter 2 with reference to Vendler, Geertz, and Hallowell, the objective is to understand the individual and his actions in terms of his personal and socioculturally constructed experience.

For the chronically ill, the behavioral environment of illness is the everyday behavioral environment. Unlike acute illness, the behavioral environment is permanently altered as strategies of illness management are incorporated. These strategies then become part of the environment in which further actions are taken.

Some components of the behavioral environment will briefly be described. A hypothetical arrangement of these components is illustrated in Figure A (p. 45). This is a static representation of a very fluid reality. An analogy employing the Bohr and Heisenberg models of the atom (greatly simplified) and movement of subatomic particles may helpful, if also a bit unusual (Petrucci, 1972).

In an atom there is a nucleus, which corresponds to the self in the behavioral environment model (See Figure B, p. 45). The nucleus is surrounded by electron shells, areas containing the orbits of electrons in constant motion around the nucleus. These correspond to the various realms containing the components of the behavioral environment. In the Bohr and Heisenberg atomic model (as opposed to earlier

Figure A:

The Self in The
Behavioral Environment

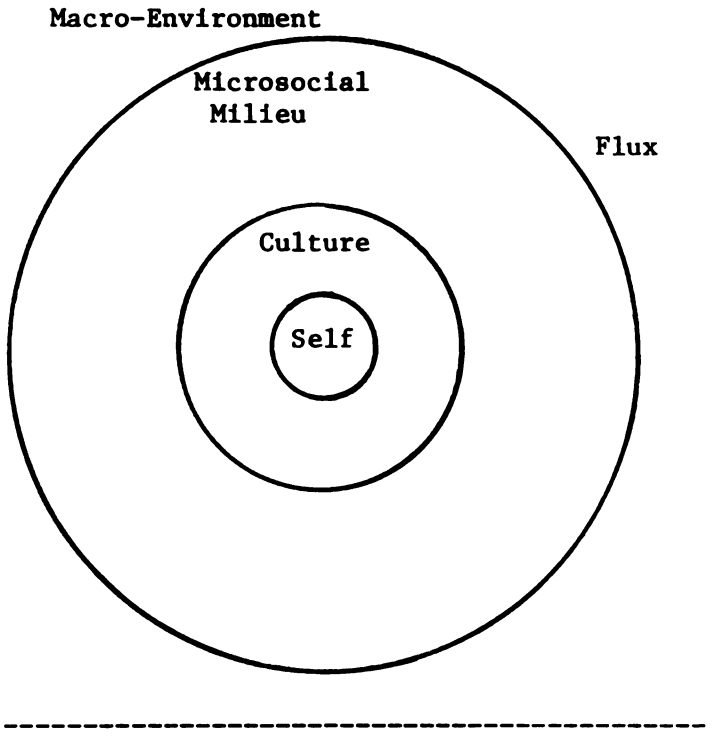
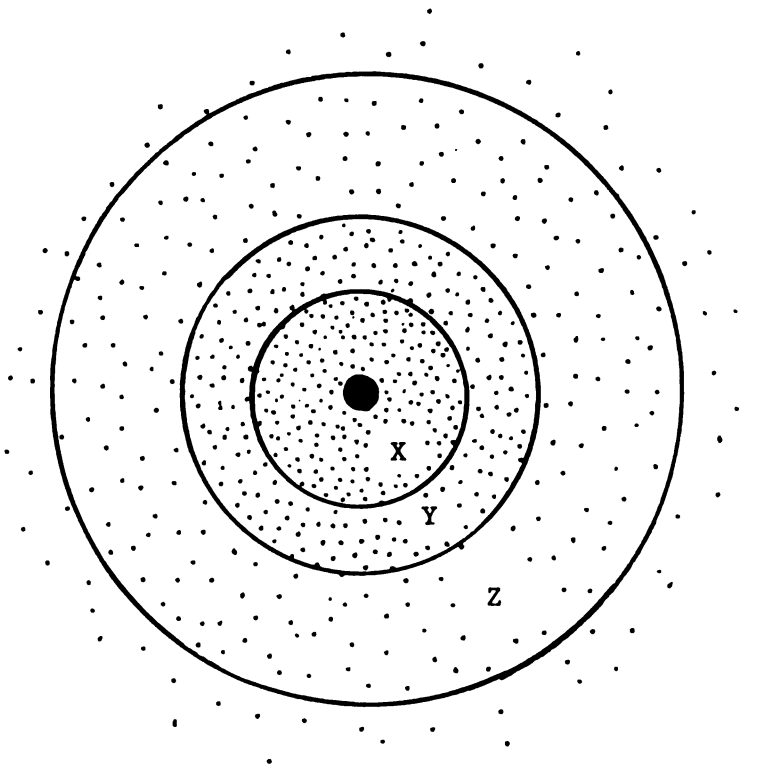


Figure B:

Bohrs and Heisenberg
Atomic Model



X, Y, Z = Different Probabilities

(From Petrucci, 1972)

models) the electron shells are only areas of probability where particular electrons are most likely to be found. In reality electrons can pass through any number of areas within the atom, crossing shells.

In Figure A the various components of the behavioral environment are arranged in probable relation to one another, as are electron shells. They are not isolated, distinct realms. In fact, there is continuous flow and interaction between them as in an atom.

At this point the analogy breaks down. Of course, social and cultural influences are not particulate, and motion is not physical. The self is not a discrete center, but a changeable consciousness, organizing and participating in its environment. To argue the analogy any further would risk the serious error of reifying a pure abstraction. The analogy is simply intended to describe a cluster of probable but changeable interrelating influences surrounding a central element.

Components of The Behavioral Environment

Physical nature and experience of the disease and illness.

The physical nature of the illness itself is an important part of the behavioral environment of chronic illness. The symptoms, impairments, and trajectories of an illness are significant factors in differentiating illness

experiences. (See Strauss and Glaser, 1975 for a discussion of these factors in chronic illness).

As was discussed in the previous chapter, the experience of an illness (and disease) is never purely physical however, but intensely personal, shaped by one's own physique, appraisal (Cohen and Lazarus, 1979) and the environment. Brody questioned whether in fact a disease possesses a natural history outside of the influential context of the sick organism (1983).

Cultural and symbolic phenomena.

Dow proposes that every system of healing is based on a model of experiential reality, which he calls the mythic world, describing truths pertaining to illness and healing (1986). The mythic world of illness and healing, especially the metaphor it contains, helps one organize and direct ones actions towards an illness experience as well as give it meaning.

The explanatory model is another key concept. As developed and used by Kleinman, explanatory models of illness are conceptual models constructed and used by individuals to explain particular illness episodes (1980). Details and refinements of the concept have been discussed elsewhere (Blumhagen, 1981; Kleinman, 1981; Young, 1982). For our purposes it is necessary to remember that the concept's utility derives from its individuality, the explanation of a particular illness episode by a particular individual.

In gathering explanatory models of more than one individual they may be consolidated and formulated as a representative illness model held by a group. In doing so, however we no longer have an `explanatory model' as used by Kleinman but a folk model of illness, a useful symbolic construct summing and expressing more diverse, individually held beliefs. It would be a mistake to expect individual models (explanatory models) to be identical to the more general folk model of illness (Pelto and Pelto, 1975).

Social phenomena.

The behavioral environment is not a rubber stamp of culture, but actively created by the individual under the influence of his social relationships. Illness experience is neither the direct experience of some absolute environmental reality nor a faithful reproduction of a cultural illness representation. Rather it is actively created by the individual in social interaction. The mythic world is the link between the social system and the self in that it is a mutually shared and created reality (1986).

The macro environment.

The unit of analysis, the self in the behavioral environment, occurs in the context of the macro environment. The political economy and health care systems significantly effect health care and illness in populations (New and Donahue, 1986; Ehrenreich, 1975; Navarro, 1976). Studies are presently emerging in which sociopolitical events at the

macro-level are shown to influence and be expressed in the experience and form of individual illness (Guarnaccia, 1987 Kleinman, 1986). These provide important insights into the individual's experience of the macro-environment, and are a welcome new perspective.

Emotion.

Emotion is crucial to understanding the motivation of illness behavior. The meaning of any cognitive phenomena for a person is how it relates to the self. To the extent that the self is engaged, it (the cognition) promises increased or decreased self-esteem. Ultimately, action is taken or not because of what is felt about its significance for the self.

The preceding model for the investigation of chronic illness could be used for any illness. It is the particular involvement and engagement of the self in chronic illness, deriving from the illness' long-term nature, which make the model especially useful for chronic illness study.

The following chapters will discuss various aspects of the behavioral environment of New Orleans Black women and the management of hypertension in relation to the self.

context of Black women in New Orleans, will also be discussed.

NOTES

[1] "Adaptation" can mean not only the noun referring to the person-environment relationship but also the process by which the fit is acheived. Other terms have been used to refer to this process, notably, "adjustment" and "coping" (White, 1974)> This is confusing. Prefereable is DeVos' usage wherein "adaptation" is the process of working out the individual-environment relationship,and "adjustment" is work done on inner psychic conflict (1976).

Coping is frequently used to refer to an individual's attempts to achieve a beneficial person-environment fit. As such, it is a synonym of the verb "to adapt" referring to the process of adaptation. Cohen and Lazarus define coping as "efforts, both action-oriented and intrapsychic, to manage environmental demands which tax or exceed a person's resources." (1979:219). There is overlap here between DeVos' (1976) concept of adjustment and coping, since coping, according to Cohen and Lazarus, includes intrapsychic efforts to manage internal conflicts. I would say that adjustment is one kind of coping. As used in this paper, adaptation will refer to person-environment fit, coping as general efforts to acheive personal adaptation and adjustment as intrapsychic efforts.

CHAPTER 4: HYPERTENSION AND BLACK WOMEN IN NEW ORLEANS: THE SETTING, THE PROBLEM AND METHODS OF INQUIRY

The Setting

Unlike most U.S. cities, New Orleans has a population in which Blacks make up the majority (55%). Although New Orleans Blacks share with other U.S. Blacks an overrepresentation among the poor and disadvantaged (Times-Picayune, 1987b), to cast them in the role of a ghetto minority [1] would seriously misrepresent the situation. The problem of primary care in New Orleans is not to provide basic health care to Blacks but to Orleanians most of whom happen to be Black. The difference is significant.

The Health Care System

The Charity Hospital System of Louisiana is a state owned and operated system of hospitals and clinics mandated to provide quality health care services to all residents of the state, with emphasis on services to the medically indigent (Storer, et al., 1986). Most public hospitals in the United States are under the aegis of local governments. Louisiana is unique in that it is the only state in the nation which supports a statewide hospital and ambulatory care system as the primary source of health care for the needy (Dubos, 1985). In essence the Charity Hospital System is Louisiana's primary health care program.

Louisiana has had a history of providing free public health care to the poor since earliest colonial times

(O'Connor, 1947). The original hospital in the "Charity" system, the Hospital of St. John (later known as Charity Hospital), was founded in New Orleans in 1736. Charity Hospital in New Orleans is the oldest hospital in the U.S. in continuous operation. Since then, the system has grown to its present size of ten hospitals located throughout the state (Times-Picayune, 1986a).

The system provides a complete range of ambulatory and inpatient care, free of charge, if necessary. The Charity Hospital system is the only institution in the state serving this function. If a person cannot pay for care, there is nowhere to go but the Charity system. With the current depressed state of Louisiana's economy and with one of the highest unemployment rates in the nation over the past few years, inability to pay for care is not at all uncommon (Times-Picayune, 1986a; 1986b).

The health care system is heavily used and delivered almost two million outpatient visits and hospitalizations for the fiscal year of 1984-85. (Storer et al., 1986). Considering that Louisiana's population was 4,205,900 in 1980, it is apparent that the system is quite a significant source of health care for the state (1980 U.S. Census).

Delivery of services is not evenly distributed, however, and much of Louisiana's public health care is centralized at Charity Hospital in New Orleans (hereafter CHNO; popularly called simply "Charity" or "Big Charity").

The present 2000 bed hospital is the largest facility in the system and the largest acute care hospital in the state (Times-Picayune, 1986a). The facility houses a major organizational complex for the delivery of health care and medical education. Both Tulane and L.S.U. Medical Schools use it as a teaching hospital.

CHNO's impact on the delivery of health care statewide is quite significant (Storer et al., 1986). In 1984-85 it provided approximately 34% of all patient care received in state institutions (593,646 visits out of a total of 1,755,697) and accounted for over 34% of total outpatient visits in the system. Residents of all 64 Louisiana parishes use CHNO for inpatient and outpatient services. Over 30% of all outpatient visits at CHNO are made by residents of parishes outside Orleans Parish (165,922 visits out of 553,075 total).

The significance of CHNO for health care in the New Orleans area is great as well, providing over 64% of all outpatient services in Orleans Parish during 1984-85 (Storer, et al., 1986). During the same period 46% of all births in Orleans Parish were at CHNO.

Expanding Need, Dwindling Resources

In 1984-85 approximately 40% of all patient care was provided absolutely free of charge; 15% was covered by Medicaid, Medicaid, 7% by Medicare and only 5% by private insurance. Only 33% of the patients were responsible at some level for payment of own care (although that level may

be quite low) (CHNO, Financial Office, 1987).[2] Because of high unemployment rates in the state fewer persons are carrying medical insurance. Thus as has happened in recent years, the demand for services at CHNO is likely to increase in the future (CHNO, Financial Office, 1987; Storer, 1986). In summary, much of the health care in Louisiana and certainly in New Orleans is of necessity state provided. This need is expected to continue into the future.

CHNO has never been well funded and has always been overcrowded. Its financial history has been one of constant political and financial battles. Reports of two and even three patients forced to share a single hospital bed have continued well into the twentieth century (O'Connor, 1947). Complaints about the quality of CHNO's health care continue to the present, with terms such as "appalling", "primitive" and "squalor" continually utilized (Times-Picayune, 1986a). CHNO administrators are aware of the problem and the Medical Director of CHNO observed "There are two levels of care [in New Orleans], the private level and the "Charity" level. I don't think that's fair." (Times-Picayune, 1986a).[3]

Due to economic problems at the state, city, and parish levels, no monies are available to expand or improve present health care delivery. Resources to satisfy the increasing need for services simply do not exist.

Medicine & Special Hypertension Clinics

At CHNO, by far the majority of hypertensive outpatients are treated in general Medicine clinic. The

clinic meets every week day morning beginning at 8:00 A.M. and continues until noon or until all patients are seen (this often extends well into the afternoon). It is divided into L.S.U. medicine clinic and Tulane medicine clinic which meet in the front and rear of the same very large clinic room. The patient load on any day ranges from a minimum of approximately 200 to over 300 patients who are divided evenly between L.S.U.and Tulane. The clinic's nursing staff is employed by CHNO , while the medical staff consists of residents from LSU and Tulane medical schools. The residents work under the supervision of faculty from their respective institutions.

In addition L.S.U. operates a Special hypertension clinic which meets Monday afternoons. Approximately 12-15 patients are seen weekly here. "Special Hypertension" is intended for those patients exhibiting the poorest blood pressure control and who require the most intensive care and education. However admission to Special Hypertension is by referral only and many uncontrolled hypertensives remain in general medicine clinic. Referrals are not made from Tulane Medicine Clinic to L.S.U. Special Hypertension clinic.

Obtaining Care in the Clinics

A physician may request that a patient see him specifically at the patient's next clinic visit, although the physician may not in fact be there that day, in which case someone else will see the patient. Otherwise patients are assigned to physicians by the nursing staff to ensure

equal distribution of patient load among physicians and to reflect as best possible the order of patients' arrival. In addition residents rotate on an approximately monthly basis. This means that patients seldom see the same physician two visits in a row. Obviously this does not enhance continuity or quality of care.

This lack of continuity also presents problems in prescription and monitoring of drugs. Since a patient frequently does not see the same doctor for two consecutive visits, it is difficult to monitor prescribed drug regimens. It is not uncommon for patients to accumulate a long list of drugs to take, as new drugs are added to the old, sometimes without knowledge of all the drugs previously prescribed. In addition patients frequently complain that medications are changed with every new doctor they see, before the old medication is finished. This results in considerable cost to the patient.

When a patient can not afford medication and has no Medicaid or insurance, physicians frequently give the patients samples from the medication room, which are supplied free from pharmaceutical companies. Drugs prescribed to patients are not always available in the medication room, and different drugs or dosages must frequently be substituted by physicians. This frequently causes confusion, compromises continuity of care and, no doubt, can detract from compliance.

After a patient is seen by the physician he orders an appointment to be made for a return visit after a period of time the physician deems appropriate. If a patient wishes to make an appointment to be seen on his own, or if he misses an appointment and needs to reschedule, he may not receive a new appoinmtent for several months. If he needs medical attention in the meantime he must go either to a CHNO walk-in clinic (where waits for service may well be all day) or to the emergency room, with equally long waits. This presents problems for the management of a chronic illness which requires close monitoring and may often result in acute episodes. The system is amended from time to time but staff and patients agree that it is still less than satisfactory.

The Patient Population

The Black majority of New Orleans' population is disproportionately represented in medicine and hypertension clinics. For the last six months of 1986, of the 13,690 patients seen in Medicine Clinic, 77% (10,606) were Black 22% (3002) were White, and .5% (82) were listed as Other. For the same period in Special Hypertension Clinic, of 316 patients, 285 (90%) were Black and 10% (30) were White (CHNO financial office, 1987).

Information on the economic level of the clinic's patients was not made available to me.[4] The level of free and medicaid related care provided by CHNO indicates that the patients' economic levels are low. One informant

phrased it this way "If you got the money to go somewhere's else, you don't go to Charity".

Statistics on disease treated in outpatient clinics are not available. A simple tally by myself of patients for one day of one school's medicine clinic showed that 62% (69)of that day's 112 patients were being seen for hypertension (although not hypertension alone). Although Black males are at highest risk for hypertension (Joint National Committee, 1984) of these hypertensives 43 (62%) were Black females, 38% of the total day's patients. The Medical Director of CHNO estimates that at that a diagnosis of hypertension is related to approximately 30% of Charity's hospitalizations.[5]

The Problem

According to biomedicine, hypertension is normally asymptomatic and can only be determined by medically detected signs, such as measures of blood pressure and ocular examination (Williams, Jagger and Braunwald, 1980). Thus hypertension control requires regular blood pressure monitoring. The poorer the control, the greater the frequency of monitoring required, with weekly, and at times, daily, measurement not being uncommon. Emergency hospitalization is required for states of severely elevated hypertension (Williams, Jagger and Braunwald, 1980). It is thus important to keep hypertension controlled for two reasons: (1) uncontrolled hypertension results in disease and death for the individual and (2) related morbidity and

more frequent medical visits further tax the health care system.

The prevalence of hypertension in Black Americans is considerably higher than that of the White population and hypertension-related mortality is disproportionately higher among Black persons(Joint National Committee, 1984). Control of hypertension in this population is thus particularly important.

This presents a problem for Charity Hospital, New Orleans, whose task it is to control the blood pressure of a significant part of the population. With over 70% of its patients being Black, CHNO's patient population is that part of the general population most at risk for hypertension and who suffer its most severe sequelae. It is apparent from its heavy patient load and the large proportion of hypertension-related hospitalizations that the institution is faced with a serious problem in hypertension control. It is also apparent that control is crucial to the basic health of the patient population and also to the functioning of the health care system.

If hypertension could be better controlled in CHNO's patients, it could reduce not only the demand for outpatient services, but hospitalizations as well. No doubt, the poor continuity of care and insufficient monitoring of the illness and prescribed medications which have been discussed influence the problem of hypertension control. At this time it seems there is little that can be done to remedy this.

Funding, and with it staffing and quality of patient care, is likely to decrease in the future. If the Joint National Committee on High Blood Pressure is correct in their assessment, however, improved compliance with treatment can help improve blood pressure control (1984).

At present there is no information available on the problem of compliance with antihypertensive treatment in the ambulatory clinics at Charity Hospital. There is no reason to expect however that the general level of compliance at Charity Hospital is appreciably better than those found in the general population.

In fact, given problems in health care delivery and low financial levels, compliance could be poorer than in the general population. The nurses and residents in Medicine and Special Hypertension clinics at CHNO share the opinion that the problem is a serious one which compromises their efforts. If this is truly the case, more effective illness managment may improve hypertension control and in turn alleviate some of CHNO's problems.

The Research Question

Early writers such as Hurston (1931) and Saxon and Tallant (1969) portrayed a rich Black ethnomedical tradition in New Orleans, and Louisiana. Although the amount of contemporary ethnomedical research in the area is limited, it does suggest that this tradition has endured. Research on Black ethnomedicine will be more fully discussed in the next chapter. Beliefs concerning blood and blood pressure

do seem to figure prominently in New Orleans Black health culture (Jacobs, 1980). Observations of contemporary biomedical practitioners support this conclusion.

Previous discussion of ethnomedicine, compliance and illness management imply that Black ethnomedical beliefs in New Orleans may have a significant influence on efforts at illness managment, including compliance with biomedical treatment for hypertension. A greater understanding of these beliefs can allow greater understanding of problems in compliance and illness management. Such understanding may make improved compliance possible.

The intent of the present study is to explore the explanatory models of hypertension held by Black hypertensives being treated at Charity Hospital in New Orleans, as well as those of the physicians who treat them. The nature of both groups' folk models of illness will be formulated and their implications for compliance and illness management will be determined.

The inquiry will be phrased in terms of the provisional model of chronic illness behavior introduced in the previous chapter. Explanatory models, health beliefs and folk illness models will be considered part of the cultural aspect of the behavioral environment of New Orleans Black women. Social aspects of the behavioral environment including the macro environment will be considered in chapter 5. These elements will be considered in relation to the self in chapter 6, 7, and 8.

Methods

The Sample

Two populations were sampled at the medicine and special hypertension clinic to elicit their beliefs and attitudes concerning hypertension. The first sample consisted of 60 Black female hypertensives aged 45-70 drawn at random from the patients of L.S.U. Medicine and Special Hypertension clinics at Charity Hospital in New Orleans. The patient sample was limited to females, who constitute the majority of hypertensive outpatients at CHNO, to control the influence of gender on health belief. This allowed the use of a sample small enough to be managed by a single investigator. Older women were used as informants since they would be more likely to be thoroughly familiar with ethnomedical beliefs. Also, since hypertension becomes more prevalent as age increase, use of older women was expected to facilitate sample selection.

Clinic charts were reviewed; those meeting selection criteria were flagged and patients, upon arriving for their regularly scheduled clinic appointments were asked to participate in the research. Approximately twenty percent of selected patients refused participation. The reasons cited were conflicts with employment, family disruptions, and obligations. There is some selection bias in that only those who agreed to participate are included. Thus participants were those whose employment was minimal or flexible enough to allow participation, who were otherwise

unemployed, and whose personal and social situations were stable enough to permit participation.

For reasons to be more fully discussed in the next chapter, it is very difficult to assess the socioeconomic status of informants in New Orleans. Social status and racial classification are very much subject to interpretation, and their determination would require a much more extensive investigation than was possible in this study.

Certainly most of sample were not financially well off, yet this is a relative term. It is difficult to determine economic status with certainty. Questions about income were often met with chilly silence and vague responses. Such questions cast a pall over the rest of the interview. Even when a straightforward answer was forthcoming, it had little meaning when considered in relation to the ebb and flow of persons sharing residences and contributing to household income. Some limited information was available from the informant's medical records, but these records are inconsistently maintained and are not always up to date. Problems in defining social status and household membership will be discussed further in the next chapter.

The second sample was composed of 15 resident physicians staffing Medicine and Special Hypertension clinics. This sample can be characterized as an "opportunistic" sample in that informants were selected in terms of who was available and willing to be interviewed on a given day. No one actually refused to be interviewed but at least

five residents somehow always managed to "disappear" upon sight of the researcher.

Research Design

The Patients

Two formal interviews were conducted per informant to elicit illness models, health beliefs, and attitudes. In addition, conversations held throughout the follow-up period were used as data.

Participants were followed for approximately two months each, and seen once every two weeks, to obtain data on compliance with prescribed treatment, diet, and to monitor blood pressure. Initial meetings were held in the clinic. Afterwards, informants ordinarily were seen in their homes rather than in the clinic, but this was according to the participant's preference. Blood pressures and dietary recalls were taken at each visit. Pill counts to monitor compliance with medications were made at the initial visit, after one month, and after the second month. Daily medication diaries were also kept by participants to monitor medication compliance. In addition conversations and observations throughout the follow-up period were used as data.

The Physicians

The residents were interviewed once to elicit general health beliefs and attitudes, illness models, and their perception of the patient population.

Variables

Cultural Health Beliefs and Illness Models

Illness models, health beliefs and attitudes were obtained by means of two interviews. The first interview focused on the five core issues addressed by explanatory models of illness: 1) cause, 2) pathophysiology, 3) mode of onset, 4) course of the illness, and 5) appropriate treatment (Kleinman, 1980). The interview schedule utilized was an adaptation of the interview used by Blumhagen in his study of hypertension, but altered to better suit the present patient population (1980). In addition, cause, the first core issue, was broken down into cause of the disease and exacerbating factors which, while not enough to cause an illness negatively influence its course. (See Appendix A for the text of the interviews.)

The second interview addressed general questions related to health beliefs and attitudes and personal health status. Satisfaction with biomedical treatment received as well as opinions concerning alternative health care systems were elicited.

The residents' interview followed closely that of the patient sample, with the addition of questions on the physician's perceptions of the patient population.

All interviews were standardized and semi-structured yet open-ended to allow for volunteering of information not directly requested by the interviewer.

Supplementary Social, Biographical and Social Psychological Data

Additional information on family and social milieu, attitudes and some biographical data were obtained from the formal interviews and field notes taken during the follow-up period. This data was used to provide context for discussion of individual cases. Where recurring patterns were found in the sample, this has been noted, even though this phase of the data gathering was not standardized.

Compliance

The measurement of compliance is a real problem (Gordis, 1979). The most accurate measures are those which are direct; for example, directly observing a person swallow a pill. Direct observation of any but a few individuals over time is not only extremely difficult and expensive, but is often intrusive and may influence the results.

Indirect observations are less intrusive, but they are also less reliable. Pill counts can measure after the fact the number of required pills taken in a certain time period. There is, however, no way to be certain by whom the pills were taken or whether they were lost or discarded. This seriously compromises accuracy. Biological assays such as urinalysis and blood tests are possible indirect measures for simple measures, but do entail some cost, possibly requiring special technology and extra personnel. Indirect measures such as these also can influence a patient's behavior and confound the data. Indirect measurement

without the subject's knowledge may be possible, but this raises a question of ethics. Self-report by the participant in the form of simple statements or medication diaries can be used but their validity depends upon the participant's honesty, accuracy, and conscientiousness in keeping a record.

I measured compliance by means of monthly pill counts to determine the ratio of pills actually taken to those prescribed. Then a percentage was computed. In addition, self reports were used in the form of daily medication diaries, two month calendars supplied to the participants. Participants were asked to keep a daily tally of which pills were taken and how often.

Information from these two sources was used to rank the informants from one to four on a scale of increasing compliance. In cases where the correct ranking was uncertain, field notes were checked for additional information to aid in ranking. Ten cases were selected at random and ranked by an independent rater. There was interrater concordance in all but one of the cases, thereby demonstrating acceptable reliability for the rating method.

Blood Pressure

Three measures of blood pressure using a stethoscope and mercury sphygmomanometer were taken at each meeting, while the participant remained seated. These three measures were averaged, to represent the blood pressure measure for that day.

Analysis

Determination of Explanatory Models and Folk Models of Illness

Informants' statements were used to determine the names and number of illnesses involved. Interviews and notes were consulted to list all possible characteristics and elements of illnesses. A coding scheme was devised based on these illness elements within the general explanatory model framework. Each informant's interviews and notes were coded to determine that individual's explanatory model of illness. Frequencies were obtained for the entire sample's responses, and illness models were compared (Frequencies are included in Appendix B).

Key illness elements, which had the highest frequencies of positive responses, were noted. In comparing illnesses, elements which differed greatly, which I have called key oppositions, were also noted. These variables wre then included in the final construction of folk illness models discussed in this study.

Semantic Network Analysis

To more easily represent the meanings associated with the folk illnesses, the method of semantic network analysis was used (Good, 1977). This method is simply a way to visually present the links between various terms associated with a central term, in this case, illness. Relationships are taken from informants statements. Percentages of positive responses link various terms with a central term

are taken directly from the lists of frequencies and offer a general approximation of the importance of each term in giving meaning to the central term.

Case Selection

The case examples presented were not elicited as formal case histories, but were selected from interviews of the sixty respondents. They were selected because they represent particularly articulate individuals, and because they well illustrate common themes and problems in hypertension management in this sample.

Quantitative Analysis

Quantitative methods of analysis were also utilized and will be presented in chapter six, where the results will also be discussed in order to preserve continuity of thought.

NOTES

[1] There is some question as to whether residence patterns in New Orleans reflect a true ghetto situation. Kaslow says there is a ghetto in the neighborhood called "Central City" (1981). I agree but with reservations. Certainly there are neighborhoods which are overwhelmingly Black in population, but these are not representative. To focus on these alone ignores the overall mixed residential pattern which is characteristic of New Orleans (Lewis, 1976).

[2] This information was provided by an administrator of Charity Hospital, New Orleans who requested anonymity. Projections and estimates are based on hospital records. Since Charity is a recipient of federal funds, these figures are not privileged information but are part of the public record. Hereafter cited as CHNO, Financial Office, 1987.

[3] I do not wish to give the impression that general care at CHNO is bad. The facility's Burn and Trauma units have won national recognition (Times-Picayune, 1986). I personally witnessed remarkable efficiency, professionalism, and dedication on the part of residents, nurses, and clerical staff working under truly taxing conditions. The fact remains, however that the institution is underfunded, understaffed, and ill-equipped to handle its enormous patient load. The level of care suffers accordingly.

[4] Information is not readily available because there are difficulties with the hospital's computer system. It is designed to bill patients, but do little else. There are hints of scandal and political wrongdoing in the choice of this system (Times-Picayune, 1986). Medical records are not computerized, but are limited to patient's charts kept in manila files. Charts are frequently misplaced and lost. It often happens that a patient with a long history of being treated at Charity will have no chart available for a physician to refer to in treatment.

[5] Personal Communication.

CHAPTER 5: NEW ORLEANS BLACKS IN UNITED STATES CONTEXT

This chapter examines Black culture and society in New Orleans in order to provide a context for discussing the experience of hypertension. As this is not intended to be an exhaustive treatment of Black New Orleans, the discussion will be limited to writings on a few pertinent topics. Only tentative assessments are to be made. A definitive and exhaustive ethnography would fill several volumes, and require extensive basic field work which has yet to be done by any researcher.

Black culture and society are normally treated as though they possess a single, homogeneous form across the nation. Studies of regional and class differences are inadequate to warrant such sweeping generalizations. Green advocates a regional culture area approach to the study of United States Blacks so as to avoid sterotyping American Blacks and Whites in terms of "poorly understood and pernicious polar opposites" (1978: 381). Green (1978) and Pearsall (1966) have both noted that it is necessary to find distinctions and common points between Black and White groups in the same areas. Only by studying the influence of region and class on social organization can reliable statements be made regarding Black culture and society.

Characterizing Blacks in New Orleans illustrates this problem. In popular literature and commentary, much is made of the uniqueness of New Orleans Blacks in comparison to other American Black populations. It is difficult to

determine just how different Blacks in New Orleans truly are or in what ways. Until quite recently there have been relatively few ethnographic analyses in the area, offering little basis for scholarly comparison. This may change since the recent past has seen the production of a number of contemporary sociocultural analyses of Blacks in New Orleans and the surrounding area. The sociocultural relationship of New Orleans Blacks to other United States Black populations has yet to be defined. General writings on American Black culture, society, and psychology thus must be used with caution when used in reference to Blacks in New Orleans and southeastern Louisiana.

A copious body of historical writings exists, however, which does demonstrate a colonial experience in New Orleans and southern Louisiana notably distinctive in some ways from Anglo-American colonies in the South. The historical experience of Blacks in New Orleans will be considered briefly as a prelude to understanding contemporary life.

History

New Orleans was founded over two centuries ago in an extremely inhospitable environment, by decree of the French Crown. Its establishment as a major city was more an act of will than the outgrowth of any natural process. From the start, New Orleans was a city (Lewis, 1976).

Despite romantic images, Louisiana was not a major part of the New World French sugar/slave empire (Spitzer, 1980). Rather, its economy was based on urban functions, and only

became involved in the sugar enterprise after 18th-century Haitian slave revolts (Fiehrer, 1979). New Orleans' urban character and relatively late efforts at sugar planting subverted much of the rigid social and occupational stratification which characterize plantation social organization (Fiehrer, 1979; Spitzer, 1980). The urban need for diversification of skills in New Orleans was paramount in creating opportunities for certain privileged Blacks to improve their social position on a scale unprecedented in the rest of the South (Kaslow, 1981).

Considerable miscegenation, institutionalized and not, characterized colonial Louisiana, stemming in part from Franco-Spanish traditions of land tenure, a shortage of women, and the large proportion of Blacks in the population (Fiehrer, 1979). Whereas Anglo-American plantation society was divided on the basis of black or white skin color, Louisiana civil codes formally recognized distinctions in social status based on gradations of skin color and racial parentage (Spitzer,1980; Gayarre, 1903). The resulting society was more complex and given to interpretive nuance than that of Anglo-America. A pattern of mutual acculturation and assimilation (biological and cultural) of Blacks and Whites similar to that found in the Caribbean region was established (Fiehrer, 1979).

These codes legally created a class separate from Black slave and White, les Gens de Couleur Libre, or the Free Colored (For ethnohistorical discussions, see Fiehrer, 1979;

Desdunes, 1973; Haskins, 1975 Rousseve, 1937; Foner, 1970). Membership in the class was generated from legally recognized Black-White unions (called placage) and direct manumission from slavery.

Les Gens de Couleur were accorded the same legal rights as Whites, it was only in informal relations that Whites asserted social superiority. Many Free Colored benefitted from their White paternity, often receiving European educations, amassing wealth, becoming slaveowners and receiving acknowledgment and protection of their White fathers. Others attained prominent status through their own wit and effort.

The Free Colored came to be known as Creoles of Color, or Black Creoles, set apart from White Creoles (See p. 78 for a discussion of the use of these terms). They could not marry Whites (who could be close relatives, given the question of paternity), yet they could not associate themselves with the servile class, which would mean downward mobility. They very closely identified with White Creoles, rigorously adopting upper class European values, manner and language (Rohrer and Edmunson, 1960; Spitzer, 1980). The Creoles of Color themselves became stratified, and their social pretensions were strongly resented by the slaves who viewed the Creoles as mannered snobs (Fiehrer, 1979).

The Creoles of Color enjoyed this high status and privilege until Louisiana's sale to the U.S. which caused dislocation of both Black and White Creoles (Spitzer, 1980;

Kaslow, 1981; Rohrer and Edmunson, 1960). American law did not recognize nuances of status within Black groups, and considered free Blacks a threat to the social order. Neither did the Americans have any of the consanguineal networks transcending racial lines which pervaded Creole society. With Americanization there began a steady decline in the fortunes of the colored Creole community. Perceived as no different from other Blacks by the new American rulers, the Creoles of color got no special treatment and were shunned (Kaslow, 1981).

The Civil War, Federal Occupation and Reconstruction completely destroyed the old Creole social order increasing bitterness and animosity (Rohrer and Edmunson,1960; Kaslow, 1981; Fiehrer, 1979). Lines were drawn along a racial axis, former prestige was lost in both Black and White groups. Resented by Whites who became bitter towards all Blacks, the Creoles of Color felt threatened by the newly freed slaves. Withdrawing to elitist isolation, the Creoles of Color made even stronger efforts to adopt upperclass manners and culture. Emancipated slaves saw the colored Creoles as threats to their upward mobility.

Some responded by rejecting Creole claims to prestige, others responded by emulating the Creole manner. Whereas ante-bellum New Orleans society had seen Creoles of color trying to pass for White (les passe-blancs), the post-war city in addition now witnessed the attempts of lower class Blacks to pass for upper-class Creoles of mixed blood

(Rohrer and Edmunson, 1960). What historically had been a rather fluid social structure, continued to be one without the benefit of formal regulation, and along different lines than those legally recognized by the post-war Anglo-American government. It was now open to more interpretation and persuasion.

The purpose of this discussion was not to demonstrate the importance of Creoles, Black or White, in New Orleans, but to describe how the Creole image gained significance in New Orleans cultural life. Blacks of the lower classes, as well other Blacks not identifying with the Creole image, share the ill feelings of the earlier enslaved Blacks toward those presenting themselves as Creole. These images, distinctions, and their manipulations continue in contemporary New Orleans along with their concomitant resentment and bitterness (Dominguez, 1986). It is for this reason that attempts to define class and race in New Orleans are fraught with problems.

Contemporary Social Organization

Stratification and Mobility

Rohrer and Edmunson offered a historical overview of Blacks and social change in New Orleans (1960). In their analysis, New Orleans of the 1950's no longer possessed a caste barrier but a class barrier. Whereas in earlier times, Whites met Blacks as social inferiors, they were now said to meet on a more egalitarian basis. While it is true

that the institutionalized caste structure was demolished in New Orleans, racial distinctions are far from gone.

Contemporary New Orleans is certainly not a color-blind society. Egalitarian contact between Whites and Blacks is frequent, but this is often in formally structured business settings, or public events. Informal social interaction between Blacks and Whites is infrequent in many portions of society and intermarriage is generally looked at askance. There remain considerable residual hard feelings and suspicion betweeen Blacks and Whites. Whether this exists to a greater degree than in other American cities, however, is uncertain and a question for research.

As Rohrer and Edmunson noted, class has increased in importance relative to race and high socioeconomic status does seem to aid in crossing racial barriers (1960). Mid-twentieth century New Orleans was described as a biracial society of three classes each, but Rohrer and Edmunson found class barriers generally not well differentiated in New Orleans Black society (1960). Social organization in New Orleans was characterized by looseness and flux, and social mobility was found to be "rampant" (Rohrer and Edmunson, 1960: 40). Dominguez' study of race and status found the same situation in New Orleans over 20 years later (1986).

Common wisdom in New Orleans holds that social status is related to social and biological heredity. This reflects a cultural mythos more than it does reality. Social status in New Orleans depends more on performance than inheritance

(Dominguez, 1986). Status is not inherited, but achieved through the succesful performance of a role congruent with the mythos of social organization.

Contemporary New Orleanians refer to "Black" or "White" Creoles. The designation of Black or White Creoles makes little sense if "Creole" is taken to mean racially mixed ancestry, as is common in the Caribbean. The contemporary definition of Creole among White New Orleanians is, roughly, an individual descended from the original French or Spanish colonists, but born in the New World. Racially mixed ancestry is denied. Some scholars have estimated that 50%-90% of "White" Creole families in New Orleans have some Black ancestry (Dominguez, 1986). This is not a popular view among White Creoles. I will differentiate between Black and White Creoles, following common usage in New Orleans. This usage, however, may have little to do with biological reality.

In present-day New Orleans, Black Creoles are less differentiated as a cohesive group than in earlier times, yet the Creole ideal remains strong (See Dominguez, 1986 and Rohrer and Edmunson, 1960 for descriptions of the this ideal). In his preface to the second edition of The Eighth Generation Grows Up, Edmunson confesses to his continued consternation at attempting to define "Creole" and says he is willing to accord the title to anyone who says he is one (Rohrer and Edmunson, 1964). A contemporary Creole is one who, more or less, fits the description.

His decision is in keeping with Dominguez' conclusion that Creole ethnicity (Black or White) (and consequently social status), is based more on perception of identity than on parentage or skin color alone (1986). Dominguez found in even the highest status White Creole families who satisfied almost all of the criteria, there was abundant non-Creole non-Orleanian ancestry. There is no "pure" Creole race. She concluded that Louisianans manipulate their own and others identities by playing with the available cultural labels subject to their current meanings (1986: 265). "Passing" occurs across all sorts of racial and class lines in New Orleans, and this, in fact, may be rule rather than the exception. Everyone is "passing" because almost no one possesses all the characteristics of the "Creole" ideal, or any of the other labels which have cultural currency. It is difficult to determine one's "real" status when status is dependent upon the successful projection of an identity, and when it may change from one context to another.

Rohrer and Edmunson attributed this social flux to the civil rights movement and desegregation and, of course, this was enormously influential (1960). Remember, however, that this fluid, manipulable quality of social organization was well established from colonial times. It can be attributed in part to legalized miscegenation (under controlled conditions), a legally recognized class of racially mixed people and the city's urban rather than agricultural history. With the removal of institutionalized segregation,

the familiar pattern of "passing" and jockeying for position emerges.

Dominguez noted that social organization in Louisiana was especially well suited to the application of Barth's ideas on ethnic boundary maintenance (Dominguez, 1986; Barth, 1969). Social stratification and categories of ethnicity in Louisiana are epiphenomena of the manipulation and application of social labels to oneself and others.

However, social organization in Louisiana is not only about boundary mainentance, but the use of emblems, symbols of group membership (Devos and Romanucci-Ross, 1982). In New Orleans especially, social organization focuses on the use of certain emblems which identify and contrast various clusters of people. Emblems such as neighborhood, religion, school, speech patterns, occupation and physical appearance are all used to attribute or deny group membership. In New Orleans, these emblems can be very specific; on which side of a street a person grew up, what year someone attended a particular school can all make a difference in the successful performance of an identity.

In the context of this discussion, I must confess that I am not really sure how to characterize the women in my sample, socially and ethnically. This is because identity depends upon perception of the other and is situational rather than objective. Finances provide only the grossest differentiations in status, and are difficult to determine (as was discussed in the previous chapter).

Only a few (5) in my sample specifically identified themselves as Creole. This information was volunteered by informants, and not systematically asked as part of the interview. The situations of two informants will be presented as demonstration of the problems in determining social identity.

The first Ms. Batiste, had a French maiden name (Mouton).[1] She lived in a traditionally Creole neighborhood, the 7th ward (Treme). A soft spoken widow, she had a stable life focused on her family. Her children, all adults, were conspicuously well-mannered, respectful to Ms. Batiste and solicitous of her needs. Upon entering (with bags full of groceries for "Mama"), they always were careful to nod to me, a visitor, wish me a good day, and ask how I was doing. When her grandchildren were present, they stood quietly in a corner or shyly came up to whisper in Ms. Batiste's ear. Ms. Batiste (and her children) were relatively light-skinned and Catholic. These characteristics of French name, Catholicism, rather formal good-manners, light skin, and Treme residence all are congruent with a Creole identity. Although Ms. Batiste herself had very little money, this in itself is not enough to deny Creole status.

Creole identity was more questionable for Ms. LeBlanc, who identified herself as a Creole from outside of Baton Rouge, and a Baptist (In New Orleans, Baton Rouge is not considered Creole but Anglo). She had come to New Orleans

30 years ago to find work. A very large woman with a medium complexion, Ms. LeBlanc also had a French maiden name (Guidry) and stable marriage. Ms. LeBlanc and her husband had been comparatively well off, homeowners in a working and middle-class neighborhood near a private Black university, but Ms. LeBlanc's uncontrolled hypertension and her husband's recent stroke had resulted in financial hardships. While always courteous, she was rather loud and considerably less restrained in manner than had been Ms. Batiste.

The LeBlanc's had one daughter who was away at college. In a living room trophy case, there was a shrine to their daughter's education. A large graduation portrait was prominently displayed in the center, surrounded by smaller photographs. The case was filled to capacity with awards, medals, report cards and diplomas. It was a material testament to their support of education, characteristically Creole.

It could be said that Ms. LeBlanc's claims were not genuine and was trying to pass for Creole. She was darker skinned, Baptist, from an Anglo hometown, and lacking the conspicuously refined manner a Creole is supposed to have. But then who is to say that Ms. Batiste wasn't passing as well, but simply was more successful by virtue of possessing recognizable Creole-like attributes. In terms of Dominguez's assertion that class and status in New Orleans are a result of perception of identity then the legitimacy of both Ms. Batiste's and Ms. LeBlanc's claims are dependent

upon the decision of the observer (1986). There is no objective way to determine social status except in terms of the broadest distinctions.

Not all Blacks in New Orleans want a Creole identity; it depends on one's point of reference. Among many contemporary Blacks, especially those in lower income ranges, Creoles are seen as snobbish rich people who've abandoned their lower status kin. The Creole ideal also is seen as a throwback to a White-dominated society.

Another informant was a woman with a French surname, Catholic, a high school education and living in Treme. I made the mistake of asking if she was Creole, thinking the question might be flattering. She became insulted and replied her husband was one those light-skinned French people from the 7th ward, but not she. "I don't get mixed up in all that foolishness, I'm just plain Black". (Actually she was a very fair-skinned woman, another Creole emblem, but not sufficient to grant Creole status.)

In recent years, a fair-skinned man of mixed racial heritage who is identified as a Creole was elected to public office. This added salt to old wounds. Many White voters were wary of electing another "Black" official, although he and his predecessor in office were lighter skinned than many "Whites". Many Blacks, on the other hand, were suspicious and critical of him.

One informant, Ruthana Bell, was particularly suspicious of him:

> All those people with the money are still going to be in. They don't care about the little people as long as they can go to parties and make their trips. Big deal, so he went to "St. Aug" [St. Augustine, a Catholic boys' school associated with the Black upper class], well my kids all went to Catholic school, these grandchildren are in Catholic school too, so what difference does that make, just because he had the money to go to those fancy schools don't mean anything. He didn't learn any more than my kids except how to get along with the rich people. I'm voting for [a Black candidate], he knows where he came from.

Ms. Bell echoed the sentiments of many in the city. The Creole candidate answered that he had heard all of the accusations that he was "passing", but they didn't bother him. "I know who I am", he said. He never did actually say who he was, however, which is perhaps the mark of a good politician. These differences and arguments are not merely fine points for the ruminations of social scientists. They are important realities in the daily functioning of New Orleans society, and influential in people's lives.

"City" and "Country" People

Another axis of social differentiation which I noted in my sample was the categorization of persons as "City" vs "Country" people. I have not seen this mentioned anywhere in the ethnographic literature on Blacks, yet it was considered important by my informants, and the subject of considerable bitterness and hositility for some.

Many of the women in my sample were originally rural, and came to New Orleans for work (n=23). They strongly disapproved of "City" people whom they characterized as lazy, untrustworthy, and unwilling to help.

I was told:

> They never heard of work, don't know the meaning of it. They'd sooner gamble or cheat to get money, anything to make a fast buck. They keep to themselves and don't know your name if you need help. In the country you can always count on people helping you whether they know you or not and the country people's what's in the city, they's the same way. The city people only want parties and fancy clothes, they be hanging in bars when they should be home. You see, it's 10 o'clock and I have all my supper already cooked. Them city women's running the streets and watching the stories, she ain't gonna start her dinner till 5 in the evening.

Those who said they were "city" people took all of this with a grain of salt. I asked what they thought about "country" people's image of the city. A "city" woman told me:

> I've heard all of what they say, but that's just not true. I've worked all my life and I make my children work too. I guess they're used to a plainer life out there [in the country]. But I don't think city people have bad feelings to the country people. They [country people] do seem to stay to themselves; they just stay together. And city people will help you, the New Orleans people know one another cause they've lived in the neighborhood all their lives. You can always go to their door to help. They might be schoolteachers but they'll come help you build your house or fix your car. My sister lives in the country since she got married and they've been all right to her, but she says they do keep their doors closed.

Both groups seemed to agree that the country children "go wild" in the city, but disagreed about whose fault it was. A "country" woman said:

> The boys have been pretty good. I haven't had to get anybody out of jail like some people. They's all working. But the girls won't work, they just laugh at me. Things are bad in this city. They see the city children doing all this stuff and they want it too. My third daughter's got nothing in her head but running the streets, my baby

> girl's on birth control pills. One day I ain't gonna be here and ain't nobody gonna look after them."

A "city" woman told me "Those kids get here and its like nothing they ever seen before. They run wild and then get my boys in trouble with them."

Similar themes were noted by Samuels in her discussion of the "Decent Christian" and "Regular Person," an axis of differentiation found in her sample of Black New Orleanians (1974). The "decent Christian" is one who does not hang in bars, who aspires to a stable home life, who isn't given to wild partying and who values hard work. They characterize themselves as quiet, churchgoing people (Samuels, 1974). The "regular person" on the other hand is one who is not afraid to have a good time, who does not mind "having a little drink once in a while". This person is concerned that she or he might be seen as snobbish or elitist, and wants to make it clear they do not think themselves "too good" to "get down" with the rest of the crowd.

No one in my sample characterized themselves as "regular persons", but many emphatically volunteered that they were "quiet, Christian women" [their phrase], often as opposed to others in their neighborhood. One informant insisted on walking me from her house to my car warning me "You have to watch yourself, baby. This neighborhood's full of niggers". Common statements were: "I don't run the streets, I don't hang out in bars, the only place I go is to church and the grocery, that's it". "I don't have a man,

[for the widowed or divorced], I don't have any use of a man, I just keep to myself". This group was comprised of both "country" and "city" women, so there no is correspondence between the Country-City and Christian-Regular Person axes of differentiation, only similarities in themes.

It is apparent that Black society in New Orleans exhibits considerable diversity, there are many criteria for differentiation and status of which race is only one (Rohrer & Edmunson, 1960). These criteria are situational and subject to perception. The description of New Orleans society as Black or White is too simplistic, as is a homogeneous view of the "Black Community". Rather there are several Black "Communities" the boundaries of which stretch and shrink according to context. The ambiguities and uses of race and social stratification in New Orleans have only been hinted at. Dominguez gives a thorough and perceptive account of the situation (1986). Other recent works discussing Black social organization in New Orleans and southern Louisiana are Jenkins (1976), Kaslow (1981), Jacobs (1980) and Halstead (1983). Rohrer and Edmonson (1960), and Davis and Dollard (1964) provide time depth for comparison.

Family and Domestic Organization

A discussion of Blacks in the New World frequently raises the issue of cultural origins. Do Blacks have their own culture, or is it simply a degraded adoption of European/White culture? Is this a pathological reaction to

slavery and other circumstances of oppression (Frazier, 1939) or a successful adaptation to it (Stack, 1974)? Is it basically African (DuBois, 1961; Herskovits, 1941), or newly created in America? These questions have aroused interest because their answers can and have been used politically toward various ends, benevolent and otherwise (Jacobs, 1980). (For more extensive discussion of these issues see Blauner, 1970; Szwed and Whitten, 1970; Valentine, 1972; Mintz and Price, 1976)

I share the same reasoned position on these questions held by Mintz and Price (1976). They hold that in no way can a culture and its institutions be transferred unchanged, but that Africanisms can be maintained at a deeper cognitive and affective level. Thus, although few elements of the various African cultures raided by the slave trade may be found intact in the New World, the cultural traditions possessed by enslaved Africans in the New World must have influenced present American Black culture and society.

The debate about the nature and source of Black culture in the U.S. has been most fully developed in writings on family and domestic organization. This debate has frequently taken the form of arguments over the "Black Family in Crisis", viewing Black families as disintegrating and degraded due to ghetto pressures (Frazier, 1939; Moynihan, 1965). Alternatively, Black family forms in the United States are held to be continuations of African cultural traditions (Herskovits, 1941; DuBois, 1969). Still

others argue that forms of Black family and domestic organization are positive adaptations to socioecomic contingencies (Stack,1974; Billingsley, 1968). (For cogent discussions of this debate regarding family life see Aschenbrenner, 1978; Adams, 1978 and Sudarkasa, 1981.)

Extended kin networks are generally thought to be the most important family type among Black Americans (Staples, 1971 Stack, 1974; Ladner, 1971; Shimkin, Shimkin and Frate, 1978). This is not the only form found, however, and other family types have been determined significant. Billingsley's comprehensive work noted numerous family types in Black America (1968). Scanzoni found little difference between middle-class Black and White families in a midwestern city (1971). While the most common family form does seem to be that of the extended kin network, there is obviously considerable heterogeneity in U.S. Black family life.

This heterogeneity is evident in New Orleans. A Black extended family made up of several households situated in close proximity to one another was studied by Jack (1978).[2] Far from a pathological social form, the family provided the central focus for members' social, economic, and emotional life. Kaslow characterized extended families in New Orleans as adaptations to the post-WWII process of ghettoizaton (1981). He noted how family ties intertwined with those of voluntary benevolent organizations to aid kin members in crisis. Rohrer and Edmunson found abundant

nuclear families in the upper and middle classes of Black New Orleans as among Whites (1960). They proposed that family organization in New Orleans is partially a function of class culture (1960).

Extended kin networks were found important in the present study's participants. Twelve women (20%) in my sample did not routinely have a kin member in residence with them. This is misleading however, since of these 12, three had family members living within one block of them. Six others regular and frequently participated in kin networks. Only three could be said to be living truly alone. These three had never had children; of these two had never married and had few kin members in New Orleans.

A constant ebb and flow of kin members participating in domestic activities was definitely the norm in my informant's households. Since visits were almost always scheduled during regular working days, this activity is noteworthy. Presumably this would be a rather quiet time in the home, and domestic activity would increase during evenings and weekends, but this apparently was not the case. I do not have adequate data to determine general family types. It is reasonable to however to state that the majority of women in this study actively participated in extensive kin networks.

Culture and Psychology

Themes and Ethos

Early studies of Culture and Personality suffered from overly generalized statements of character and ethnicity. They assumed a psychological homogeneity within a population which has not been supported by subsequent research. Psychological studies of Blacks in the United States have been similarly limited. These studies can still be useful, however, if they are taken only as frequently recurring themes within a population and not as descriptions of national character or modal personality.

One of the most commonly noted themes in writings on Black American culture is a sense of oneness, interrelatedness and synthesis within the cosmos. Nobles proposed that this oneness could be located in the extended self-concept which incorporated and was interdependent with the environment, and conceived of the self as a minds-body whole (1974, 1985). A corollary of oneness is an emphasis on communality, which placed a great value on collective survival, on sharing and giving. According to Nobles this theme, founded in African philosophy, pervades U.S. Black and African culture (1974, 1985).

White noted six themes in Black New World culture. These are: 1) oneness and synthesis, (2) emotional vitality, (3) realness/"telling it like it is", (4) resilience and strength of spirit, (5) the value of direct experience (6) distrust and deception (1984).

According to Snow, United States Blacks see the world as hostile and dangerous (1974). They feel that most people will do ill if it is in their interest, that it is more natural to be bad than good. She noted a sense of helplessness, of fatalism and resignation to the evil of the world.

I did not find this sense of helplessness and mistrust, although danger was thought to exist. When asked if the world was a bad or dangerous place the most consistent answer was "It ain't the world, honey, it's the people in it". The general feeling was that the Good Lord made the world so it has to be good, it is just the people out there with their greed and meanness who are causing trouble. This was seen as a recent development, however; past times were better but crime, poverty, and war were considered increasing evils (informants repeatedly mentioned instances of child abuse they had heard of. To women for whom motherhood is so strongly valued, this was the greatest abomination imaginable). They felt one did have fear the evils in the world, but one could protect oneself by only associating with good people.

I did observe what might be called an "ethos of suffering", which relates to the fatalism Snow noted. This was particularly salient in the realm of health and illness. When asked why did people get sick, they said it's partly because people don't take care of themselves, but mostly sickness is just inevitable. "Everybody has to have some-

thing. It's just according to whatever's there for you." "God don't make you sick, He don't work like that, but Christ suffered and you have to too" "It's just your cross, we all have to have a cross". "The doctor's can do everything they want, but if God think's you should have it you're gonna have it."

Observed from the outside, this ethos can be seen as fatalism or resignation, but to my informants suffering had positive worth. This was a part of the deeply felt Christianity all informants professed. "The Good Lord didn't put us here to be happy, He put us here to do His work. If we get our heaven in this world, what can we look forward to in the other ?"

This was also seen in part as the devil's work. "I keep hearing about God giving us trouble but you don't hear about the devil no more. And I tell you he is active among us; he is keeping himself busy." What can be seen as fatalism on the one hand can also be seen as a logical means to make intelligible and bearable a life of diffulties and hard work.

Psychological Problems

Early psychological studies found significant hostility, anger and anxiety among U.S. Blacks (Kardiner and Ovesey, 1951; Davis and Dollard, 1940). Much of this research was reviewed in by Pettigrew (1964). A later study by Grier and Cobb had similar results, concluding, however, that this was not pathology but a reasonable and realistic

response to Blacks' position in contemporary U.S. society (1968).

Researchers finding anger and hostility have said that this anger was suppressed, since U.S. social organization discouraged the overt expression of anger toward Whites and White society (Kardiner and Ovesey, 1951; Davis and Dollard, 1940). It was reasoned that Blacks have general difficulty demonstrating assertiveness and expressing legitimate anger as a result of discrimination and minority status. A later study by Crain and Weisman corroborated the earlier research (1972).

Writers in Black studies argued that suppressed anger is not necessarily a consequence of slavery and minority status. (Nobles, 1974; White, 1984). They refer to the African-based sense of oneness and communality. In a culture that values collective survival and in which people are psychologically interdependent, active aggression against the other in reality is an act of aggression against oneself (White, 1984).

Early researchers also recorded a displacement of anger directed inward toward the self and one's own people (Kardiner and Ovesey, 1951, Davis and Dollard, 1940). A consequence of this was proposed to be low self-esteem among Blacks. But Jenkins suggests it is necessary to distinguish between the evaluation of one's ethnicity and personal self-esteem (1982). One's identification with one's people is not the total foundation of individual self concept, which

can be highly valued for personal qualities such as competence.

According to Jenkins, a stable African cultural background has afforded Blacks in the New World a sense of competence as human beings from slavery to the present, giving a sense of worth greater than the treatment received (1982). A sense of competence then neutralizes ambivalence about Black ethnicity, helping to explain Black psychological survival over time.

Even if Blacks have had past difficulties with self concept and assertiveness, this is changing. As the caste system in the United States weakens and negative sanctions against aggression and anger have diminished, there may be less reluctance to assert oneself. In a more recent experimental study of Black response to racial insults, subjects showed no hesitation in showing hostility and anger (Wilson and Rogers, 1975).

Powdermaker called into question Black inassertiveness, differentiating between apparently passive action and genuine intent (1943). Passive resistance is not passivity but a strategy to retain some measure of autonomy in world where overt resistance is dangerous (Jenkins, 1982)). Blacks, through passive resistance, have resisted dehumanization and struggled to realize a sense of self that is meaningful in the face of slavery and other coercion (Powdermaker, 1943; Jenkins, 1982).

Being unassertive gives a moral victory over one's oppressor. Turning the other cheek and returning good for evil permits the triumph of strong Christian convictions held by U.S. Blacks. One also acheives victory and gratification in the awareness that one is effectively deceiving the oppressor, revealing his foolishness and undermining his authority in the eyes of those wise enough to understand the situation. Ralph Ellison characterized the practice as "overcoming`em with `yesses'" (1964).

Anxiety has also been mentioned as a problem for Blacks and this is notable in New Orleans. Davis and Dollard's (1940) early study in New Orleans and Rohrer and Edmunson's follow-up to this study both found significant anxiety in New Orleans Black (1960). Jacobs also recorded significant anxiety in the Black patients of a New Orleans (1980). As will be discussed in following chapters, anxiety and stress were repeatedly vocalized problems in the present study as well. Given the ambiguities of social organization discussed earlier, as well as other stresses and vagaries of Black life in New Orleans, this is not surprising but is quite an understandable phenomenon.

The Need for a Black Psychology

Psychological studies of U.S. Blacks have generated great controversy, especially the earlier ones such as The Mark of Oppression (Kardiner and Ovesey, 1951) and Children of Bondage (Davis and Dollard, 1940). Many of these focused on psychopathology and deficiency in an attempt to address

minority groups' response and adaptation to the very real problems of racial prejudice and socioeconomic discrimination in the United States.

Studies within this genre have been strongly criticized as racist, selectively focusing on the weaknesses of minority groups such as Blacks while neglecting to examine their strengths (Guthrie, 1976; White, 1984; Baldwin, 1986). These criticisms are not unfounded. Early research on Black psychology derived from a time and mind-set wherein Blacks were seen as problems rather than people (Baldwin, 1964).

Charges of ethnocentrism are also with some foundation. Criticisms of Black families as pathological because they do not fit a mid-twentieth century Euro-American ideal of the nuclear family are not legitimate. In addition, some of these discussions have a distinctly sexist tone. It seems to bother male researchers that Black females are accorded a strong position of authority in domestic relations. They express concern that males will grow up emasculated in such an environment. It has been demonstrated that a strong female figure in the family does not preclude a strong male image, and that adequate male role models do not have to be the father for a family to produce psychologically healthy offspring (Stack, 1974).

On the other hand, it is difficult to conceive how a people as American Blacks, with such a long and horrendous history of maltreatment by the larger society, could escape without some percentage of the population experiencing

psychological ill effects. Ethnic minorities elsewhere have exhibited psychological problems of adaptation to minority status (DeVos, 1980). Cayton's discussion of his own experience and feeling are a testament to the reality of the problem (Cayton, 1951). This is not to say that U.S. Blacks are especially prone to psychopathology, but that by virtue of their social position historically, certain types of disorders and problems are likely to be more characteristic of Blacks than of other groups.

A rejoinder to this argument has been that Blacks have demonstrated a remarkable resilience and toughness of spirit which has proved adaptive, and this is certainly true (Baldwin, 1986; Jenkins, 1982; White, 1984). But exaggerated statements of Black psychological strength present the danger of creating a distorted image of the "Super Black" which is as fallacious as the Nazi image of the "Aryan Super Race". They also create a situation where, since it is asserted that no damage has been done to Black psyches, there is in fact no problem, no need for social change and Black mental health can be ignored by policy makers.

Calls for a Black psychology free from the ethnocentrism of psychology in the Euro/White tradition are legitimate. Certainly there is a pressing need for a psychology of Blacks in a post-colonial non-African environment. This is basic to any analysis and understanding of U.S. Black culture and society. Many calls for Black psychology, however, are overtly political with the avowed

purpose of building a psychology based on Black cultural themes and values, and of selectively emphasizing positive data over negative (White, 1984; Baldwin, 1986).

An ethnocentric Black psychology is not an improvement over an ethnocentric White psychology, nor is one in which the ideal of objective science takes a back seat to political agenda. A cross-cultural psychology (intersecting with psychological anthropology) does exist, with the explicit goal of understanding and transcending cultural biases in psychological study. This field has been conspicuously neglected in Black Psychology literature. Adopting a cross-cultural position could resolve many of the dilemmas of bias in the study of Black psychology.

Black Women in the U.S.

One of the most important perceived roles of the Black woman in the United States is as a mother. Many researchers have critically described the Black mother as a matriarch, alluding to her power over large kin networks which allegedly deprives males of their self-esteem and masculinity. The legitimacy of these criticisms have been discussed in the previous section.

Many Black families however, can be reasonably characterized as matricentric or matrifocal (Billingsely, 1968; Staples, 1971; Aschenbrenner, 1978; Gonzales, 1970; Jack, 1978). The importance of the mother in this setting is essential to both the practical and affective functioning of the family. In a working class New Orleans Black family,

Jack found, not that the mother had authority to coerce, but that as the spiritual leader and the conscience of the family, she was greatly influential (1978). Her influence came less from direct command then from cajoling and persuasion.

Many writers have characterized male-female bonds as weak in Black families (Frazier, 1939; Moynihan, 1965; Queen and Halbenstein, 1967). Sudaraska proposes that consanguineal rather than conjugal relationships are emphasized in Black families (1981). This gives the appearance of matriarchy in families where conjugal ties were sacrificed in favor of consanguinity. In New Orleans, Jack found husband-wife bonds important and not eclipsed by the mother-daughter dyad so frequently mentioned in other studies (1978).

In the present study, mothers did seem to be especially important, so that families could reasonably be characterized as matricentric. Where a husband was present, the bond generally seemed to be exceedingly strong, with husbands conspicuously solicitous about their wives' welfare. Although there were only 15 informants with husbands present, quite a number of informants (20) had been widowed, something rarely pointed out in discussions of the large number female-headed households in the Black population.

Mother-daughter bonds did appear strong, but so did mother and son. Both sons and daughters were observed to actively give aid, solace and affection to their mothers.

This is only based on informal observation, however, so no generalizations concerning the true nature of domestic relationships in my sample can be made with any certainty.

Two major images were described by Ladner's report on the American Black woman (1971). One image is of the loving, gentle mother, always nurturing. The other is that of the hardworking woman, emphasizing competence, effectiveness, and a no-nonsense approach to life. These are not mutually exclusive and in fact Ladner found varying mixes of these as ideals expressed by women.

Samuels investigated role ideals and self image among Black women in New Orleans (1974). Like Ladner she found the ideals of the mother and the hardworking woman. She also found the opposition of the decent Christian woman vs. the regular person. Samuels' informants offered mixed images, as did Ladner's, and could be characterized only in terms of the dominant image.

The New Orleans women described themselves as mean, stubborn, rebellious, giving quid pro quo, independent, uncompromising and selfish (Samuels, 1974). The Black woman was said to be quick to anger, hot-tempered, volatile and unpredictable. She tells people exactly what she thinks, whether in agreement (as in the New Orleans affirmation, "yeah, you right") or not oftentimes resulting in an explosive fight (Samuels, 1974). She wants her own way and is proud of this. On the other hand, New Orleans Black

women expressed a willingness to share, to be open and frank, to enjoy life and to care.

Many of these characteristics are especially important in sexual relationships, a realm not usually discussed in literature on Black women in kin networks. Samuels noted an ethos of strength among Black women (1974). This approached female dominance in sexual relationships, but Samuels acknowledged that maybe it was just more symmetrical than the male-female ideal in White society. The male-female relationship was characterized by a principal of like for like, with escalating competitive responses, until one person has enough and leaves. She noted that jealousy and possessiveness were equated with caring, fueling the competition in sexual relationships.

One's sexuality was a source of pride and an integral part of one's self (Samuels, 1974). This aspect of self did not diminish over time, for one's sexuality was not affected by aging. As one woman phrased it "it's the last thing to wrinkle." Thus these qualities of self, especially important in relating to men, continued throughout a woman's life.

In sum, the idealized Black woman's role in New Orleans is a strong, competent, and loving mother. She is a potent force to be reckoned with in the family, imparting practical wisdom and spiritual values to those around her. This is a difficult role to live up to. It bestows upon the Black woman great honor and respect, but carries with it

tremendous responsibility as well. Some of the consequences of this role ideal for physical and emotional health will be discussed in relation to hypertension in the remaining chapters.

NOTES

1 All informant's names used in this study are pseudonyms.

2 From my own experience, and discussions with New Orleanians, this has been a common residential pattern in New Orleans for Blacks and Whites. It does not seem to be as common among Whites now as it was a few decades ago. This is certainly worthy of further study.

CHAPTER 6: BLACK HEALTH BELIEFS IN NEW ORLEANS: HYPERTENSION AND COMPLIANCE

Afro-American Blood Conditions

Most studies about American Black health culture have dealt with magico-religious cults and systems of healing (Snow, 1978; Kuna, 1974/1975; Hall and Bourne, 1973; Wintrob, 1973; Tinling, 1967). There is considerable disagreement in these studies concerning the nature, boundaries and definitions of various, sects, cults and healing systems. There is regional variation in terminology, overlap, and in reality, probably considerable use of multiple systems by single individuals in search of care and healing. In New Orleans, numerous systems have been identified formally: Santeria, Spiritualists (Jacobs, 1984), Voodoo/Hoodoo (Hurston, 1931; Saxon and Tallant, 1969), as well as the practice of "root doctors" and herbalists (Webb, 1971). These studies tend to focus on formulations of health and healing from the pracitioners' perspective and are not representations of the health beliefs of the general lay population.

Recent studies about U.S. Black health beliefs are few but strikingly similar in their findings. All populations sampled have shown unusually great concern for matters of the blood, its nature and behavior in the human body. A great number of blood illnesses and conditions exist, yet they are all variations on the theme of blood out of balance in the body due to deleterious emotional, social, and nutritional influences.

In a review article, Snow characterized the health beliefs of Blacks in the southwest and in Michigan (1974). Regarding hypertension, Snow found that the term "high blood pressure" or simply, "high blood", as used by rural blacks, did not refer to the biomedically recognized condition (1974; 1976). Rather, "high blood" is a condition wherein the blood is too rich, thick and hot, and total blood volume is excessive. The blood rises up toward the head and remains there. This is caused by certain foods and body and environmental temperature.

Low blood, the polar opposite of "high blood" is a state of abnormally thinned and weakened blood. There is insufficient blood volume to sustain a normally healthy body, and the result is weakness, fatigue and lethargy. This is understood to coincide with the biomedical iron deficiency anemia. Snow gives no indication of the prevalence or regional variation in these beliefs, however.

The Miami Health Ecology report describes similar beliefs among U.S. Blacks in Miami (Weidman, et al., 1978). The Miami study found the terms high and low blood used. High blood, high blood pressure, or just pressure were found to be used interchangeably. The body was conceptualized as a series of containers and vessels wherein thickened blood became sluggish and tended to form clots, or become clogged in certain parts of the body, perhaps the head or heart. Thickened blood was associated with cold weather in the winter. Cold makes the blood "contract", and capable of

collecting "impurities". If not cleansed properly it can become "bad blood", an abnormal state which may cause further disease. (Weidman, et al., 1978: 546)

Low blood in Miamian Blacks is quite similar to the condition of the same name described by Snow (1974, 1976). It is also understood to coincide with sickle cell anemia. Another condition, "falling-out", is usually the result of high-blood but may result from low-blood as well. Falling out is a semi-conscious state of sudden collapse where the eyes remain open but unseeing, and hearing is unimpaired (See Weidman, 1979 for a thorough analysis of this condition).

The health beliefs of Bahamian and Haitians in Miami were also similar to those of southern U.S. Blacks in Miami. For Bahamians, seven conditions were found related directly to blood: high blood, low blood, thin blood, tired blood, bruised blood, clots and bad blood. "Blacking-out", a condition characterized by dizziness, darkness before the eyes and collapse into a semiconscious state, is related to having either high or low blood. Weidman believes it to be the equivalent of falling-out for southern Blacks (1978, 1979).

High blood, as for other groups mentioned, is characterized as a state wherein the blood is accumulated high in the body or rushes to the head. Nervousness frequently contributes to it. Low blood encompasses anemia and is characterized by weakness, lethargy, and dizziness.

Haitians in Miami were similarly concerned with blood abnormalities. They were also concerned about the buildup of bodily fluids in the body, such as blood, vaginal secretions, urine and semen. High blood and low blood were present in the discussion, yet how they compare to high and low blood in Bahamians and southern Blacks was not described. Tension was mentioned as a Creole term for hypertension caused by too much grease and not enough blood in the body (Weidman, 1978: 516).

Other conditions related to blood were mauvais sang (bad blood), saissaissement (shock), faiblesse (weakness), depression and la congestion. They will briefly be described because they have remarkable similarities to elements of blood beliefs in New Orleans. Although these illness forms do not identically coincide with those in New Orleans, general complaints and causes are strikingly reminiscent of concerns expressed in New Orleans.

Mauvais sang is a circulatory disturbance in which the blood becomes agitated and begins to rise in the body, at times rushing to the head (Weidman, 1978). This can lead to many serious distrubances. It is related to hurt feelings, anger, or emotional termoil. Saissaissement is associated with violent emotional shock. It is characterized by coldness, weakness, rapidly beating heart, and thinning of the blood like water.

Faiblesse is weakness and feebleness caused by malnutrition and/or insufficient blood. Darkness passes

before the eyes but one does not lose consciousness. It is sometimes equated with the biomedical anemia but the two are not identical. Depression is a state of feebleness and weakness as well but more serious than faiblesse. It is associated with worry, inadequate food and insufficient sleep. The worry or anguished feelings are said by some to concentrate in the blood (Weidman,1978).

La Congestion is a state where the blood accumulates in the chest, neck, and head. It is accompanied by dizziness, headaches, and fullness and constriction in the lungs, chest and throat. It may be caused by mixed emotions in ambiguous situations where one senses one has been wronged but is unsure or has no recourse (Weidman, 1978).

Finally indisposition is believed by Weidman to be equivalent to the blacking out of Bahamians and falling-out for southern Blacks. It is characterized by dizziness and darkness before the eyes, weakness and inability to move, speak or hold up the head. If one is standing when it occurs, collapse and loss of consciousness to some degree is likely (Weidman, 1978).

Weidman concluded that all of these Afro-American blood conditions were based on general health beliefs concerning the blood and its proper state in the body. Normal blood is pure (good), rich (nutritious) and moderate in volume while moving warmly, steadily and tranquilly through the body (1978: 468). Overly cool blood thickens or coagulates, blood which heats up moves more rapidly.

Blood was not said to circulate in the sense of the Western cardiovascular model but rather rises and lowers. Two dimensions were found in conceptualizing blood as high or low, one was volume the other, direction of movement. High blood is expanded blood, and low blood is contracted. Movement was either in the right or wrong direction, that is going down or coming up. The particular combination of disrupting forces and qualities determines the type of blood abnormality which develops.

The health beliefs described for U.S. Blacks and for Caribbean ethnic groups in Miami are quite similar to those described in the Caribbean itself. A recent analysis of move san in Haiti has been published by Farmer (1988). (Farmer uses creole terms. Mauvais sang, or bad blood, is French). The bad blood is said to stem from malignant emotions due to shock (seizman, or saissement) chronic financial problems, and mixed personal and social stressors. This can lead to spoiled milk (let gate or lait gate) in pregnant and lactating women so that illness is transferred to her child. Let gate is often considered a sign that move san is present. (Weidman noted that in Afro-American health culture, illnesses frequently serve as causes or symptoms of others (1978)).

Folk Beliefs Concerning Hypertension in Other Populations

Folk beliefs concerning hypertension are not peculiar to Afro-Americans. Some important studies in other populations should be noted here.

In a study in Washington State, Blumhagen investigated health beliefs and high blood pressure in a primarily Anglo-American middle-class sample (1980; 1982). He found that his informants tended to implicate emotional factors and psychological stress with the etiology of a condition they called hypertension rather than with that of high blood pressure. Blumhagen described hypertension (as opposed to high blood pressure) as a folk illness which he characterized as "hyper-tension". Blumhagen concluded that, in his population to his sample, hyper-tension represents a state of increased emotional tension and psychological stress, whereas high blood pressure refers to the medically recognized condition.

A study of Moroccan Jews in Israel showed that hypertension was thought to be caused by eating certain foods (fat, salt, pepper, sugar, meat, and alcohol), worrying and "nerves", body heat, dizziness and falling (Greenfield, Borkan and Yodfat, 1987). Here dizziness and falling are causes of hypertension rather than the sequelae of "high blood" as in the Afro-American populations.

In southern Appalachia, Nations, Camino and Walker documented the "popular illnesses" [their term] presented in a university primary care clinic (1985). High blood was presented as a condition in which blood levels fluctuated wildly under circumstances of emotional arousal or eating the wrong foods. Less frequently presented was hyper-tension which the researchers took to represent the state of nervous

tension described by Blumhagen as opposed to one of increased blood pressure. These conditions were not described in detail.

Finally, Garro studied cultural illness models of hypertension in an Ojibwa community in Manitoba, Canada (1988). Interestingly, the Ojibwa label for high blood pressure translates as "blood that rises". Garro describes four key dimensions of the Ojibwa high blood pressure model: 1) High blood pressure is not always high; it goes up and down; 2) When it goes up the blood rises, and blood collects in certain parts of the body; 3) Where the blood collects determines what symptoms are perceived as well as consequences 4) High blood pressure arises from a state of imbalance,or too much of something. correction of the imbalance result in improvement of the condition and diminution of symptoms. This imbalance can be caused by overweight emotional upsets and dietary imbalance.

Weidman was of the opinion that Afro-American beliefs about blood could be traced to origins in African health culture. She cited a study by Bisilliat (1976) which described bush illnesses in Mali, West Africa. She found striking parallels regarding the movement and action of the blood in relationship to illness. It would be unreasonable to expect African ethnomedicine to have had no influence Afro-American health beliefs. Certainly some elements of ehtnomedicine should have survived from the parent health culture.

The similarity, however, of some of the non-Afro beliefs about blood and hypertension to those found in Afro-American culture, warn against a too-facile tracing of Afro-American beliefs to African origins simply on the basis of similarities. It has been argued by Metraux (1953) that Haitian blood beliefs reflect beliefs from 17th century France. Snow also argued for the European origin of American Black blood beliefs. Although Weidman certainly does construct a compelling argument, the similarity of beliefs concerning hypertension and blood in such widely dispersed populations as Moroccan Jews, U.S. Blacks and Canadian Ojibwa does produce some doubt about African origins.

Gaines has argued that certain continuities of belief in Latin American/Caribbean, Southern Black and White, and Appalachian populations can be traced to an ancient pan-Mediterranean tradition with its ultimate origins in Homeric Greece (1984). Although sub-Mediterranean African influence is likely in Afro-American belief, widely found parallels in geographically and culturally diverse populations preclude ruling out an influence from Europe and the Mediterranean. A possibility is that some of these beliefs are so ancient that they were spread throughout the Mediteranean region of Europe and Africa as well as the very sophisticat-ed kingdoms of West Africa, which certainly were not isolated.

Tracing paths of cultural diffusion is a thankless task suffering from excessive speculation, little evidence, and

even less possibility of a final answer. In any event, the question of ultimate origins of these beliefs is still open for discussion.

Folk and Medical Beliefs Concerning Hypertension in New Orleans: Results of the Patient and Practitioner Interviews

The Patients' Illness Models

Informants described their illness using the general terms "pressure" or "pressure trouble". When asked for more specific terms the response was usually "high blood pressure", "high blood", or "hypertension". Many informants said they just used the term "high blood" for "high blood pressure" but discriminated between " high blood/ high blood pressure and "hypertension". Over half said that these two illnesses were different but related. 53% (32) differentiated between high blood and hypertension, 37% (22) said there was no difference, and 10% (6) said they did not know or were not sure. Of those who felt there was no difference, six women said they were aware that some people differentiate between the two. This suggests a fairly widely recognized belief within the population.

Despite individual variation in explanatory models, two basic folk illness models emerge from the interviews, "high blood and "High-pertension" [1]. These two illnesses will be discussed and then compared to physician's illness models. (See Table I for patients' characterizations of these two illnesses, pp. 115-116.)

One can have both folk illnesses at the same time, although they don not have to both begin at the same time. Furthermore, one illness can go away and the other begin. Each illness requires its own appropriate strategy for management, even when occurring at the same time.

The pathophysiologies of both folk illnesses seem to work on what can be called a "thermometer" model. Participants describe normal blood as being "at rest" or "quiet", wherein the blood is lower in the body. When "pressure trouble" occurs, the blood rises in the body towards the head.

The pathophysiologies of these two illnesses differ markedly in other respects. In general, high blood is said to be a "disease of the blood" wherein excessively "hot", "thick" or "rich" blood rises up in the body, clogs, and tends to remain there (it is said to be "elevated"). Participants say their blood can be elevated for months at a time: "it stays high." The illness is said to "work on the heart too hard".

In high-pertension, the blood is usually "at rest". At times of sudden intense emotion, the blood shoots up suddenly to the head, but then goes back down. This sudden rise can cause instant death. High-pertension is said to be a "disease of the nerves." In high-pertension, the blood tends to go up higher, all the way to the head, and more

Table I
Patients' Responses Describing Salient Characteristics of High Blood and High Pertension*
(From participants recognizing two folk illnesses)

n = 32

	High Blood	High-Pertension
Pathophysiology		
hot, rich blood	18 (56%)	3 (9%)
thick blood	19 (59%)	0
blood moves up	27 (84%)	16 (50%)
blood moves up suddenly	3 (9%)	30 (94%)
blood moves to head	14 (44%)	30 (94%)
blood stays up	28 (88%)	0
blood clogs	19 (59%)	2 (6%)
Course		
predictable	29 (91%)	4 (13%)
unpredticable	1 (3%)	24 (75%)
episodic	3 (9%)	27 (84%)
symptoms present	23 (72%)	24 (75%)
can be controlled	23 (72%)	12 (38%)
Cause		
heredity of illness	19 (54%)	1 (3%)
heredity of personality	0	11 (34%)
personality (not inherited)	1 (3%)	9 (28%)
diet	26 (81%)	0
"bad nerves"	0	30 (94%)
stress	10 (31%)	14 (44%)
money	5 (16%)	13 (41%)
anger	0	12 (38%)

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* Only positive responses are included in the table. Remaining categories (No, Don't Know, Not Mentioned) are omitted for the sake of clarity.

TABLE I (continued)
Patient's Responses Describing Salient Characteristics
of High Blood and High-Pertension

	High Blood	High-Pertension
Exacerbating Factors		
"bad nerves"	18 (56%)	3 (9%)
stress	10 (31%)	26 (81%)
worry	5 (16%)	25 (81%)
anger	0	19 (59%)
money	1 (3%)	11 (34%)
children	2 (6%)	11 (34%)
diet	24 (73%)	2 (6%)
heat (body/environment)	8 (25%)	2 (6%)
hysterectomy/menopause	7 (22%)	7 (22%)
Treatment		
prescribed drugs	24 (75%)	10 (31%)
diet	29 (91%)	1 (3%)
weight loss	11 (34%)	1 (3%)
"nerve pills"	0	9 (28%)
not worrying	2 (6%)	31 (97%)
relaxation	9 (28%)	30 (94%)
rest	22 (67%)	24 (75%)
stay quiet	4 (13%)	18 (56%)
stay away from people	0	10 (31%)

rapidly than in high blood. It is said to "accelerate" in high-pertension, whereas in high blood it only "elevates". One informant said it "shoots up to my head and rings like a bell".

This dichotomy is similar to that described by Blumhagen (1980, 1982). His predominantly White middle-class sample considered hypertension (Blumhagen called it hyper-tension) to mean an individual was very nervous and under a good deal of stress. High blood pressure denoted the biomedically recognized illness involving impaired cardiovascular functioning. Elements of New Orleans `high-blood' and also `high-pertension', show strong similarities to the folk illness `high blood' described by Snow (1974). They both involve blood which travels upward in the body. In `high-pertension' the nature of the blood itself (excessive volume, too hot, rich or thick,) is not as important as in `high blood'.

The course of high blood is said to be predictable. Once the blood "is up" it can be expected to stay up over a period of time It's rise is often related to diet. Eating the "wrong foods" foods was frequently noted as a trigger. For example, respondents made such statements as, "I know if I eat a little piece of pork it'll go up and stay up for weeks" and "I knew if I ate that gumbo it would run my blood up but I did it anyway".

High-pertension is thought to be extremely unpredictable and episodic, since the blood only goes up when someone is

very upset emotionally and this is not easily foreseen. Because it is unpredictable, sudden, and the blood goes up higher than in high blood, high-pertension is thought to be more dangerous.

The two illnesses are differentially caused. High blood is generally caused by heredity ("It's in the family") and eating the "wrong food". Participants considered the most harmful foods to be pork (fresh or salt), salt, "seasoning" (defined as adding garlic, onion, bay leaf, thyme, celery, bell pepper, salt and pepper), and "grease". High-pertension is caused by "bad nerves", stress, worry, and anger. Food was not a causal factor in high-pertension.

An important aspect of this emotional causation was the belief that an individual had high-pertension because she had a nervous, excitable temperament and was given to worrying. Some women thought high-pertension could be inherited through the inheritance of this type of personality.

Women thought that men could have high-pertension and high blood too. Six women said that men's pressure troubles were more from drinking alcohol than from stress and emotional problems as is the case for women.

Various exacerbating factors can aggravate the pre-existing conditions. Factors in high blood are "wrong foods", stress, and heat (weather or body temperature, which make the blood hotter and thicker). Worry and anger did not figure as important problems, and "nerves" were not thought to exacerbate high blood.

The most important exacerbating factor in high-pertension is "nerves", followed by stress, worry, anger, financial problems, and children. Only two persons mentioned diet as a problem. Again the etiological dichotomy between of diet and heredity in high blood versus emotion in high pertension is apparent.

Hysterectomy and menopause were considered by some women to exacerbate both high blood and high-pertension. According to patients, when the menstrual flow is stopped, excess blood goes up to the head, aggravating one's "pressure troubles". As one woman phrased it "there's no place for all that waste blood to go so it backs up into your head."

Appropriate management of the two differs accordingly. The majority of women thought appropriate treatment for high blood included medically prescribed antihypertensive drugs, dietary control, and, less importantly, weight loss. This is in direct contrast to the management of high-pertension for which medication was not thought particularly useful. Of those who thought medications might help, some women said these should be "nerve pills", or some other medication to cause relaxation and sleep. Neither dietary control nor weight loss were considered effective in high-pertension management. Most important in the management of high-pertension was for the individual to avoid worrying and to relax, rest, stay quiet, and get away from people. Although rest was important for the treatment of high blood, these other factors were much less important.

A number of home remedies such as garlic, vinegar or lemon juice in various combinations to thin and cool the blood and draw it away from the head were considered useful for both illnesses but were seen as supplements to biomedical care and not as substitutes.

It is interesting to note that, although essential hypertension is generally considered asymptomatic except for times of severe crisis, only four individuals said they absolutely never experienced symptoms. Twenty-three (72% of the 32 individuals recognizing two illnesses) said those with high blood would ordinarily experience symptoms and 24 (75% of the 32) said the same for high-pertension.

There is not enough difference between symptoms mentioned for high blood and high-pertension to truly suggest separate symptomatologies. With the exception of disorientation, fewer individuals listed symptoms for high-pertension than for high blood. Only two persons mentioned this as a symptom of high blood while 13 mentioned it for high-pertension.

The array of symptoms experienced for both folk illnesses was long and varied including headaces, weakness and dizziness, blurred vision, seeing spots or glitter, nosebleeds, "glarey" eyes, the "blind staggers", blacking out and "falling out" (see Weidman, 1979), chest pains, drowsiness, red eyes, smelling fresh blood in the nose and tasting fresh blood or having one's breath smell like blood. The sensing of blood in one's mouth and nose and reddened

eyes are said to indicate the presence of blood at a dangerously high level in the body; one's blood has "gone up".[2]

In summary, according to approximately half the patient sample, "high blood/high blood pressure" and "hypertension/high-pertension" are different illnesses. "High-pertension" is considered a nervous disease; not well controlled by medication or diet. It can cause instant death. High blood is a disease of the blood and heart more easily controlled by medical intervention.

The Resident Physician's Models

Illness models expressed by the residents staffing the clinics are quite different from those expressed by the patients (See Table II, p. 122). Most notable is the small amount of variation in the residents' models. This is, of course, to be expected since standardized knowledge is a goal of medical education.

All residents recognized only a single disease entity which could be called either hypertension or high blood pressure. Two, however, did think that `hypertension' was more appropriate as a disease name while `high blood pressure' could imply only a measure of blood pressure.

The residents expressed the pathophysiology as a process wherein peripheral vascular constriction resulted in peripheral resistance against too great a blood volume for the system's capacity. The end effect was a cardiovascular

TABLE II
Physicians' Responses Describing Salient Characteristics of Hypertension

n = 15

	Hypertension
Pathophysiology	
vascular constriction	15 (100%)
excessive blood volume	15 (100%)
system functioning at an excessively high pressure	15 (100%)
Course	
symptoms only in severe crisis	5 (33%)
symptoms possible anytime	6 (40%)
symptoms probable	2 (13%)
completely asymptomatic	2 (13%)
Cause	
unknown	15 (100%)
heredity	5 (33%)
obesity	1 (7%)
multifactorial	2 (13%)
Exacerbating factors	
diet	9 (60%)
obesity	5 (33%)
salt	4 (27%)
stress	3 (20%)
smoking	2 (13%)
Treatment	
medication	15 (100%)
medication alone	3 (20%)
weight loss	4 (27%)
relaxation	2 (13%)
diet	9 (60%)
personality change	1 (7%)

system operating at excessively high pressure with possible damage to the system and other organs.

All residents agreed that the cause of essential hypertension is basically unknown, five thought heredity was implicated, one also blamed obesity and two said the etiology was multifactorial. Exacerbating factors were thought to relate to general lifestyle including poor diet (high in sodium, fat and calories), obesity, and smoking. Only three mentioned stress as aggravating the condition.

Appropriate treatment was unanimously thought to be medication; only three residents, however, felt medication alone would normally be adequate. Dietary control was considered important, weight loss was mentioned but only two mentioned relaxation or stress management as useful.

Only two residents felt that hypertension was completely asymptomatic. While five residents thought that symptoms were experienced only in times of severe hypertensive crisis, six said symptoms were possible at other times and two felt sure their patients experienced symptoms during the regular course of their illness. As mentioned above, only six patients experienced no symptoms and most experienced a wide variety.

It is medically acknowledged that symptoms can be experienced in malignant hypertension (a crisis state of severely high blood pressure requiring immediate emergency treatment), and infrequently in a small percentage of hypertensives. In the general population of mild and

moderate hypertensives, symptoms are considered rare (Robertson, 1983).

Both patients and medical residents interviewed acknowledged the presence of symptoms in hypertension, even the though the disease is considered asymptomatic by much of the medical profession and for this reason is called the "silent killer" by the American Heart Association. This represents a disjunction betweeen the general biomedical description and illness as experienced in real life by both patient and practitioner. Patient and practitioner responses suggest that biomedical disease theory inadequately reflects what actually is reported in experience and practice.

Furthermore, although residents concurred that the duration of the illness was lifelong, five then volunteered that, in their experience, they'd actually seen it "go away", where the patient's blood pressure was controlled to the point that medication was no longer required, the blood pressure remained controlled, and the patient was "cured". As one resident phrased it "I know it's not supposed to happen, but I've seen it happen".[3]

The physician sample is too small to draw any real conclusions, but it does call to mind the often cited distinction in anthropology between overt culture, what people say they do and think,) and covert culture, what they really do and think; the difference between idea and practice. The question of overt and covert culture in medicine has scarcely been addressed and certainly could be

investigated for its influence on practice, treatment and illness management.

Congruence of Patient and Physician Models

Great incongruence occurs betweeen the patients and practitioner's illness models. The most fundamental difference is that 53% of patients recognize two illness entities whereas professionals recognizes only one. This means that, unkowingly, patients and practioners are often not even discussing the same illness. Although neither high blood nor high pertension are congruent with the biomedical hypertension, the greatest incongruence seems to be between high pertension and hypertension.

In both high blood and hypertension there is thought to be excessive blood volume, heredity, diet, and overweight are thought to be etiological factors and medications and low sodium diets are thought appropriate managment strategies. In high pertension however, the cause is thought to be emotional upset and excitable temperament. For these the only appropriate treatment is avoidance of emotional arousal, rest, and relaxation. Diet and overweight have negligable roles as exacerbating factors and the only medication thought particularly useful are "nerve pills". Yet in hypertension, stress and emotion are considered to be lesser factors and and medication and dietary control are crucially important.

Although most of the residents (12) were aware of folk terms for hypertension, eight of these felt that they were just folk terms for the same illness treated by biomedicine.

Only three physicians knew something about the recognition of different illnesses by the patients they treated. One resident said high blood meant having a high hematocrit (which may indicate his awareness of the folk belief in excessively "rich" blood). Another said high blood referred to the period before menses and low blood after menses. A third said high-pertension meant the patient was too tense.

Relation of Health Beliefs to Compliance

Methods of Quantitative Analysis

The general hypothesis states that folk health beliefs are related to compliance with biomedical treatment. Folk health beliefs were operationalized as two variables, `Illness Model' and `Self Diagnosis'. `Illness model' describes whether the informant believes there are different folk illnesses involved (high blood and high-pertension) or simply one (which is assumed to be the same as the biomedical high blood pressure/hypertension). The possible categories are: two illnesses, same illness, don't know. Self Diagnosis describes from which illnesses, folk or biomedical, the informant believed herself to be suffering. Possible categories are high blood, high-pertension, hypertension, both high-pertension and high blood, don't know.

As noted earlier `compliance' is operationalized as a composite rating from one to four of increasing compliance with biomedical treatment. These four ranks were then collapsed into two categories `poor' and `good' compliance, due to the relatively small size of the sample. This is not

a problem since the four ranks were simply artifacts of the analysis and did not represent any absolute category boundaries.

Two statistical test were used chi-square and lambda. Chi-square is used to determine the statistical significance of a hypothesized relationship. Lambda is a measure of the strength of a hypothesized relationship. It is a proportionate reduction in error measure, and its value can be interpretated to mean the proportion by which error in predicting the distribution is reduced with knowledge of the independent variable. See Brockett and Levine (1984) for further discussion of these statistics.

Correlations

The rate of noncompliance with prescribed antihypertensive medication was found to be 52%, a finding which is consistent with the 50% generally found in compliance research on hypertension.

The patient's illness model (whether or not high blood and high-pertension are different illnesses) was significantly related to compliance (See Table III, p. 128). Chi-square showed the relationship to be significant at the .01 level. Of those who were noncompliant, 20 (65%) persons believed the illness to be different, whereas only 6 (19%) persons thought they were same. For those who were compliant, 12 (41%) thought there are two different illnesses while 16 (55%) thought they were the same.

TABLE III

Patient Belief That High Blood and High-Pertension are Different Illnesses vs. Compliance

n = 60

High Blood and High-Pertension are Different Illnesses	Poor Compliance	Good Compliance
Yes	20 (33%)	12 (20%)
No	6 (10%)	16 (27%)
Don't Know	5 (8%)	1 (2%)

Chi-square: 9.1556 P<0.0103

Lambda, with compliance dependent: 0.3448

Lambda showed that 34% of the error in predicting compliance can be explained by patient's illness model.

Although high-pertension is considered a more serious illness than high blood, medical treatment is not considered useful and it is thought to be difficult to control the environmental factors that trigger emotional upsets. According to Health Belief Model research, the low perception of control and treatment efficacy suggest that compliance would be expected to be lower among individuals self-diagnosed with high-pertension. This was found to be the case in our sample.

Self diagnosis (high blood, high pertension, both or high blood pressure) was significantly related to compliance at the .001 level in the Chi-square test (See Table IV, p. 130). Those persons who labeled themselves as having high-pertension were by far the least compliant with treatment. Those with high blood alone exhibited greater compliance, while those who did not differentiate between illnesses showed compliance levels similar to that of the general population (Joint National Committee-1984). Lambda showed that 52% of the error in predicting compliance can be explained by patient self-diagnosis.

This is a very strong correlation, especially for the social sciences. Lambda is a PRE (proportional reduction in error) measure. This means that one can improve the prediction of compliance in this population by 52% if one has a knowledge of patient's self-diagnosis, a cultural variable.

TABLE IV

Patient Self Diagnosis vs. Compliance

n = 60

Self Diagnosis	Poor Compliance	Good Compliance
High Blood	1 (2%)	6 (10%)
High-Pertension	10 (17%)	1 (2%)
Both	9 (15%)	5 (8%)
Not Sure	5 (8%)	1 (2%)
Not Applicable*	6 (10%)	16 (26%)

Chi-square: 19.2448 P<0.0007

Lambda, with compliance dependent: 0.5172

*Respondents thought high blood and high-pertension were the same.

This is an important result. It demonstrates that culture is not simply a secondary consideration for health care, but a factor of singular importance which must be addressed in explaining illness behavior and improving health care delivery.

Case Presentation

In order to better understand the behavioral environment in which compliance and noncompliance take place, we now turn to selected case examples of hypertension management. The illness histories and personal explanatory models of six women are presented to provide social context and cultural meaning for the relationship between folk beliefs and response to hypertension.

Cases

The first case illustrates the relatively simple, direct efforts neccessary to manage high blood.

Case 1: Althea Bernard is a 61 year old widow who lives with her grandson and niece in a rather poor, but old and stable neighborhood. Ms. Bernard grew up here and has lived within the same four-block radius all her life. She says "I wouldn't live anywhere else". She has five grown children who aid her financially as well as they can. Ms. Bernard also derives a small income from selling pralines (pecan candies) and "cold cups" of frozen "kool-aid" to neighborhood children.

Ms.Bernard has had high blood for 30 years, since she the birth of her last daughter. "They had to give me a shot to get it down it was so bad. They got it down but I've had it ever since." When Ms. Bernard's blood goes up it stays up, so, she says "you got to take your medicine all the time". This is unlike high-pertension according to Ms. Bernard, which "shoots up but comes down". Ms. Bernard says

all you can do is take your medicine, watch what you eat, rest and pray. She feels the medicine must help because her blood's not really high now. During the winter she ate some pork roast a friend had brought and she got terrible headaches. "It must have done something to my blood and it went up real high. The doctor at Charity Hospital said it might be that." This would not have influenced high-pertension however, because, she says, "food and pork aren't bad for high-pertension." She does take a nerve-pill but it does not do anything to her blood because she does not have high-pertension. Ms. Bernard says the only time she doesn't take her medicine is if she forgets, which only happens occasionally. Ms. Bernards compliance was, in fact, excellent and her blood pressure was well-controlled during the time I saw her.

Since medication and dietary control are thought to be effective, illness management for Ms. Bernard is fairly straightforward. Ms. Bernard's life can be characterized as stable and quiet, and, while she is certainly not well-off, she does not lack the basic necessities of food and shelter.

One gets the impression that she comfortable and content with her life. This stability, without doubt, supports her efforts at management of high blood.

Compliance may not be so simple a matter for those with high-pertension however. Since high-pertension is a disease of the nerves, medication is not thought to be an important element of treatment. Rather, rest, quiet and perhaps tranquilizers are considered appropriate.

Case 2: Rosie Mae Batiste is a 64 year old woman who has had high-pertension for forty years, since the birth of her first child. "It was up so high then, the doctor said I must have seen St. Peter." Ms. Batiste was concerned because the doctor told her she had high blood pressure the last time she went to Charity, but "I'm sure all along it's been high-pertension. I don't know, I guess high-pertension can make you go into high blood pressure". Ms. Batiste said she had high-pertension because she worries too much, "My children say' Mama, you worry too much', and I guess I do have my share. The doctor thinks I'm real worried or upset about something. Sometimes that comes up. They ask me if I'm worried. Is it somebody I'm living with or something, my children? They ask me that a lot".

During one interview a bill collector came to the door. When Ms. Batiste came back she said "you see this works on my nerves too, this is why my pressure goes up". Her doctors had prescribed Lasix (a diuretic) and Slow K, a potassium supplement, which caused no side effects she was concerned

with. "It [the medicine] don't bother me, it don't cause me any hardship." She did admit:

> I skip the pills some of the time, but I do try to take care of myself more better as I get older, a stroke is what I fears. I just don't feel like it sometimes. When my blood goes up, I don't think it really does me any good, and I don't want any of it on the other days. I just don't think I really need all that stuff...I just try to stay relaxed and get rest. I think the Lasix is just for fluid, I don't know if it really does anything for your pressure".

Ms. Batiste used to take Sinequan "for my nerves", and she thought that helped. She now takes Benadryl, an antihistamine, for an allergic rash, and feels it helps her high-pertension. "The Benadryl helps some but it makes me too sleepy. Sometimes I'll take a Goody's [a headache powder] to relax. I heard of drinking carrot and celery water, but that's just nasty." Ms. Batiste took only about 40% of her medication and her blood pressure was poorly controlled.

Even where medication is considered possibly effective other aspects of the illness "High-pertension" make it difficult to control. In the next case, the episodic, unpredictable nature of high-pertension is significant.

Case 3: Florida Joseph is a 54 year old widow with eight adult children. She lives with one of her daughters "little Florida", who pays the rent, and little Florida's two small children. Ms. Joseph receives S.S.I check and her other children aid her financially. Her medication is paid for by "medicaid". Ms. Joseph has had high-pertension for about 18

years. It began when she was still working in dietary services at a hospital.

> At work you had to keep your anger in, if you got mad there wasn't nothing you could say about it. You'd get mad and flare up but you'd have to keep it in to keep your job. Ad that kind of stuff builds up in you and makes your blood go up...with high- pertension there's no warning, you don't know when your blood's gonna go up so you can't treat it like high blood.
>
> With high blood:
>
> You know the blood's always up so you can do what's necessary to keep it down. You can take your medicine, you can do things, work on it all the time...With high-pertension there's no warning, you don't know when your blood's gonna go up. It could be down, you could be feeling fine; and all of a sudden your blood goes up so high it could kill you. That's the trouble, no warning; you don't never know when to take your medicine...I might be at the grocery store and get dizzy because the blood goes up. I have to sit down and wait it out and take some medicine or I might fall out.

I asked Ms. Joseph why didn't she just take it all the time, just to be sure. She said taking:

> all that medicine when you don't need it, that works your system too hard, Besides that's not the main thing. As long as I'm calm, I'm all right. But if I get excited, my children get sick, my pressure will shoot up...People who get high-pertension are people who are under pressure and a lot of things happen that they can't do nothing about.

Ms. Joseph said she had not been taking her pills because her "blood's been okay". Her blood pressure was never controlled in the whole time I saw her. When I went to see her for her last blood pressure measurement no one was home. When I called later in the day "little Florida" said her mother had been taken to the emergency room because she

was feeling sick and her blood pressure was too high. When I last spoke to Ms. Joseph she said "Well, with that high-pertension you never can tell."

Unlike Ms.Batiste, Ms. Joseph believed that medication could possibly help her high pertension. Since, the illness is so unpredictable, and volatile, however, she never knew when to take it, and disapproved of taking medication at times when it was not needed. Consequently, Ms. Joseph's compliance was poor.

The interaction of folk beliefs with side effects of certain blood pressure medications can be influential, in different manners, depending upon the individual's interpretation and assessment of the situation. The next two case illustrate this.

Case 4: Lillie Dubose is a 70 year old spinster who lives alone in one side of a small "shotgun" double. Her only living relative is a married brother. She was experiencing severe financial difficulties since her only income was less than $300 a month in Social Security. She did get her medication free through "Medicaid". Ms. Dubose says she has "low blood" and high-pertension. She knows she has low blood because her mother had it and because she was very pale and has small veins like her mother. Ms. Joseph is not sure when her high-pertension started because she had only gone to the doctor this year at the urging of her brother. She has high-pertension because "I'm poor and worn out and there's a lot of pressure on me". She had worked as

a housekeeper all her life and now the doctors have advised her not to work. Now, she says, she has no money and can not eat like she should. A year ago, she had to move out because the house she had been living in around the corner had been sold and the rent was being raised. Ms. Dubose had had to move her things largely by hand and that is why she had high-pertension now. She said high pertension means you have too much `pertension', you are too tense and the only thing for that is "not to get mad, for your life to change or to die. It will knock you out, much quicker than high blood pressure."

At first the doctor prescribed "Aldomet" but that made Ms. Dubose feel "very, very sick." The doctor then changed her to "Minipress" which like "Aldomet"can cause weakness, dizziness and drowsiness although usually only initially. Ms. Dubose said the doctor was experimenting on her with a strange drug and she did not want to take it. She bought the "Minipress" but it made her feel ill as well. Ms.Dubose said people have a big vein in your head where the blood collects. (This she says only is found in humans and pigs). The medicine was pulling the blood down too hard, all the way down to her feet. "I can feel it going past my knees, they ache and feel weak. She's [the doctor] pulling all the strength out of my body." Ms. Dubose took no more medicine.

Ms.Dubose interpreted the side effects of dizziness, drowsiness, and weakness to mean that the medication was pulling her blood down too far. In combination with her

condition of low blood, the medication was drawing the blood dangerously low and sapping the strength from her, resulting in her refusal to take the medication. Experiences with the same medication can be interpreted differently however, as the next case demonstrates.

Case 5: Odile Porche is a 66 year old woman with high-pertension. Ms. Porche says it runs in her family, you get it from being nervous and worried and upset. Ms. Porche says she gets "pertension attacks" when she yells and screams and gets mad.

> Child, I tell you, I have had it bad. It's not too bad right now, I haven't had one [an attack] in a long time. What I do is I stay in bed a couple of days and the next day I'm feeling alright."

Her attacks are unpredictable:

> With high blood you know its up, but the pertension can hit you at any time. It bothers me some, but there's no sense in worrying. You get to worrying and you're just gonna run your pressure up. The pressure pill helps. You have to take all that medicine. It all has a drug in it. It makes you quiet and calm and that's what they want you to be. I take it and it puts you right to sleep, you can't stand up. I think it really works.

Ms. Porche is taking "Aldomet", the same medication which Ms. Joseph first took and which she felt made her sick, yet Ms. Ms. Porche interprets her experiences differently, perceiving the drug to act as a sedative. It therefore is of use in the treatment of a nervous disease like high pertension. Since Ms. Porche, however, like Ms. Joseph, only feels the need to take her medication when she has an attack,

she is medically noncompliant and her blood pressure is poorly controlled.

The behavioral environment becomes more complicated when high blood and high-pertension are both involved and complicated by financial contingencies.

Case 6: Doretha Jackson is a very large woman who has both high blood and high-pertension since 1957. Having left her husband after he started "acting ugly", she raised three children by herself, and cared for her dying mother the "best way I knew how". Ms. Jackson has always had financial difficulties, having twice lost all her possesions once in a hurricane and two years later in a fire. She now lives with her youngest daughter who works as a nurse's aid at a local hospital, and her 7 year old grandson whom she cares for while her daughter is working. When I first met Ms. "Dee" (as she likes to be called), she was taking prescribed antihypertensive medication for her "high blood", watching her diet and drinking white vinegar. She said the pills "thin and draw water off you're blood, I think they cool your blood". For "high-pertension" she said, she was trying to control her mind.

> I've always had a bad temper you know, if you can control your mind, you can control your blood. But that mind makes your blood start to boiling like in a pot. The pills ain't gonna stop it, you're gonna have high-pertension no matter what, there's no one who can stop it except yourself.

In the next few weeks when I saw Ms. "Dee" she was having financial difficulties. Her daughter's hours at work

had been cut back and Christmas, with its expenses, had just passed. When I asked to count her pills she said she had run out.

> I didn't have the money, you know, so I been off them for about a month. I had me some little expenses I had to take care of and I just didn't have the money. Besides, I'm watching what I eat for high blood, I'm real good about that, I use margarine or Crisco cause meat and butter have grease. Margarine cuts your pressure and grease will make it go up. I've been drinking vinegar too...I wouldn't mind buying the medicine if I had the money, but I'm careful of what I eat and it won't help the high-pertension anyway. You have to think positive, not negative cause if you think negative that will hit you and make your pertension build up and that will be something else.

When I last saw Ms. Dee, she had been off of medication almost two months but had just had her prescription refilled by half.

In this instance a patient was willing to take her medicine, but since she needed to spend her money on other things, she felt she had acceptable alternative strategies to manage her health. Her beliefs supported taking medicine for only one of her "pressure troubles" high blood, but not high-pertension. She was noncompliant in the sense of obeying doctors orders, but from her own perspective she was adequately managing her illness.

Unlike Ms. Jackson, Ms. Dubose and Ms.Porche, had no financial obstacles to taking medication, yet their assessment of the nature of their illness and medication precluded complying with their prescribed drug regimens. Ms. Jackson would have complied had she been financially able. Each of the six cases thought they were taking appropriate

steps to manage their illness and support their health, yet only one, Ms. Bernard could be described as compliant from the biomedical viewpoint.

Afro-American Blood Illness and the Moral Order

Before I had access to the work by Weidman and Farmer, I began thinking in terms of a thermometer model for the pathophysiology of high-pertension and high blood. Only later did I read that in Farmer's analysis, bodily fluids, including blood, were used as "moral barometers" in Haitian folk illness (1988). The condition of certain bodily fluids were, in Haiti, said to represent one's social and moral state of affairs.

Later, I also read Weidman's analysis of blood conditions in Haitians, Bahamians and Southern Blacks in Miami, which agree closely with Farmer's assessment (1978). Weidman used the analogy of a container (the body) bearing numerous channels (blood vessels and organs) contaning a fluid under pressure (blood). The similarity of container and fluid models is obvious in the analyses by Farmer, Weidman, and myself. More to the point, however, is that both thermometers and barometers are instruments of measurement.

Weidman noted that well-being depended upon the maintenance of a healthy full-bodied state of blood with just the right amount of strength to support the body and ward off disturbances from outside the body: from natural, super-natural, or human sources.

This agrees closely with the data from New Orleans. The situation was described in this way by one of my informants who had both high-pertension and high blood:

> You need a little bit pressure. You need a certain amount in your body like a plant, you know. If you don't have enough you'll fall over all weak and get sick. You need a certain amount in your body to keep you strong. Like aspirin, you put aspirin in the water that you give plants. And you need some medicine in your body too; it prolongs life. But just enough, too much or too little, too much or too little of anything and you get sick.

According to Weidman, the overriding concern in Afro-American health culture is to have good elements enter one's life and to have the bad leave it. Anything falling short of this goal is disruptive of the blood's state and can cause sickness. "... the body is the arena in which disturbance manifests itself" (Weidman,1978: 569). Two disorders examined by Farmer, move san and let gate, serve, in his analysis to "submit private problems to public scrutiny" (1988).

The body can be seen as an instrument measuring disruption and distress in the interaction of the self and its environment. This is the case as well in high-pertension, which is a disease cause by emotional upsets and an excitable temperament. Episodes of illness imply disorder in one's life causing upset.

To a certain extent this may also be true for high blood. Although high blood seems a rather mechanical illness with little social or emotional implications, it may not be quite as simple as that. Possible meanings of high-

pertension and high blood will be discussed in the next chapter.

NOTES

[1] Eight informants explicitly used the term `high-pertension'. They explained it to mean one had too much `pertension' a general term to describe stress,`nerves' and worry. More may have been saying `high-pertension' but, by not specifically mentioning `pertension' I misunderstood and thought they were saying `hypertension' which is a homonym of `high-pertension'.

In this report `high-pertension' will be used to distinguish it from the biomedical `hypertension' and Blumhagen's `hyper-tension'. `High blood pressure' will be used the same as hypertension, whereas `high blood' will be used for the folk illness contrasted with `high-pertension' in New Orleans.
High-pertension will be used in direct quotations of informants only for informants who explicitly distinguished between the two folk illnesses in their interviews.

[2] The source of these symptoms is problematic. It is possible for antihypertensive medications to cause many of these symptoms as side effects, yet many women experienced these symptoms before undergoing treatment. Some of these symptoms can be attributed to severely high blood pressure not being treated, while nosebleed can occur in even moderate hypertension. Many of these symptoms are nonspecific to hypertension. It is possible that some persons aware of cultural illness models interpret nonspecific complaints such as headaches and dizziness as part of the experience of high blood and high-pertension.

[3] Recent research suggests that "cures" of mild hypertension can occur. Clinical trials of 184 mild hypertensives showed that sodium restricted diets and weight loss allowed approximately 70% of the sample to maintain blood pressure control for five years after withdrawal of prolonged drug therapy (Langford, et al., 1985).

CHAPTER 7: UNDERSTANDING ILLNESS EXPERIENCE: THE MEANINGS OF HIGH-PERTENSION AND HIGH BLOOD

Meaning and Emotion in Illness

I have argued that the implications of a chronic illness for the self are important in understanding illness behavior. It is the emotional emotional engagement of the self in a situation which accounts for action (Rosaldo, 1984). Illness has emotional as well as cognitive meaning for the self, which together serve as motivation to action.

Semantic network analysis has been developed by Good and utilized as a method to investigate meaning (Good, 1977; Blumhagen, 1982). This is simply the presentation in schematic form of the various connotations associated with a single symbol, the illness. Good calls these semantic fields. These are taken from informants statements about the nature of an illness. The weight a certain connotation carries is indicated by the number of informants (or percentage of sample) stating it. Interrelationships are taken qualitatively from informants' statements.

This is not ethnoscience. As used here it is not intended as a precise method, and no assumptions are made about correspondence betweeen the diagram and cognitive or cultural structure. It is intended simply as a useful way to graphically present quantitative and qualitative information concerning illness connotations for the purpose of discussion.

Semantic networks of high-pertension and high blood will be presented to demonstrate the metaphors inherent in

the folk illnesses. Since behavior cannot be explained by belief alone, the emotional valence of these metaphors will also be discussed as a bridge between belief and motivation to action.

The Meanings of High-pertension

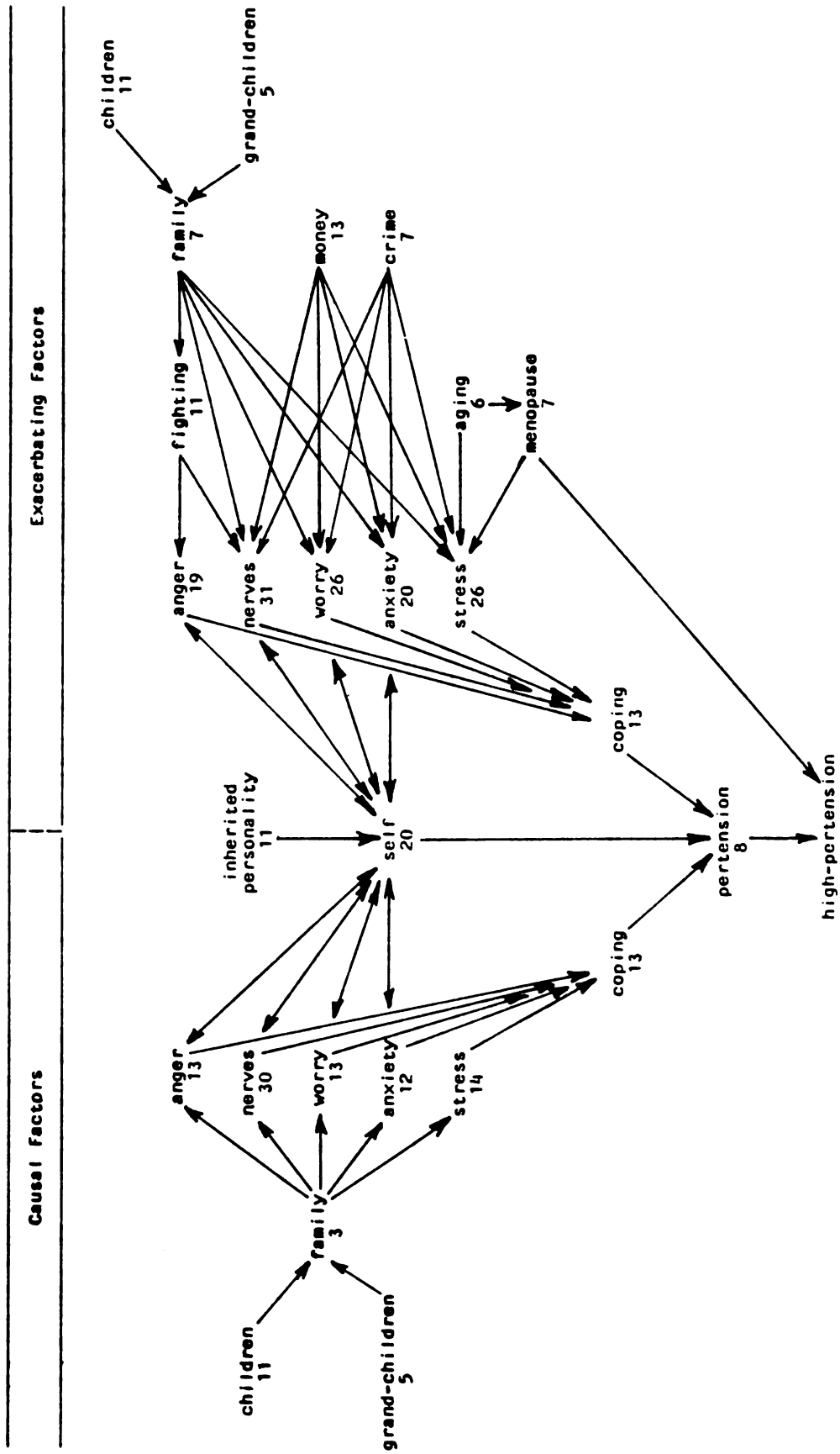
Emotion and Disruption in the Behavioral Environment

High-pertension is overtly a disease expressive of psychosocial disorder. By this I do not mean to imply the presence of psychopathology, but distress and disarray in one's behavioral environment. There are several meanings of high-pertension. These meanings refer to one's emotional, cognitive and social life.

The semantic network for high-pertension exhibits much density in the area of emotional causation and exacerbation (See Fig. C, p. 147). To say that one has high-pertension is to say that one is experiencing considerable emotional arousal. Several emotional themes are expressed in high-pertension. "Nerves" or "bad nerves", in itself a folk term (Guarnaccia and Farias, 1987), was considered a major cause of high-pertension by almost all of the women subscribing to folk illness models. Terms such as anxiety, worry and stress were also frequently used.

Figure C

SEMANTIC NETWORK OF HIGH-PERTENSION
N = 32
Positive Responses



The importance of these themes is demonstrated in the following statements:

> It's the children. You know these children just work on my nerves. That makes your pressure go up, all their fighting and fussing. They be fussing and I be hollering, and that be working on my nerves. [L. Armstead]
>
> I have nine kids and that's enough to run your pressure up... The doctor told me I had high blood but I know it had to be hypertension. I always had low blood, I always been a skinny little thing...It had to be my nerves that ran it as high as it was. I was going through menopause, it started after my periods stopped and where would the blood go except to my head, But I really think it was my nerves. The older I get the less I can take things. My nerves are broke. [R. Bell]
>
> I know a girl at work that has it real bad. She was at work and got sick and was looking for pills. I told her I had it too. She had it really bad. She can be sitting around and if somebody drops something on the floor she'll jump ten feet in the air and start screaming. She gets real, real nervous. I don't have it that bad. [R.Bell]
>
> I try not to worry about it. There's nothing you can do. And if I worry I'm afraid it'll go up worse." [L. Gilbert]
>
> It goes up at the doctor. As soon as I walk into Charity and see those white coats, it jumps up. I'm afraid of what he's going to tell me. [L. Verrett]

Nerves are said to be "like anxiety and worry" except that there is frequently a physical manifestation. With "bad nerves" an individual frequently experiences trembling and shaking. He or she may cry out, scream or shriek, or feel a compelling urge to do so, even though one may not. A description of an attack of nerves is quite similar to a many descriptions of an episode of high-pertension [called by some a high-pertension or pertension attack] but it does not

necessarily involve the folk cardiovascular system of improper blood states and rising blood in the body.

I asked an informant the difference between nerves and high-pertension:

> When you got nerves you be worrying and thinking about something and you be shaking and afraid, and you scream and say `Lord have mercy, somebody help me'. But when you with high-pertension, you be shaking too and you don't know where you are. You might be mad and screaming, and the shaking is more on the inside too and your blood runs up real quick like. You might get the staggers and fall out. [T. Coleman]

The following statements are examples of high-pertension episodes.

> When I was little they took me to see a girl from school. Lord, have mercy, she was all crippled up. I couldn't take the shock. I started screaming. In a few days I had pertension and I started screaming and shaking. I wouldn't let anyone near me. They had to hold me down. My auntie put vinegar on my neck to bring the blood down. [A. Dabney]

Ms. Bell works part-time as a telephone solicitor. It's a high pressure job. "That man keeps coming around to see if you calling". Her high-pertension began around ten years ago.

> I had a lot of troubles. I felt like I was going to fall out. I was dizzy and weak and nervous. I didn't know where I was. I was taking care of a sick father, he had sugar diabetes and had to take shots. He was incontinent. I didn't know anything was wrong until then. I started crying a lot. I stayed in the hospital six weeks and I was shaking and crying all the time. The doctor said he couldn't find anything, it was just my nerves. He said what I should do is go out get drunk and have a good time. [R. Bell]

Apparently "nerves" is slightly more of a somatic state than anxiety, "stress" or worry, but less so than high-

pertension which involves the blood. Nerves can lead to high-pertension (but not necessarily), yet having high-pertension can be the cause of "bad nerves". One can suffer from nerves without having high-pertension.

One singular symptoms of high-pertension, experienced by several (13) women with high-pertension, is what they call "disorientation". This was mentioned for high blood by only two women. Disorientation seems to be a state of emotional arousal wherein doesn't know what one is saying or doing. One does not know where one is or loses one's direction, and one may experience alterations or impairment of the senses ("It's like being in the twilight zone"). This may be accompanied by the "blind staggers" (one stumbles blindly into things) and a feeling that one is going to "fall out".

Some of this can be explained biomedically by severe hypertension. The important point, however, is that informants see it as part of the experience of high-pertension and extreme emotion. The opinion seems to be that a strong emotion overpowers one, so that one is "not one's self." Examples of disorientation and high-pertension are presented here.

> I used to have bad trouble with it. It would go up and I would be yelling and carrying on. I would be saying things, sometimes horrible things, and not even knowing what I was talking about. And half the time I wouldn't remember any of it after. Most of the time now though, I just have a little dizziness. [R.M. Batiste]

> Once I went to sleep on the Galvez bus. The bus went to Canal Street. I thought I was on the wrong bus. I got disoriented, I got scared. Everything seemed different on Canal Street. I was at Krauss

> [department store] but it looked like it was in the wrong place. I smelled blood on my breath. I got all hot, and I went into Krauss and started falling into things. People were looking at me and saying things I couldn't understand, and I ran out of there. I got myself to Hotel Dieu [hospital] and bathed my face, and then I felt better. [E. Perez]
>
> I was making my groceries at the Venus market on Dryades Street. I was worrying about my mother and how she died and left me all alone. That scared me a lot. I was grieving and the devil was busy. I felt dizzy. I got disoriented and I heard people talking but I couldn't see no body around and I could see but I couldn't really see, and I was feeling sadder and sadder. I started walking funny like all over, and I was all disoriented and I didn't know where I was or what I was doing. I started falling over and some children I knew stopped and helped me get home. And that's how I knew I had high-pertension, cause of being on Dryades." [A. Taylor]

It is interesting that what would be called anxiety by psychiatry and psychology seems to be so important in the sample. Anxiety has been mentioned as a problem in other writings on New Orleans Blacks (Jacobs, 1980; Rohrer and Edmunson, 1960; Davis and Dollard, 1964) Whether this means that there is inordinate anxiety among Blacks in New Orleans in comparison to other cities can not be ascertained from present data. Rather this is a problem for psychiatric epidemiology. When one considers the difficulties met by Blacks in New Orleans, high levels of anxiety would not be surprising. In any case, anxiety is certainly perceived to be a serious problem by my informants, particularly in reference to high-pertension.

Anger that is difficult to control is also considered important in the etiology of high-pertension. Explosive expressions of anger or its suppression are described in

terms of regret. Depression, sadness, and grief are also emotional states mentioned by informants.

> Boy, when I get mad my blood runs up and I ache all over. I get angry, I get mean; I feel like I'm just gonna pop. [L. Payton]

> High-pertension, that's anger that comes over you. Pertension hits the brain and causes the brain to expand. It gets larger in the head like you're gonna burst.[D. Jackson]

> There's a difference between just getting mad and getting mad from high-pertension. When you get angry there's a difference; you get real, real mad and you can just scream. It's not like when you just get a little bit mad and just normally get angry. With hypertension you could just scream; you want to pop. [T. Coleman]

> If only I could just keep my mouth shut. With high-pertension I get real nervous and all upset and angry and mad. I get so angry. I don't know what to do. I just can't stop. I can't control it. It's a disease I wouldn't wish on a dog. [E. Perez]

> In high-pertension you get mad and upset, or you get your feelings hurt and you know somethings going on. You get excited, other people are all excited and then you get excited yourself, or sometimes you start feeling sorry for yourself or maybe you feel sorry for people. You have a deep sympathy for them. You start feeling sorry and you're feeling really sorry for yourself, and having really strong feelings, and those feelings seem to get the best of you, and you get high-pertension. [B. Morgan]

The Social Milieu

The source of this emotional distress most often is said to be disruptions in one's immediate social milieu, although problems such as crime and finances are important as well. Problems with family relationships, contemporary and past are the most prominent (see Fig. B).

Cecile Rogers is a widow who lives alone in the house

where she raised her children. One daughter and her grandchildren live across the street and others live nearby. Ms. Rogers has high-pertension which she attributes to her marriage:

> I had problems with my husband that brought it on. I didn't know I really had it. I used to have headaches but I was ignoring it. I went around feeling bad all the time, trying to hold things together. I have it from tension and worry and alcoholic husband.

She had spent her life with him but:

> Girl, girl, it was a trial. I could tell you stories. Now he was a good provider, I got to give him that, but he caused me a lot of trouble. He was out drinking all the time and when he wasn't he was in here with his fighting. I did right by him though, I took care of him when he was sick. I don't have nothing to feel bad about. It's a shame to say it, but I'm glad he's gone. Now I just need to get out the house, away from all those bad memories. I got high-pertension from my past life. My children say I need to go out for a ride, and me and the lady next door sometime we take a ride on the streetcar. That seems to help. I'm getting high-pertension from just sitting around this old house.

Multiple worries and problems have contributed to Theresa Coleman's high-pertension. A 51 year old divorced Catholic with, nine children, Ms. Coleman lives with her daughter and son-in-law. She just started having high-pertension about a year ago, and says it was because of her family. She had had a lot of problems with her children, and she was divorced from her husband:

> But he kept coming around and bugging me even after the divorce... See, we had had a lot of money in the bank, but when my husband left and I went to take the money out of the bank, the money was gone, and there was only a dollar in the bank. He had taken the money away and spent most of it, and I couldn't get any alimony from him. I was trying to

> take him to court and there was a lot of trouble. He kept coming around and telling me stuff, threatening me and things like that, telling me I was going to Hell for divorcing him. I didn't feel real good about that, but he left me, I dont' see why I have to put up with it.

Ms. Coleman is also concerned about her children. Her son has already had two serious auto accidents and was arrested for drunk driving:

> I went to the country to see my son the other day and he was speeding back driving at 85 miles an hour. I told him he's the reason I have high-pertension...My baby girl in there [in the next room], she has sickle cell real bad and she's getting sicker and sicker and weaker. That's why I'm staying here these days, and she has a little baby herself. My younger son has it but he's never been sick with it, not like this...I definitely think that's the reason for my high-pertension, the divorce and my children.

Problems Representative of Older Black Women

Many of the problems expressed are especially representative of older Black women. Since they generally have large kin networks and occupy a central role in these networks, they have much responsibility and the worries which accompany it.

They are worried about their children, whether they will find employment, become involved with crime and drugs, and stay out of jail. These problems have all been made more acute by Louisiana's poor economy and are keenly felt in the poorer neighborhoods.

Crime

Many of New Orleans' neighborhoods can not be called safe. Several of the public housing projects I visited have

been the site of gang murders, and are increasingly becoming known as battlegrounds in the drug trade. Violent crime outside one's door is a way of life for many women interviewed. The day after I visited one woman in the Magnolia housing project, there was a gunfight between police and two men right in front of my informant's apartment. Shots entered several businesses on the block and my informant is now understandably frightened to open her door.

Imelda Larks has high-pertension and high-blood and lives in the Calliope St. projects, currently being fought over by rival drug networks.[1] Two years ago her 17 year old son had gone out to buy groceries. He was crossing the open court in front of his family's building where groups of people usually congregate. He was a few feet from the stairway door, when an argument broke out among some men. Guns were produced and Ms. Larks' son was killed when he was accidentally shot by a stray bullet. She has another son living with her who continually gets in arguments with the people down in the court. Ms. Larks lives in fear that he will suffer the same fate as his brother. She says this runs her pressure up.

Fatigue

Many of these women are simply tired. Lives marked by constant work, worries about money and children, and a struggle to maintain a minimum standard of living, have simply taken their toll. The life circumstances of all the women in this sample belie the stereotyped image of the Black

welfare mother, avoiding employment and giving birth to children to reap increased welfare benefits. The next cases are expressive of the hard work and fatigue informants have experienced and their role in high-pertension.

> It came from working too hard and having a drunken husband. I got fed up and left him and the house with my children. I had thirteen children, that did it too. I was worried and working and taking care of the white family while I had my own babies...I got no complaints, they treated me like family, the boys still come to visit me, they's grown now...They call me Mama, they say "I got a Black Mama and a White Mama." But when you got to leave your own babies what are sick, to take care of somebody else's, well that kind of gets to you. They'd cry and carry on and say `Why you leaving us to take care of them white children'? And I'd say `Well...you want me not to work and you want to starve?'...But it wore me out, I'd get home, hear'em their lessons and sleep a little while. Then I'd fix supper and get everybody to bed. Then I'd be up while it was still dark getting their clothes and cleaning and I'd wake up the big ones. I was gone on the bus before the babies got up. [A. Eugene]

Amy Washington is a 56 year old woman with high-pertension. She has never married and has one child living away from home. She works as an aide at a public nursing home on New Orleans' West Bank, across the Mississippi river from the main part of the city, Charity Hospital, and other public health care. She lives in a rather out-of-the-way West Bank neighborhood along the riverfront, accessible by only one through street and far from public transportation.

> There's a lot of high blood pressure in my family. Mama gave it to all of us, it came on down the line. I'm the only one with high-pertension though. High blood is something you inherit, but high-pertension come from nerves. It got bad as I got older. I guess you have more problems as you get older. I went to the mental health clinic and

they said I have bad nerves. Bad nerves'll make it worse.

My sister says to rest. Well she can. She's got a house and a husband. She stays in bed late and watches her stories. She gets up when she wants. Me, I'm pulling double shifts trying to pay the rent on this piece of trash [her apartment]. I tell you I am tired. I got my brother's baby girl staying with me,and my boy is in college in Michigan. I don't know when I'm gonna be laid off. Thy're talking about closing us all down. Now where's them old people gonna go?

...I don't know what the hell my pressure is. I can't keep running to Charity, they won't let me off work, not for that long. That car out there stopped running, my brother's supposed to look at it but I ain't seen his face yet. I got to take three busses to get there and I got to walk all the way to General De Gaulle [avenue-a little over a mile away] to catch one. I'd be gone all day and dead by the time I by the time I got there.

I gotta be careful, you can't stir things up too much cause they's alway's got people watching, waiting to complain and next thing you know I'll be the next to go [be laid off]. Sister [a Catholic nun who was also a physician] had her clinic over here at Fischer [public housing] but they closed her down. Now we all gotta go across the river. You know, I guess my blood would be down too if I could stay in bed all morning."

Personal Tragedy

As a group, those women having high-pertension seem to have experienced an inordinate amount of personal tragedy. A few striking examples will be presented here, but continuing themes of tragic personal loss will be evident throughout subsequent informants' discussion of their high-pertesnsion.

Johnnie Johnson is a 51 year old woman who lives with her daughter in a dangerous neighborhood in half of a sparsely furnished "shotgun" double. She keeps it tightly locked with the shades drawn. Twice when I went to visit her

there were men outside loudly arguing. Once, the argument came to blows, and I was very frightened standing on the porch while the men fought across the street. It seemed like an eternity before Ms. Johnson's daughter unlocked the door to let me in.

Ms. Johnson discussed her condition:

> High-pertension is when you're thinking on something real hard or you worry real hard. I had a lot of pertension. I think high-pertension comes from worry and grief. My family thinks I worry too much; they try to keep worry from me. In 1971, I had a 21 year old daughter that was murdered and left a 4 year old child. I had a 18 year old boy killed in 1976. All that had come into it, I guess. They never knew who did it, they just found him, shot with a bullet in his neck.
>
> I've been doing better though. I had a hysterectomy that made my blood go up some but I'm not worried, it only makes things worse. It doesn't worry me now; it worried me at one time. My granddaughter was dying with sickle cell a few years ago; that was pretty bad. It took a long time...But after that was over I been feeling better.
>
> It's just when you get older, high-pertension's when you get older. It might go away if I keep myself strong and try not to think back. See, my brother had a stroke, he's got high blood. I keep after him to take his medicine, but he don't. For high-pertension there's no medicine. But Alfred, he's just contrary. He don't want to be bothered.

Ms. Johnson called one day to cancel a meeting. She said there was sickness in the family and she wouldn't be able to see me for a while. I called and began seeing her again almost two months later. I saw her for two more meetings. One day she called to cancel our appointment, her brother Alfred had died with a heart attack. She said she felt too bad to see me and she'd call later. A few weeks passed and I

called again. She said to give her some time, she needed to wait till her life was more settled. I called again and spoke with her daughter, who promised to have her return my call. I did not hear from her again. Quite possibly her life has never become settled.

Several women with high-pertension have been treated for mental health problems. The following case is of a woman who had a long history of psychiatric problems. I had no access to her psychiatric records, and her medical records simply noted that she had been treated for depression and anxiety. The events of her life readily offer themselves as possible cause.

Andrelean Dabney is a 64 year old woman who lives in the St. Bernard Projects with her 17 year old "son" (he is actually her sister's son whom she raised) and 15 year old granddaughter who call her "Mama". There usually was a flow of young people, many of whom called Ms. Dabney "Mama", in and out of the apartment. (It is uncertain how many were actual kin and how many were simply using this as a term of affection and respect). Ms. Dabney says she had three children, all boys:

> I had three "C" sections for my children and I didn't need any transfusions at all my blood was so high...My pressure's never been normal. It started when I started having children 40 years ago. I didn't know I had it. I was born with high-pertension and didn't know it. Everybody in my family has it, my children were born with it. Of course two of them are dead and that worries me a lot. That's one reason I have it. My husband died when they were very young and I had to raise them by myself.

Ms. Dabney never remarried. She spoke about her sons' death:

> They had gone to the country. Someone they knew knew with a newborn baby called to them. They were in a boat and called to them saying the boat had turned over. My boys were both lifeguards and one just jumped in but never came up. And my other boy jumped in after him and he didn't come up either. The undertaker had them embalmed before I even got the call saying they were dead.
>
> They was murdered, that's what I think. There was somebody in the water down there and them peoples did it on purpose and pulled my babies down on purpose to rob them. And that embalmer he did it cause he wanted the money. The man from Channel 4 Eyewitness News came and told me there was some sort of a coverup when I went to get they bodies. They killed my babies so's they could get the money, and everybody else and the police kept they mouths shut so they could keep the money too.
>
> That's why I got it [high-pertension]... I go to church and ask God to help me. I ask Him why's He done this to me... I'm worried all the time. Anything that comes along. Yeah, give me nerve pills, that's what I need...The doctors are giving me a blood thinner. They call that thinning the blood to keep the blood clots out, so your blood don't get stuck. But I want nerve pills...It was worse after my children. For a while my mind left me. I didn't know names or anything. I'm not worried, if I worried I'd be dead long ago. You just give yourself up to God.
>
> Sometimes I think about that when I get real down. I get so nervous I start to drop things. I ask God to take me away. I don't want to be a burden on anybody like that. I don't want to leave my children to take care of me. I'd rather just leave my children. When God's ready he'll get them and take them. Sometimes I ask God to take my child first, so they don't have to take care of me.
>
> And you know it happened with my boy. I knew it would happen, I had a funny feeling. I opened up my eyes once and I saw my husband and my aunt. They were both dead and I saw them coming in blue and white. And I said `I hope you ain't coming to get my child'. When they come to me I realized what was happening. It was a week before. I said `Lord, what are you all come here for?' If it was a

> blessing or something, a dream, I don't know what it was.
>
> They killed my son not long ago. They shot him, and they carried him to the St. Thomas Project. For no reason, for no reason they planted dope on him around his hands. He was a good child; I know they just did it to be mean, they was somebody who didn't like him. He was a good boy and I know he wouldn't have done anything like that. [This was not her biological son, but a grandson whom she'd raised].
>
> Yeah that give me high-pertension. But you just gonna be sick, it's just God's will. There's a lot of pressure in my family. When you live with pressure you never know when you're gonna die.

Life Problems in High-pertension and High Blood.

Questions about personal histories regarding loss, death of children, and problems with violent or alcoholic spouses, were not systematically asked as part of the interview. Consequently, there is no base of standardized data on which to draw comparisons between groups. However, among those women having high blood alone (admittedly a small number), not one individual mentioned such a history of grave problems.

Rather, all individuals refused a sick label and said their families were well also. There was little sickness in their families. In general they portrayed their lives as stable, and characterized themselves as content. They were similar to Althea Bernard, the woman with high blood whose case was presented in the previous chapter.

Of all the women with high blood alone, only Anita Leonard expressed any significant discontent or worry, and this had not yet fully developed. She was beginning to worry

about her son's behavior, his choice of friends and possible involvement with drugs. She had high blood, but felt that she might be developing a case of high-pertension. Her situation will be described more fully in the discussion on the uses of high-pertension later in this chapter.

Problems of Self: Stress, Emotion and Coping

High-pertension's meaning is not only a matter of emotional arousal deriving from social disruption and problems of living. A key part of the illness is one's response to disruption in the behavioral environment.

Stress is a term used frequently by informants. As in most popular use of the term, it means disruption requiring response. Lazarus points out, however, that it is an interaction between self and environment that produces stress by means of cognitive appraisal (Lazarus, Averill and Opton, 1971). It is what one thinks of a phenomenon which causes it to be "dis"-stressing.

This is certainly true yet it leaves out the key to meaning and action, which is emotion. Not only is it what one thinks, but also how one feels about about a particular disruption in the behavioral environment that makes it stressful. Distress then is localized in the emotional and cognitive interaction between self and disorder in the behavioral environment. There is something about one's habitual ways of coping and reacting which produce distress, there is something about the self.

Twenty (63%) of the women with high-pertension said specifically that an individual had high-pertension because she had a nervous, excitable temperament and was given to worrying. High-pertension comes from who you are, and how you habitually relate to your environment with its problems. High-pertension can be viewed as an illness of temperament; an excitable, distressed self in the behavioral environment.

To illustrate this a few brief statements will be presented, followed by a few more detailed case examples:

> High-pertension is because of your personality. You the kind of person that get real mad and excited...I might get to the point where the high blood pressure'll go away, and I can stop taking my medicine, but I'll always have high-pertension, because that's just the way I am. [T. Coleman].

> I can't hold nothing in my heart against a person. I have to let them know. It's just the way I am. I guess I'm gonna have it [high-pertension] all my life. [L. Payton[

> I'm convinced the job did it.[Caused high-pertension] It's just the way I am, I have a really high pain threshold. I'm able to take an awful lot before I react, and that's not good for you. [E. Estiverne]

> Things scare me more than other people, I'm the sort of person that takes things to heart. I can hold it all in when there's trouble but then I fall apart later. [Florida Joseph]

> I think I have high blood, not high-pertension cause I'm a pretty stable person. In high-pertension, it means the least little think [sic], it gets flared up. You get upset all the time, your nerves get shattered. It's like having a nervous breakdown. [O. Doucet]

> My problem is pertension. Too much pertension. My pertension is real high. I'm not the kind that gets angry, but the kind that has to do stuff, to be busy all the time. I be running around outside in the yard, like you saw me just now, early early in the morning, hosing down the banquette [sidewalk], digging around in the flowers, I just got to be moving...It [high-pertension] means you're high tempered and your blood goes up. High-

> pertension is from the nerves that's got you high strung. [A. Tureaud]

Of those believing high-pertension came from one's self, nine individuals (45%) thought high-pertension could be caused by the inheritance of this type of personality.

> Yeah, I know about the high-pertension, but high blood pressure and high-pertension are kind of different. High-pertension is when you get upset. People getting angry is what causes high-pertension, but people getting angry, you can inherit it, like from your mother or something, if she was an angry person... But they both [high blood pressure and high-pertension] work on the blood. [T. Bourgeois]

Odile Porche's "pertension attacks" were described in the previous chapter as well as her belief that anti-hypertensive medication was intended to make a person sleepy in order to calm one's nerves. She says high-pertension runs in her family. "My daddy had it. He got mad one day and got a pain in the back of his neck and he died that night." Ms. Porche says she's just like her daddy, and her "pertension attacks" of angry screaming are just like her father's:

> My blood just boils, and you don't know what's making it happen. You can't help it. I can't control it, I'm the kind of person who just can't keep my mouth shut for nothing. That pertension can hit you at any time...It's higher and stronger than with pressure. If you have pressure your blood is up, but not as high as with pertension.

Odessa Marshall is a 52 year old woman who lives with her husband and four children in a small, sparsely furnished apartment at the rear of a larger house. Ms. Marshall had gone to a prominent Catholic girls high school, but had quit in the 11th grade to get married. The neighborhood is mostly industrial. Ms. Marshall's apartment is usually filled with

noise from the auto body shop next door. She has high-pertension and not high blood. Ms. Marshall says general "pressure troubles" run in her family:

> Mama has high-pertension, Daddy has high blood. He shows his feelings; me, I hold it inside... I'm just like my Mama, and she has it real bad, as bad as anybody could have it. She had a stroke. Mama tried to work it off. I used to get up and work. I never would stop or slow down, even when I wanted to. I just kept doing and doing.
>
> ...I used to hold everything inside, and it made me sick. My heart would be hurting. It would feel like I was gonna explode inside and scream. I would want to go into a corner to cry. High-pertension gets to your heart. You have pains, you're weak all over. You feel like you want to do away with yourself, do away with all the noise. You don't want to hear any noise. I can't stand noise.
>
> ...I think it was caused by my children, by having children. Maybe I should have waited. Maybe I should have finished school and gotten married a year or two later. I like school, I liked studying. But I had to learn. I think I was stupid doing what I did. I could have been a better person if I'd stayed in school. I wanted to be a nun. I wanted to be a WAC or a nun. Maybe that would have made me feel better about myself. I had the first two [children] too close together. There was too much keeping up and it made we want to scream. My sister said I had too many children and I shouldn't have gotten married to the man I got married to.
>
> What I should do is show it and take it out on other people. If I was a fighter I wouldn't have high-pertension. If I would have been a different person, I wouldn't have had high-pertension. If I'd done things different, I'd have been a different person.
>
> I just have to pray harder not to let it get me down. See my husband's not working and we have financial trouble now. I worry about my son. He has a bad eye on one side; I used to worry about how he'd do in school, but that's me. I guess I'm just a worrier. It scares me, it really do. I get scared with high-pertension.

The next woman's perceived inadequacies, a vocal and quick temper, in combination with worries have resulted in high-pertension.

Elnora Perez is a 61 year old woman with 9 children and 14 grandchildren. Her husband left 20 years ago. With only a 4th grade education, she worked as a housekeeper to support herself and her children. Ms. Perez has had high-pertension off and on since she was pregnant:

> It got worse around the time I started having trouble with my husband. But it's really me though. If I could learn to think before I open my mouth, but I gotta say what's on my mind...My husband has nervous problems too. He holds it in but I can't, I feel like I'm gonna explode if I dont' say something. They both work on the blood though. I get so angry, then I get a splitting headache and I have to lie down. I'm sick all over.
>
> Maybe things would be better once I learn to cope with life and not be so afraid about things that make me nervous. I have a fear of doing things right; I'm afraid I'll mess things up. It's just the way I am. That's just me. See I have to call Social Security for my daughter and I'm afraid I'm gonna get it wrong. I woke up worrying about it, I been thinking on it all day.
>
> ...Look at this, I got the shingles on my face and it hurts. That's no way to look. I don't want to go on the bus looking like this. I can't go to Canal Street. I'll go out worrying and it'll just run my pressure up. I might get the blind staggers; I don't know where I am. I'm afraid I'll fall out and people'll think I'm drunk or something...I'd be better if I could only learn to relax, but it's real hard for me. When I was out working and in real life, in full command of life, I never was sick.

The next informant has a self-described emotional nature. She has difficulties controlling her emotions, and feels these emotions are turned inward upon herself and building up. She is afraid that these emotions will cause more illness.

Bettie Morgan is a 50 year old widow who lives with an adult son in house that she and her husband bought just before his death six months later. "High-pertension is when you get upset and your blood jumps up all of a sudden; with high blood it stays high and you don't know it. They take it and tell you..."

Ms. Morgan has both high blood and high-pertension. "I've had high blood over 15 years now." She didn't know she had it:

> I was walking to the door to get my mail and fell out. The mailman found me on the steps. They took me to the doctor but my blood wasn't so bad then. It wasn't elevating like it is now. It's gotten worse. But I always did have the high-pertension even before high blood because I was always easily hurt and upset. It seems like I just take things to heart. I take things too seriously. I was always that sort of person that's easily excited. I always been an emotional person.
>
> If I get angry I try not to because it just makes me feel worse... but my father had a hot temper. I got it from him. My father had it because he was a strong willed person. It's not the way I want to be but I just can't control myself...With high-pertension I'm just not myself. If somebody cut my head off I wouldn't even feel it because I'm so upset and I'm just not myself at all.
>
> ... People who have a short temper have high-pertension. You get real upset and you hold it in. You get this feeling, this strong, strong feeling; and you hold this feeling in. You don't say anything, and it gets worse and worse. And then later on you still feel really bad and you feel like you want to cry and you can't cry. You just keep feeling like that, like the feeling can't come out and that's what high-pertension is. It's just this tension and excitement that builds up. With high blood pressure you might be getting dizzy and you feel pressure but you're not all tense like with high-pertension.
>
> The doctor fusses at me he says I don't have long to live if my pressures as high as it is. He said if I live till I'm 60 its gonna be real painful to live. I'm trying to take care of myself. I want to live, but

> sometimes I just get tired of living the way I am. It got worse after my husband died and I never been the same. I know I'm not not supposed to feel that way but I'm just tired of struggling. I don't know why he up and left like he did, it's just God's plan.
>
> Sometimes I dwell on sickness I sits and worries how bad I might be and then I get a headache and then I think this must mean I'm thinking too hard; then I worry about that. I think I must be giving myself a stroke.

In all of these statements one gets a sense of personal responsibility, of identification of self with the illness. It is not only a question of emotion causing high-pertension. Rather, to be emotional is to be high-pertensive. To be one's self is to be high-pertensive.

Illness As An Expressive Form

High-pertension is an illness largely expressed in somatic terminology, but expressive of psychosomatic phenomena, that is involving the psyche and the soma.

The term "idiom of distress" has been used by Nichter to describe the metaphorical function of some illness, that it symbolically represents psychosocial distress in lives of the ill (1978). While this is certainly true, it should be pointed out that the idiom is more than linguistic or cognitive. The sum total of an illness is much greater than verbal statements or cognitive representations of experience. Illness includes also somatic phenomena, emotion and behavior. Illness is lived, felt and performed, not only thought or spoken about.

High-pertension is an idiom in which to express problems in the interaction of the self and its behavioral environ-

ment, particularly in the social area. These problems are formulated and expressed in terms of the cultural aspect of the behavioral environment, the mythic world of the Black woman in New Orleans.

Blood seems to have great importance in the Black woman's mythic world, and this is expressed in high-pertension. One's blood rises with the problems of the world, at times it boils up and almost spills over. One's worries, fears, angers and frustrations accumulate as does one's perceived inability to cope with them, damaging the body and ultimately resulting in death.

The meaning of high-pertension can be seen from its appropriate treatment. Since high-pertension is culturally defined as a disease of the nerves and temperament, appropriate treatment is not biomedical but psychosocial. As Lillie Dubose, the 70 year old spinster phrased it, the only thing for high-pertension is "not to get mad, for your life to change or to die. That medicine's no good." This theme was repeatedly expressed by informants. Even when medication was thought possibly effective, the most appropriate treatment was rest, self-control and control of the social environment.

The Somatic Idiom

What seems to be occurring is actually two conceptually distinct phenomena, somatization and the use of somatic metaphor. Somatic metaphor means that something, frequently emotional distress, is expressed using somatic terminology or

symbolism. Somatization means the occurrence of actual somatic phenomena as expression of nonsomatic phenomena.

Somatization and somatic metaphor, while epistemologically separate, can easily be part of the same experience. The use of somatic metaphor to express some underlying emotional state implies the presence of somatic phenomena, since emotion is in part a physical event. Physiological events are an integral component of affective arousal (Cannon, 1929; MacLean, 1976; Levi, 1979). If somatic metaphor is used to express underlying emotional arousal, then it can be expected that physiological events will, to some extent, be associated with the use of this metaphor.

The cardiovascular system from both a folk and biomedical perspective is sensitive to emotional arousal. When folk statements about somatic response to emotional arousal are made (e.g. "Getting angry just runs your blood up"), they are true at both the metaphoric and hypothetical level. Folk medicine and biomedicine differ not on the question of whether affect can influence cardiovascular functioning in hypertension or high-pertension. They differ rather, as to the nature of the organs and processes involved, and the importance accorded to the influence of affect in etiology. When an informant says that a bad marriage or money worries runs her blood up, this is not merely a poetic statement about her emotional condition. What she says may well be literally so.

High-pertension is overtly a psychosomatic illness. It is expressive of emotional arousal arising from the perception of one's self as inadequately coping with distress in the behavioral environment. The sources of distress are social and moral problems. These sources are macro as well as microsocial, and moral, because there is a sense of personal responsibility for illness in the context of cultural beliefs about good and evil.

As noted earlier, the sources of distress are problems representative of Black women. This is especially true of older Black women who often find themselves in central roles of reponsibility for large networks of kin and others. They have greatly important roles in child-rearing, for their own children, and frequently grandchildren, nieces and nephews as well as fictive kin.

This is expressed in the etiological role of negative emotion such as anger in high-pertension. This negative emotion frequently is said to derive from problems with children and marriage. The burden of responsibility for holding one's family together, for survival and safety, is expressed in anxieties over finance, crime and drugs. These are not qualities of the self, but have their origins in the low status Blacks possess in the social order. Thus several levels of social phenomena are involved in the illness.

Not only does high-pertension present an idiom for the expression of negative emotion, it affords the Black woman an acceptable means for the its behavioral expression. The

idealized mother and wife should be loving, strong, opitimistic, and solicitous of her family's well-being. Uncontrollable anger, anxiety and sadness are not greatly valued traits in a mother.

Also, according to some studies, cited earlier, the expression of negative emotion has been a problem for Blacks in post-colonial America. High-pertension allows the legitimate expression of negative emotion which would

ethnicity, gender and social role. Since illness is the source of negative behavior, personal responsibility on the overt level (no matter what is believed on the covert level) is absolved. For women who are tired of holding their feelings in, or anxious about letting them go, high-pertension provides an outlet of personal expression.

Illness as Life Passage

High-pertension can be seen as something of a marker, a milestone of life passage. The biomedical illness hypertension is likely to occur later in life. So is the appearance of high-pertension which frequently occurs after pregnancy or childbearing. Menopause and hysterectomy are implicated in general "pressure trouble" such as high-pertension and high blood. At one level this is simply because there is no outlet for menstrual blood and this contributes to excessive blood volume (Weidman noted this in some informants). Menopause and hysterectomy are also

however, indicative of a life passage; menopause is commonly called a "change of life".

This sense of change is reflected in feelings about high-pertension. Twenty women said they noted a change in themselves and their life since developing high-pertension. They try to worry less and rest more. The following statements indicate successfully negotiated change.

> The high-pertension's not as bad as when it first started. Since I've gotten older I started letting problems not bother me. When you have a lot of children the problems get really bad and you take it all on yourself. But now that they're older I let it rest on them. If they still want to be with their problems bothering them, keep having all that foolishness, then there's nothing I can do about it...I don't let it bother me as much as before because I can't.[R. Bell}

> When I was younger, I used to worry about what poeple thought. But I don't worry any more. I tell what I feel, then bye-bye and that's that. My children are all grown; they can take care of they own troubles now. I'm gonna live to my retirement. [M. Claverie]

> I used to worry about my kitchen and always be in the kitchen, but now the doctor told me not to worry...about the house and I just sort of let the house go. And that's what you have to do if you got high-pertension...My granddchildren don't bother me at all, cause now I make'em go hom. They used to be always in the house all the time, but I finally put an end to that. [L. Jeannemarie]

> Nope, I ain't gonna worry about it no more. I put in my share on this earth. I ain't gonna make myself sick no more, that ain't right. I did my best for 'em when I could, but now it's their turn. That what you have children for. Now they can take care of me. [A. Cantrelle]

> We were talking about it the other day, me and my daughter. We were saying I'm not as worried as I used to be, now that they all grown, and I quit work. The nerve pills help keep my blood down a lot too. [V. Plaisance]

> I try to get more rest now. I try to walk and sew. Maybe I need to rest more. I try not to worry because

> if I worry too much I'll get sick. Maybe you should talk about what's bothering you more. I used to hold it in, but I changed and now my mouth's too big. [O. Marshall]

Gutmann, over the past twenty years, has comparatively analyzed the developmental psychology of aging in several cultures (See Gutmann, 1977 for a synopsis of this analysis). He notes among older women a detachment from socially ordained strictures and norms. This is not disengagement as proposed by Cummings and Henry, which describes a withdrawal from active life and the human arena in anticipation of death (1961). Rather it is a move from passive to active mastery of life and the environment. Gutmann says of this change in women:

> Across cultures and with age, they seem to become more domineering, more agentic and less willing to trade submission for security...looking across cultures at actual behavior, we do find mid and late life `women's liberation,' even where this development is not given formal recognition.

The data suggest that high-pertension may serve to provide this recognition, phrased in a socioculturally acceptable manner. High-pertension marks and legitimizes a change from one phase of life to another. It legitimizes role change. You can not legitimately say you are tired of being a mother, especially in a culture where motherhood is so highly valued. But you can say that sickness makes former role-specific behavior dangerous and, therefore, impossible. High-pertension is a culturally stuylized illness which allows behavioral change that would otherwise be frowned upon.

Illness as Instrument

Earlier, I discussed the expressive and instrumental uses of symbols. High-pertension is not only expressive of the problems and distress encountered in the daily life of many Black women in New Orleans, but it also offers them a way out. By marking a life passage, it allows change from a high to relatively lower pressured status. It allows women to at least partially put the role of the caregiver behind, and to acknowledge personal needs for care and to legitimately tend to one's own well being.

Furthermore high-pertension offers a means by which to defuse conflict and manage immediate social interaction. High-pertension can be used as a social tool for managing the social milieu.

One doesn't have to do much deep interpretation to see this. High-pertension is a dangerous, possibly fatal illness, which is volatile, episodic and unpredictable. Since episodes are triggered by emotional upheaval it is necessary to control the emotional tone of personal interaction and manage social proceedings. The following anecdote illustrates this.

Elnora Perez's house was always noisy. She usually had a window fan running, soap operas on TV, tapes of Mahalia Jackson spirituals playing, and two small grandchildren running in and out giggling, all of which I had come to expect in my visits there. One particular day the two grandchildren were running through and arguing over a

transistor radio that belonged to Terrell, Ms. Perez's 20 year old son. He came running after them to get it back, and whacked one on the bottom when they refused to give it to him. The child began to wail and her mother, Wanda (Terrell's sister) came in and asked what the hell did he think he was doing hitting her child. He laughed at her and began to walk away. She punched him in the back; he swung around and punched her in the arm. They were in a deadlock pulling each other's hair and screaming. Up until then Ms. Perez (and I) had tried to ignore them, but this was too much. "Get out of here with your fighting, get out" she yelled, standing up and flailing at them with a handful of papers. "What do you think you're doing acting like that with the nurse here? Y'all gonna run my pressure up for sure. You giving me a headache, you want me to have a stroke?" She turned to me, "Take my pressure and see what it is." She turned to her children "You want to have to take me to Charity?" At first her children reacted to their mother's anger with laughter (they did seem to be enjoying their fight), but when I began to take her pressure everyone, including the grandchildren, settled down into silence. As would be expected, her blood pressure was indeed high, and the rest of the visit proceeded in peace and quiet.

Another informant, Imelda Larks lived in cramped public housing with two sons, a daughter and son-in-law and four small grandchildren. She took to her bed for three days, sick with high-pertension, because the grandchildren had been

too noisy and unruly. When I visited her (on the third day), she was in a robe and nightgown, had the windows closed and the shades pulled. The children were carefully kept still and a safe distance away.

Many families have stories of family members who died suddenly from high-pertension induced by family discord. Two stories are presented here.

> My oldest brother died with it [high-pertension]. He and his wife were fighting. He kept saying he felt bad, he had indigestion. He kept saying "Woman, leave me alone," but she wouldn't, she just kept in there going at him. They gave him an Alka-Seltzer and a Goody's [headache powder]. A little while later he fell out right in front of everybody and me. They took him to the hospital and they brought him back to consciousness three times; but then he died. It must've popped through his heart. [E. Perez].

> ...It's like with my sister, my sister got upset with her children. She kept telling 'em to stop. They kept running around and telling on one another and bothering her. She got all upset and her face got all twisted. Right before that happened she put her hands up to her head, stood up and said "you see what you're gonna do -- you're gonna do that to me" and then she had a stroke and died right there. Upset will do it quicker than anything. It's with the nerves. Now how do you think them children felt? Her face got all twisted and upset. It killed her right on the spot. [A. Tureaud]

This is a powerful threat with which to control family and friends who behave improperly. Rather they are enjoined to cultivate a peaceful milieu for the high-pertensive relative, to refrain from any action that would make her angry, worried, or excited. High-pertension can be a useful agent of social control and a tool to manage the behavioral environment.

Anita Leonard had high blood. She was concerned about her teenaged son's behavior; he had been staying out late,

she suspected he was involved with drugs, and disapproved of the company he was keeping.

One day I was at her house for an interview while her son was there. The interview did not go well. Ms. Leonard spoke little and there was considerable tension in the atmosphere, but I did not know why. It did seem that Ms. Leonard and her son had been arguing before I arrived. I asked her if she suffered with her nerves. She said "I didn't used to, but now, with this one [she nodded to her son], I'm getting bad nerves, I think I might be going into high-pertension, now he's going to give me high-pertension." He mumbled something which I could not understand, got up and left, apparently angry. We continued the interview but her attention was not focused on it.

The cynic might dismiss this as using illness for secondary gain, which, on a simple level, it is. However,it is more than that. The "beauty" of high-pertension is that it is a culturally formulated expression of a problem which also contains strategems for the management of the problem built in. Individuals sharing a culturally formed view of illness discuss their experiences in terms of these beliefs in an attempt to make sense and organize their health experiences by fitting them in with what culture teaches them. A folk illness such as high-pertension is the result. Part of this process is presented in the next example.

Florida Joseph, the woman whose high-pertension stemmed from her job, was discussing her family's health while her

daughter, little Florida, was present. She said little Florida was anemic and probably wouldn't have high blood pressure [her words] but rather high-pertension. "She'd had a lot of trouble and had always been weak, always been nervous. She's more nervous than I am." Little Florida asked me to take her blood pressure. It was only slightly elevated and biomedically would have been termed borderline hypertension, but only if this measure was obtained rpeatedly over a period of a few weeks. I explained that this did not necessarily mean she was sick; that blood pressure normally fluctuates. Ms. Joseph said little Florida was nervous just like her but "Little Florida isn't as strong as I am. I can take it, she can't, she get's more nervous than me." Another daughter who was also present said, "That's true, she's been nervous ever since she had her babies". "I'm not nervous", said little Florida. "Yes you are, you be worrying all the time about everything" her sister answered.

On my next visit to their home I learned that little Florida had gone to the clinic and gotten a prescription for a drug used to treat hypertension. Little Florida was beginning to adopt a hypertensive role, after she had been given a social identity as a nervous troubled person, congruent with the cultural definition of someone with high-pertension.

Some persons resist change in self and role however. Lillie Dubose said she was not sure when her high-pertension started. She had only recently gone to the doctor because

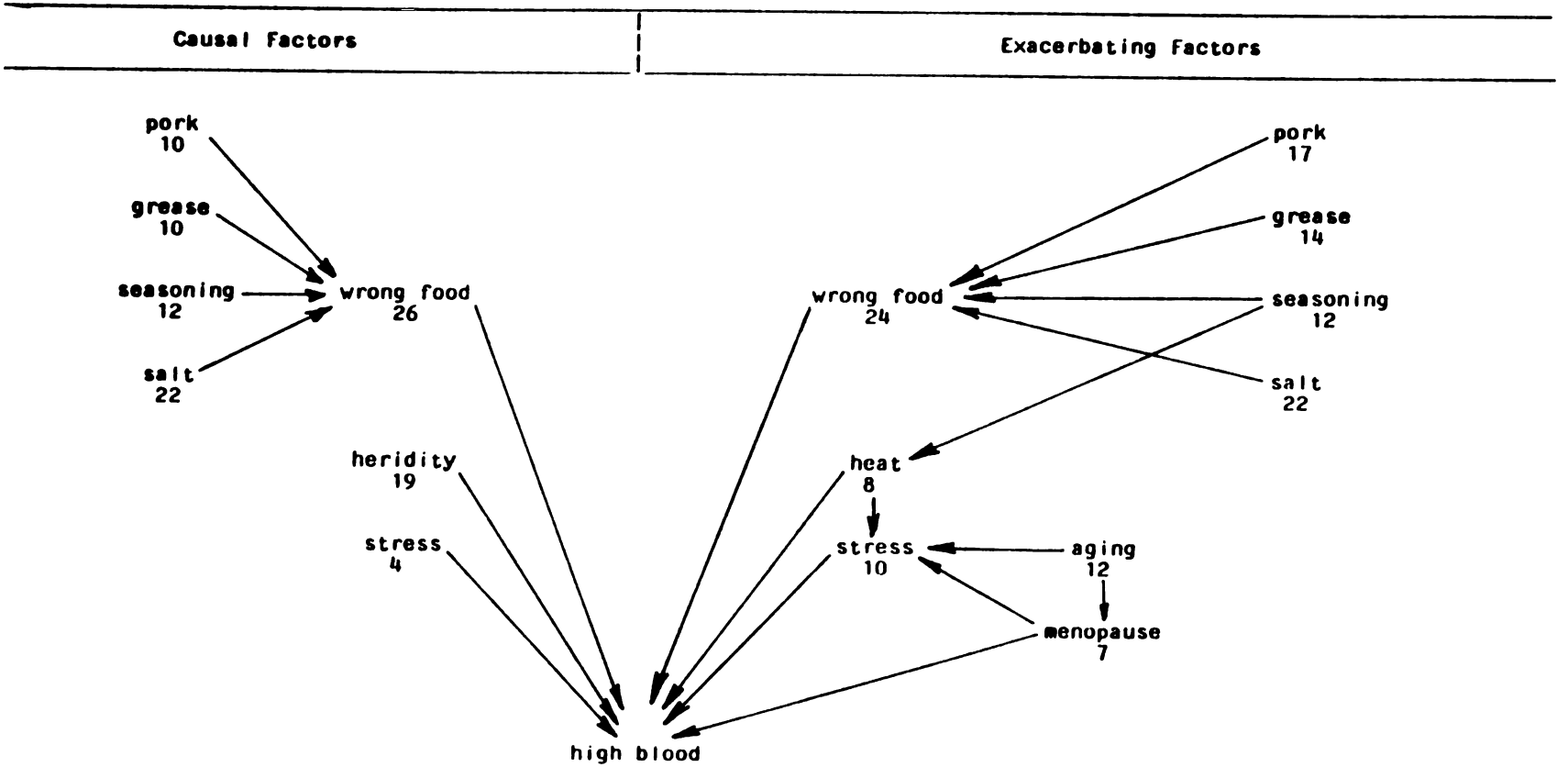
her brother wanted her to. "I never was a sick person, I never went to the doctor, this is the first time in a long time. I never was a nervous person before, but all this stuff they're doing is giving me pertension and I don't want none of it." Ms. Dubose resented having high-pertension because she was told by doctors she should no longer work. She had no extensive kin network to derive any emotional benefits from high-pertension, that is she had no "audience" for the expressive functions of high-pertension, nor a large group of persons to control. To Ms. Dubose high-pertension simply meant a loss of livelihood, and the onset of bad times.

Illness As Emblem: High Blood, Ethnicity, and Social Status

The semantic network for high blood shows an emphasis on food and heredity (see Fig. D, p. 181). These foods are salt, pork, grease and seasoning, which have a negative impact on the condition of one's blood. Pork (I have collapsed the categories in this network, but actual responses were often specific types of pork, pickled pork, pickled tips, tails, hocks, pork chops, and "seasoning meat") is said to make the blood too rich, it causes the body to produce too much blood, and it thickens it. Salt makes the blood thicken or coagulate.

Figure D

SEMANTIC NETWORK OF HIGH BLOOD
N = 32
Positive Responses



Weidman's southern Black informants in Miami said that cold blood was too thick but this is not the case in this sample (1978). Blood which is too "rich" or thick is said to be too "hot". Sunlight heats the blood and makes it thick and sluggish as well. In the summertime, blood thinners may be necessary to negate the effects of the sun by thinning, cooling and cleaning the blood (blood thinners include lemonade, lemon juice and vinegar, epsom salts, laxatives).

A person may have a hot temperament or nature as well, this body heat can make a person prone to high blood. "Seasoning" not only thickens the blood in the same manner as salt, but the heat associated with spiciness can cause the blood to heat and thicken. An excess of these elements cause to blood to elevate or rise in the body resulting in high blood.

High blood seems to be a much simpler disease than high-pertension. It does not have the same richness of meaning as high-pertension, which is to say it is less emotionally charged. The causes are on the surface and are matter of fact. In part this is because the self is not held responsible for the illness. High blood comes from food and heredity, that is, from the environment and not the essence of one's self.

Although high-pertension and high blood both involve the same beliefs concerning the functioning of blood and the cardiovascular system, one's self is not engaged in high blood to the same extent that it is in high-pertension,

consequently less emotional arousal is expressed in high blood.

The mechanics of heredity, heat, and food in the etiology of high blood are illustrated in the following statements:

> High blood runs in the generations. In the old days it was in the family. You're just gonna have it anyhow like your hair or skin. It's not so much what you do, it's inherited. [T. Bourgeois]

> I think it's some kind of inheritance--It's in both sides of the family. I have third cousins that have it. Some people say it doesn't matter that far out, but that's not true. As long as they're supposed to be in the family the blood is there; and it's just as strong. I used to have red hair. It's the same with my third cousin and a lot of my relatives, they all have that red hair that gets darker as you get older. And the high blood is all there too. [LeBlanc]

> You see salt makes your blood thicker and pork does the same thing, that's why you shouldn't eat those things. Lemon juice might help to cool the blood down and thin it., but pork is really bad you have to stay away from it all the time. It might be okay to eat a little bit of it in the winter, but it's too hot for pork in the summer. It'll just make my blood too hot and too thick. My mama said you have to stay away from wine, specially red wine in the summer cause that'll build up the blood, but beer is okay, it's good for you when it's hot cause it'll cool you off. I don't like wine anyway, but sometimes I have me a little beer or whisky." [M. Elder]

> See I don't put much salt on my food. I don't eat pork maybe a little sometimes. Maybe a pork chop fried real good, because pork is bad for you especially in the summer. [J. Butler]

Lillie Dubose, who has high-pertension, discussed pork and high blood:

> You not supposed to eat pork, it'll run your blood up to your head if you eat too much. My daddy was from the country. He killed pigs and he knew all that. He said the pig's just like a man. The pig, he got a big vein in his head just like a man. You don't know that? You going to be some kind of doctor and you don't know that? What they teaching you in that school? If the blood

> goes up it makes that vein pop just like a balloon and kill you dead. That's why you can't eat pork, it 'll stop up your vein.
>
> It [high blood] means your blood is high, it's so high it makes you sick. It's worse in the summer, especially in the summer. I'm very sick with it. I get all hot and weak and dizzy. I feel like I'm going to collapse and I start to smell like blood. [I. Larks]
>
> When you have low blood you don't have enough, you're weak. When you're high, it makes your blood come up and you have too much. You get hot in the summer and you sweat. Your pressure has a lot to do with that. It's bad in the summer for people who have high blood. [D. Schmidt]

Most of the meaning expressed by high blood is located at the hypothetical rather than metaphorical level. This is not to say, however, that high blood carries no deeper connotations. Twenty women said that pressure trouble was a special disease of Black people. This was because Blacks were said to have more troubles, be under more pressure and ate the "wrong" foods. High blood was said to originate in Black dietary habits.

I wish to make a tentative proposal that high blood, for some individuals, can be expressive of ambivalence and anxiety toward ethnicity and status in Blacks. This is represented by attitudes towards what can be perceived as traditionally Black diets. I do not have enough data to fully support this assertion, yet there is enough to outline an argument worthy of further investigation.

The earlier discussion of blood in Afro-American folk illnesses holds true for high blood as well as high-pertension. The folk model of the cardiovascular system as a

thermometer or barometer is believed to hold for all persons. Different illnesses merely imply different disturbances in it's functioning.

Whereas negative emotions and social situations influenced the blood in high-pertension, high blood is influenced by "bad food" or "bad parentage" (heredity). It is caused by negative influences on the blood which have a deleterious impact on the blood's state. There is still the sense of evil influences invading the body and blood which Weidman noted in Afro-American beliefs about blood and which were discussed regarding high-pertension. The following statements suggest a sense of pollution of the body and blood from the environment.

> What's bad for it is salt, cholesterol, eggs, seasoned foods, because it puts sodium in your blood cells, it changes your blood. I can feel the blood going up when I eat that stuff. Pork chops, like fried pork chops are bad for it; that's not a clean food. Pork has all kinds of diseases; you have to boil it real good. My mother says it's bad to put that in your blood, you should be eating vegetables and boiled foods." [F. Barthelemy]

> You shouldn't eat salt and sodium cause they's all chemicals and all that acid stuff is bad too. I can't remember the name of the medicine, I take it to bring the acid down from my blood, to run it out of your system, out of the blood. It's too many chemicals in the blood, you putting too many chemicals in your body cause of what you eating. You not supposed to have chemicals in your body. [E. Perez]

> It's cause of what I was doing five years or so ago. I'd been messing with people drinking beer, all kind of stuff. Lord forgive me for that. The Lord gives you a body and you should treat it better, not letting all kinds of stuff into it. [E. DeBeau]

It is widely noted in the literature that food behavior is culturally influenced and part of a larger sociocultural

system. Whitehead observed that as a part of a cultural system food behavior frequently meets needs other than the obvious nutritional and biological ones (1984). Food behavior can be used as an ethnic, racial, or class marker. Numerous writers have also noted that dietary choices and practices are sumbolic of ethnicity and of social status (Kalcik, 1984; Douglas, 1978, Abrahams, 1984.)

Kalcik also notes that change in eating habits are used to signal a change in status usually from a less to a more desirable group (Kalcik, 1984). Food behavior is not simply a matter of individual taste, but a performance (whether conscious or not) of ethnicity and social status, an expression of identity as membership in a group (Kalcik,

ethnicity.

This is certainly true for Blacks, especially in New Orleans and southern Louisiana where food holds such importance. (A local supermarket jingle goes: "While others may only eat to live, in New Orleans we live to eat"). The "Creole" cuisine in which Louisiana takes so much pride was largely the creation of Black cooks working in their own and White kitchens.

The "bad" foods for high blood (Pork, seasoning, grease, salt) all are components of traditional Louisiana diets, particularly those of Blacks and rural Blacks in Louisiana. The following statements suggest that the "bad

foods" which lead to high-pertension are those associated with Black ethnicity by informants.

> It means we eat a lot of the wrong things. Black people just like the wrong food, you shouldn't eat a lot of pork but we do. Pork and salt. I can feel the blood going up if I eat 'em, but if I don't, I don't necessarily feel any better. We always ate lots of pork in my family. I grew up in the country, White Castle around Bayou Goula, you know where that is? I had a beautiful life. Where I lived it wasn't pretty, but beautiful. But I guess we just ate the wrong food. [P. Tolliver]

> People get sick cause they eat the wrong food, they build it up high and then they have heart trouble. And all that highly seasoned food that's too much for you. It puts too much fat in your blood, then you can't pump your heart. With me the problem is food and sweets and highly seasoned foods. I love all of these things. I'm from Plaquemines parish, a Creole from Plaquemines parish and I like all that seasoned Louisiana food, we all do. I got sick cause I wasn't eating right, I was eating the wrong food. And it's inheritance. My brother and sister have the same thing and I have an auntie tha's got it. If she eats any seasoning her blood goes up too. I been eating gumbo, so I think my pressure might be up a little today. [L. Jeannemarie]

I complimented Alma Prejean on her beans and rice which she had me try. After that she liked to try out different foods on me when I visited. She cooked me a special dish a pot of chitterlings in brown gravy with rice. This was cooked "Just for you, see I can't eat that stuff any more. It'll run my pressure sky high. But I do love it. They say its bad food, but it might not work on you the same way cause your're White." I asked her to clarify this. She replied, "Well, everybody's different, that's all. Things work different on different people and you don't hear White people having too much high blood."

Douglas proposes that food habits and practices remind us of what is to be eaten, in what order, and what is not lest it "consume" us, causing the loss of self and identity. Abrahams observes food choices are a way to designate order, what is good or bad for you, to categorize us from not us (1984). He says that food behavior is a part of what Mary Douglas calls the purity rule, the minimal absolute standard of what may and may not be done by members of a group. Food expresses what is healthy and clean.

Douglas posits that "bad foods" connote a sense of pollution, what is dirty and unhealthy, what is not representative of "us" (1975). According to Douglas, dirt is something out of place, that which doesn't belong. Dirt is something that is left over from proper categories, something residual. Pollution occurs when residue invades otherwise ordered categories. "Bad foods" are then ones which don't fit in orderly categories or which are out of place.

In United States society, Blacks are social residue. They are not a part of the mainstream; not well integrated into the prevailing social order. I think this is being expressed by informants statements concerning food and high blood. In high blood, Black foods then are seen to a certain extent as polluting, out of order. There was definitely some ambivalence, almost a sense of embarrassment or apology in the discussion of Black foods, bad foods for high blood.

> Most Blacks have it. It must be an improper diet. Colored people always ate fat. They think you're supposed to be fat. See, vinegar helps. Vinegar rots your food and helps digest it faster so the fat doesn't

> collect. I eat mostly vegetables. Meat, some starch, but don't give me beef; it makes me sick. Beef is too bloody and rich. Red beans are bad for you; they's got too much iron; they's too rich for your blood. All the food colored people like. I don't eat pork at all. But sometimes you eat things you aren't supposed to. I ate gumbo made with [pork] neckbone and my pressure was up the next day. [E.Perez]
>
> People get sick with high blood cause they don't do what they're supposed to do. You know a lot of us still cook with grease. Everything, even greens, we all cook it with grease. We all haven't gotten away from that kind of stuff; and that's gonna make you sick. You can't eat like that. I broil all my food, I don't fry things, but some of us just have to fry everything in grease. Things just can't be like we used to." [F.Joseph.]

Olivia Doucet is a stylish 50 year old widow with no children. She's worked for the family of a prominent doctor at Ochsner Medical Center for twenty years. She showed me pictures of all of them. "See my baby was stillborn, so I say this is my family, these are my children". She talked about her high blood.

> I guess I got it from my mother. Oh, God did she have it. I guess we just inherited it, all of us in the family... But, I'll tell you the truth. The average Black person likes good food. That's the trouble. They like to eat all that pig tail and stuff like that. They don't know how to cook unless they put a piece of meat in something. And pork will run it up. You get it from when you were a kid, eating all that stuff... I've been trying to follow the Ochsner's diet. My mother said to take lemon juice and water. She says it works; I don't know. I've seen people eat just a little piece of pork and they got sick in the next few minutes. I think pork is just bad, you got to change your way of eating.

High Blood and Social Status

Food which is bad for high blood represents not only ethnicity, but social status, the place of Blacks in the social order and poverty.

> When we were young, you know, you'd get a piece of hog and just eat it. But that's too much grease. And we didn't have light bread like they have now. We used to eat biscuits every day. Too much of that stuff made your body full of cholesterol. We used to take cream of tartar in the summer to clean you out for summer. How you live in your early life, that's what you make of yourself later on. You don't get rid of it. You grow up poor, Black and you end up poor and sick. [A. Tureaud]

> I guess its from the wienies and starch, poor food like that. If I have money for fruit and vegetables, cheese or whatever, I follow the diet, but if I don't, I fall back on what I can afford, on what I know best. That's why people cooked like that, `cause they didn't have no money. [A. Jones]

> I think the blood's building up in me and its because of my weight too. It's really hard not to eat too much and to eat certain foods. I try not to eat the wrong food, but sometimes you just have to. You know Black people don't have too much money. Sometimes you have to eat what you got...I feel really fat inside. The fat might be closing up against all my insides and mashing up against everything. That's what the medicine's for to keep the fat from stopping the blood...This is a hard diet to stick with. When I was small we didn't have enough to eat. I don't feel really bad about it a lot of us were that way. We were really poor and we hardly had any meat. I used to say when I grow up I'm gonna have money and I'm gonna eat everything I can. Only it's really funny, now I can't, even when I have the money. [J. White]

High blood is caused not only by what you eat now, but what you used to eat as a poor black child. It is a disease for Blacks, having its beginnings in childhood. The other key etiological factor in high blood is heredity. Along with ethnicity and social status one inherits high blood. It is an illness of origins, of family and of past and present social status and poverty whose effects continue to haunt you into adulthood. As members of an ethnic group falling between the cracks of American social organization, the Black women in the sample are becoming ill.

Heredity, food choices and ethnicity are all related, part of one's membership in a group. I propose that high blood, at least in part, is an illness expressive of ethnicity, of ethnic and social origins; deriving from one's membership in a socially disvalued group.

Ambivalence and Group Membership

In the discussion of Black psychology, I noted that many researchers observed what they called suppressed rage and aggression turned inward towards the self and one's ethnicity. These are, admittedly, strong statements and care should be exercised not to accept them uncritically. As stated earlier, research samples in these studies were not always representative of larger populations. It can be said, however, that a certain ambivalence about one's Blackness has been found in numerous studies. Possibly, it is this ambivalence which is being expressed in high blood.

In New Orleans, a recent study of Black youth demonstrated a negative evaluation of Blackness among lower income groups (Halstead, 1983). Rohrer and Edmunson had earlier predicted this would be found among middle class Blacks who would wish to distance themselves from a lower status group and identify with the higher status Whites (1960). Halstead proposes that recent changes and advances of Blacks in U.S. society would make Blackness more an element of pride among those who are better educated, well read, and sensitive to social trends nationwide (1983). Lower status, poorly educated Blacks would remain alienated

from national trends and less influenced by national thought. Rohrer and Edmunson's assertions were based on data that is very old, and Halstead's study is of youths, so that neither can be used to support the present argument concerning high blood in older Black women.

It is likely that there is some negative feeling about one's ethnicity considering New Orleans' history of concern with race and social status. The ambiguity of race and status fostered by the survival of the Creole mythos is likely to contribute to ambivalence and anxiety focused around ethnicity and status. There has been no recent study of this in the general population however and this must remain simply a possibility for further investigation.

It is also possible that negative feelings are not directed at one's ethnicity <u>per se</u> but toward the ambiguous and disadvantageous social position Blacks have been made to occupy in United States and New Orleans social organization. Negative feelings have definitely been expressed towards present and former poverty, and the diets which are representative of it.

This discussion of ambivalence and negative affect is not intended to demonstrate that Blacks in New Orleans have poor self-esteem, nor that poor self-esteem is implied by high blood, but that, for some individuals, there is some affective ambivalence about one's ethnicity and social status expressed in high blood. This ambivalence is not tied with

one's sense of personal self, however, but self as group member.

If food is symbolic of ethnicity and social status, these foods "say" that a person is part of a residual ethnic group, socially marginal, perhaps rural, and widely viewed as backward and certainly poor. This is enough to inspire ambivalence at some level. One may enjoy eating Black foods and feel good about being Black. However, in the face of the general social order and prevailing social attitudes one may have negative feelings about the social implications of one's ethnicity at the same time.

This situation of ambivalent emotion can be considered an instance of affective dissonance, discussed in chapter 2 (DeVos, 1975a, 1975b). In the situation described one may hold positive feelings about one's parentage and ethnic associations, yet, aware of one's place in the social order, experience some negative feelings. One is experiencing status anxiety.

These feelings are not so much about one's personal self but of one's self as member of a group. There is little sense of personal responsibility for the illness, as one is not responsible for one's ethnicity. Rather, it is an unavoidable, inherited quality of the self, an ascribed status.

Jenkins (1982) discussed studies of United States Blacks differentiating between the individual self and self as a group member. He attributes black survival and mental health

to this ability to differentiate between the two. Because there is less engagement of individual self in high blood than in high-pertension, there is much less affective arousal. This is the case in the situation I've described, yet because the individual self is not responsible, not emotionally engaged, one can to a certain extent transcend the situation and avoid excessive emotional arousal.

Whereas high-pertension is an illness of the self in the behavioral environment, high blood is an illness of the group in the behavioral environment and the individual can remain relatively uninvolved. This, perhaps, accounts for the relatively straightforward, matter-of-fact attitude toward illness and illness behavior taken by persons suffering from high blood. They feel like they are in control, with the aid of medications and dietary caution.

Contrast this with the statements of high-pertensives who are anxious, worried, and angry about a self and environment out of control. Who feel there is little to be done for their illness. Therein lies the real difference in meaning between high blood and high-pertension.

NOTES

[1] The names of neighborhoods and housing projects are not the informants' actual places of residence. They are genuine place names in New Orleans, but have been reassigned to protect informants' anonymity.

CHAPTER 8: CULTURE, ANXIETY AND BIOMEDICAL COMPLIANCE: THE APPLICATIONS OF ANTHROPOLOGY IN PRIMARY HEALTH CARE

"Pressure Troubles" As Culturally Stylized Illnesses

Neither high-pertension nor high blood can be considered culture-bound syndromes. There is little culturally bound about them. The opposition of physical to emotional etiologies is similar to the dichotomy described by Blumhagen for Anglo-Americans (1980). They also bear striking similarities to blood illnesses found in other Afro-American health cultures (Farmer, 1988; Weidman, 1978) as well as non-Afro cultures (Blumhagen, 1982; Garro, 1988). Furthermore, there is a disease "hypertension", which from the biomedical point of view, underlies the folk formulations.

Rather, I prefer to use Stein's concept of a culturally stylized syndrome, an illness which is a culturally constituted expressive form (1985). It becomes elaborated as a virtual aesthetic field and a Durkheimian collective representation of shared problems and feelings.

According to Stein, certain illnesses bear the burden of heavy symbolic stylization and group preoccupation. This can be said of high-pertension and, less so, of high blood. High-pertension is a richly expressive form, accommodating numerous dilemmas, feelings, and frustrations experienced by Black women in the course of their lives.

Stein introduced this concept in a discussion of alcholism in which context he discussed possession theory (1985). Possession is not a universal part of culturally

stylized syndromes, yet some of Stein's discussion is warranted in relation to high-pertension.

In reading some informant's descriptions of the illness as one of a nervous, excitable self, one gets a sense almost of hysteria and dissociation. One can't control it, it's the way one is or always has been, yet one is not oneself. Persons are overcome by anger, anxiety, sadness or grief, not fully aware of what they are doing or saying. The individual is beyond conscious control.

In possession, the self is said to be invaded by a spirit. LaBarre discussed spirit possession in various cults (1975). He observed that the possession is not by an alien pyche but the:

> . . . overwhelming of conscious ego functions by ego-alien primary process mentation...ego function is `possessed' (overrun or displaced) by ego alien process...The one who is sacredly possessed does justifiably what he wants to do but cannot in his secular state. (LaBarre, 1975:41)

Of course this is substitution of psychoanalytic for spiritual language and metaphor. If we substitute folk medical phrasing we could easily be describing an episode of high-pertension. One is disoriented, not one's self, overwhelmed by negative emotion, and not really responsible for one's actions. The metaphors may change, but the meaning is apparently similar.

Lest we be too hasty to conclude that high-pertension represents merely individual pathology, we should heed Farmer's caution against ignoring the "social origins of much -- if not most -- illness and distress". (1988:80)

High-pertension and high blood are particularly apt idioms of distress for Black women. If Black women in New Orleans are experiencing psychological distress, there is ample data from the social area of the behavioral environment to suggest probable cause.

Biologically, Blacks as a group are likely to have biomedically detected and defined hypertension, which provides the legitimation and basis for cultural elaboration. As a culturally stylized syndrome, high-pertension provides a framework for the expression of problems shared by Black women in New Orleans. It also provides a means by which some personal control can be exerted over these problems by justifiying behavioral change that might otherwise be unacceptable.

High blood, while less heavily symbolized, does bear the "burden" of considerable group preoccupation. "Bad food" and the state of one's blood as it "runs through the generations" are important concerns in the everyday lives of the women interviewed. It is possible that this is emblematic of what could be termed "status anxiety", an uneasiness over one's ethnicity and the position occupied by one's ethnic group in the larger social organization.

Both folk illnesses, within a culturally stylized idiom, serve to express psychosocial problems and distress experienced by the women as individuals within a certain sociocultural group. Some resolution of these problems is

offered by the illnesses, again within a culturally stylized idiom.

Blood, High-Pertension and Compliance

Black health culture contains knowledge which biomedicine has neglected, if not forgotten. That is, a patient is a whole person, mind and body, and both must be addressed in treatment. Expressed theoretically, the mythic world of Black folk medicine is adequate to address this, but the mythic world of biomedicine is not. In its effort to be scientific, biomedicine has succeeded in narrowing its attention to the somatic only. Frank noted that "the physician is an expert scientist-technician whose job it is to get the body into good running order again, and many psychiatrists dream of the day when they too can obtain triumphant cures with pills and injections" (1964: viii). As Malinowski observed, where scientific empiricism reaches its limits, magic is called in to reduce anxiety (1955).

Non-scientific ethnomedical practice (magic, if you will), is able to reduce anxiety and provide catharsis. It is able to symbolically resolve emotional dilemmas, or affective dissonance (DeVos, 1975). In so doing, it is likely to have a somatic effect as well. It can overtly address that part of human illness which biomedicine frequently does not, or if it does, only does so inadevertently.

As an overtly psychosomatic illness, high-pertension does not readily lend itself to treatment by biomedicine

which seeks only somatic cause and solution. The women interviewed have stated in no uncertain terms that the cause is their nerves, and chronic nerves at that. The central problem they wish addressed, their illness, is anxiety. This chronic condition, together with a host of other undesirable affective states, is having a deleterious effect upon their body as part of their everyday life.

Biomedicine is not offering a solution to this. The solution which is being offered, antihypertensive medication, is, in the patient's perception, irrelevant. Women with high-pertension are acting accordingly; illness behavior is directed to managing the major problems as high-pertensives perceive them. They are not taking their medicine, and biomedically they are noncompliant.

Women with high blood are taking their medicine. They are concerned about their diets. For one thing, as I have argued, there is less affective arousal to be addressed in this illness. What anxiety there may be seems to be represented by the condition of the blood. Since medication and dietary control are perceived to have a beneficial effect on the blood, biomedical treatment is accepted as useful in treating the illness "high blood".

Unbeknownst to biomedicine, its treatment is symbolically congruent with the cultural idiom of high blood. Biomedical treatment is accepted because of the symbolic healing it inadvertantly provides, and not for the

efficacy accorded it in biomedicine's mythic world. Yet, biomedically, the patients are cconsidered compliant.

A Cautionary Note

Care must be taken not to expect a single factor to explain large amounts of variance in behavior. The statistics did show relatively strong relationships between belief in folk models of illness, self diagnosis of folk illness, and compliance with prescribed medication. Yet, it must be remembered that folk illness models and self-diagnosis are abstractions representing more complex and fluid realities.

Folk beliefs are not acted upon in a vacuum but in the totality of the behavioral environment, and, as such, are considered in conjunction with other contingencies of everyday life in efforts at illness management. The examples presented have suggested the complexity of these efforts and of the behavioral environments in which they were made.

It can not be argued that the folk beliefs presented are alone sufficient to explain behavior. Nevertheless, this study demonstrates how crucial is some knowledge of the patient's mythic world in understanding illness behavior and efforts at illness management. The mythic world provides a framework for the organization and understanding of somatic and affective phenomena which together create an illness and give it meaning.

Similarly, the physician's mythic world creates and colors not only his or her apprehension and comprehension of the patient's illness but influences action towards that illness's construction and treatment.

When these two worlds meet in everyday medical care,the result can be the creation of new symbolic forms and areas of agreement incongruent with original worlds. This was apparent in the case of some medical residents coming to accept their patients' reporting of symptoms as characteristic of high blood pressure, as opposed to official medical teaching. Perhaps health education is a mutual process.

Folk Health Belief: Interaction Between Folk Medicine, Biomedicine And The Individual

The unanwered question of just where do all these ideas come from remains. To answer this (if indeed, this is even possible) requires an investigation quite different from the present one, and one which I am not prepared to undertake. I can only offer a few observations and thoughts which may help in some future inquiry into the problem.

The importance of blood and emotion in Afro-American health beliefs in other regions has been demonstrated by Snow (1974), Weidman (1978), and Farmer (1988). These are obvious possible sources of some of the ideas found in New Orleans. More remote, African health culture is a likely source.

Lambo said that African health culture is far more socially based than biological and much reciprocity perceived between mind and matter (1964). (He described West Africa, the area from which most Blacks in Louisiana are said to have originated). Disease is viewed as a social sanction and there is great concern with having good relations with other people, both past and present. Furthermore, he asserted that anxiety was the most common and crippling disorder in Africa. These observations could reasonably be applied to Black New Orleans folk health beliefs, which would not be out of place in African health culture.

Yet, Blacks in New Orleans have not existed in a vacuum, and it would be ludicrous to expect their health culture to be identical to those from a place they have not seen for hundreds of years. Black culture is strong, but it interacts closely with the larger society. The similarity of the high-pertension/ high blood dichotomy to hypertension and hyper-tension described by Blumhagen suggest considerable belief and sentiment in common with the rest of the American population (1980).

The women in this sample have most certainly been reached by the mass media. Everyone, even the poorest of informants had at least a television and usually, a radio. There was copious health education literature at the CHNO clinics, as well as posted around the public housing projects. This is a population which has virtually been

inundated with information about hypertension from the American Heart Association. Undoubtedly this has had some influence.

Several women expressed the opinion that high-pertension is a modern illness, one which has been newly discovered by biomedicine. One woman told me the "old people's treatments seem to have lost their energy or something, they just don't work like they used to." Possibly there is a substrate of African and Afro-American beliefs about illness and blood, upon which new ideas from doctors, the media and the general population are being superimposed. If, in fact, this is occurring, the fit at present is awkward.

People are strongly influenced by biomedical and lay interpretations as well as folk models of illness. Biomedicine and folk medicine are systems in interaction only in the abstract. In real life, individuals, both patients and practitioners, are trying to make sense out of new knowledge in terms of what is already known and believed. The sources of "folk" medicine are persons acting within and between their own belief systems and those of others.

Illness, Expression and Adaptation

High blood in New Orleans offers a culturally-framed opportunity for the expression of ambivalence and anxiety about social and ethnic status. It provides a complex of

symbols by which this ambivalence can be acted upon and negative affect expurgated.

High-pertension, too, can be seen as a culturally appropriate idiom for the expression of self and chronic distress in the behavioral environment. It also provides a mechanism for personal adaptation in the context of this experience, in that it aids in the construction of a manageable behavioral environment.

On the other hand, high-pertension can also present a serious obstacle to the management of the biomedical chronic illness hypertension. Although affective distress is dealt with in folk treatments for high-pertension, many physical needs are not. Self diagnosis of high-pertension can prevent treatment of serious disease and poses a threat to biomedical efficacy.

The elements of illness are never purely medical. This is never so true as in the case of a chronic illness which becomes an integral part of the life experience, shaped by culture and becoming a part of the self. In chronic illness much of an ill person's behavior is illness behavior since life is reorganized around the experience of illness. Illness behavior can be viewed as efforts at personal adaptation. This is certainly true in high-pertension which explicitly calls for adjustments in the self and social milieu to bring about health: physical, social and psychological. Certainly as Virchow proposed, all medicine is sociology and sociology, medicine (Rosen, 1972).

Conclusion

It may seem that the reader has been led rather far afield from the initial discussion of a primary health care problem in New Orleans, yet this is not so. The problem was formulated as one of swelling demand for services in the face of diminishing resources. Lack of adequate hypertension control was seen as a significant factor in that demand, one which could be better managed if patient compliance with treatment could be improved.

The role of such "soft", impalpable phenomena as illness models, feelings, beliefs and symbols in compliance has been demonstrated. These factors have important implications for general illness managment and health care delivery especially at the level of primary health care, which is by definition unspecialized and addressed toward general health.

In primary health care, it is crucial to acknowledge that illness is tied in with social phenomena at the macro as well as micro level. The problem is one not only of restructuring health care delivery, but of questioning the nature of health care itself, as wells as instigating social change. One's entire life is possibly an object of treatment.

Ethical questions arise concerning control, and who "owns" an illness. The specter of medicalization of everyday life rears its head. These are topics for another

discussion, but one which will have to be addressed by biomedicine and the lay public as well.

For now, more immediate questions can concern us. Illness terms used by the practitioner in diagnosis may differentially influence compliance in persons holding these beliefs and may provide a key to explaining problems in illness management. If medical intervention is to be effective, health professionals must be aware of the folk health beliefs, the "mythic worlds", of their patient population. These beliefs must be addressed in health care delivery.

The manner of address is not something easily decided. The destruction of cultural beliefs through patient education is ethically problematic and, realistically, much easier said than done. When illness meanings are so deeply and functionally embedded in sociocultural context, the wisdom of education is questionable. On the other hand, health professionals can not be asked to compromise the integrity of their medical practice through a biomedically false representation of disease and treatment. In the end a solution may lie in the negotiation of some mutually agreeable illness construct rather than complete concession of one mythic world to the other. This can only come about after serious consideration, perhaps involving deliberations between agents of both groups.

The introductory statement expressed the intent of demonstrating anthropology's utility in primary health care

in a technologically sophisticated, complex society. This paper demonstrated the contributions of the anthropologist as ethnographer. Further contributions must come from the anthropologist as "culture broker", negotiating between the "soft" realities of culture for change in the hard realities of illness behavior, primary health care, and human well-being.

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APPENDIX A: Patient-Practitioner Interview Schedules

Interview 1: Beliefs About Hypertension -- Clinic Patients

1. Why did you come to the clinic today?
2. What is the name you usually call your health problem?
3. Have you ever heard it called anything else?
4. What is the difference between these names?
5. What do they mean?
6. When did you first know you had this problem?
7. How did you know?
8. Did you feel it?
9. Can you tell if it's better or worse?
10. What do you do when you think it's worse?
11. What do you think caused it?
12. What do your family and friends say about it?
13. Why do you think it started when it did?
14. Why has this happened to you and not someone else?
15. How bad is it?
16. How can you tell?
17. How long do you think it will last?
18. Do you think it will lead to something else?
19. Will it get better or worse? Why?
20. Does it cause you problems?
21. What kind of problems are they and which are worst?
22. Does it frighten or worry you? In what way?
23. How are you taking care of it?
24. Do you think your medicine will help? How much?
25. Does your medicine make you feel good or bad?
26. Does your diet help?

27. Can you tell me what's going on inside of you? (Can you draw me a picture of what's happening and how your treatment works?)

28. When you don't tale your medicine or follow your diet, what are some of the reasons?

29. What's the most usual reason?

30. Why don't other people take their medicine or follow their diets?

31. Is there anything else that might be done for it?

32. Is there anything that might help that the doctors or nurses haven't told you about or might knot know about?

33. How does it work?

34. What do you want from the doctors and nurses when you come to the clinic? What do you expect?

35. Is there anyone besides the doctor or nurse who might help?

36. What could they do? How could they do it?

37. Do you know anyone who's seen a person like this?

38. Have you ever seen anyone like this?

General Health Beliefs and Attitudes - Clinic Patients

1. In general how well are you?

2. How well do you usually feel?

   Does anything ever hurt? Do you have headaches?

   Do you feel tired and worn out? Do you feel weak?

   Do you feel dizzy? Do you black out or fall out?

   Do you feel too hot or too cold?

   Do you feel worried or tense? Do you suffer with nerves?

   Is your blood too thick or too thin?

   Is it too hot or too cold?

   Do you have enough blood or too much?

   Does your blood move and circulate well enough?

3. How well are your family and friends?

4. How well do they usually feel?
   Do they have any of the problems I mentioned before?

5. On general do you feel worried or concerned about your health?

6. In general, why do people get sick? Why do they get sick when they do?

7. What happens when people are sick? How do they feel? Can you tell if other people are sick?

8. When people are sic what things can they do to feel better? What things do you do to feel better? What do your family and friends do?

9. How do these things work?

10. Is there anyone besides doctors and nurse who can help sick people? What do they do? How does this work? Do you know anyone who's ever seen a person like this? Have you ever seen a person like this?

11. Have you ever heard of faith healers, spiritualists or root doctors? What do they do? How does this work? Do you anyone who's seen a person like this? Have you ever seen a person like this? Why or why not? Do you think you might ever in the future?

12. In general, what would you say the world is like? Is it a good, safe, place? Is it a bad,dangerous or frightening place?

13. Do people have control over their lives in general, or do things happen because of chance? Because of God's their health?

Interview Themes for Physicians

1. Is there any difference between high blood pressure and hypertension? What do these terms mean? Have you ever heard it called something else? What does that mean?

2. How can persons know if theu have hypertension? Can they feel anything? Can they tell if it's worse? What should they do if they think it's worse?

3. What do you think causes hypertension?

4. Why does it start when it does?

5. How serious a condition is it? How long does it last? Can it get better and go away? Is it cause for alarm or worry?

6. What kind of problems might it cause a person?

7. How do medications and diets work to alleviate hypertension? What's happening inside a person? Could you draw a picture of it?

8. Why don't people take their medicine and follow their diets?

9. Is there anything that can be done aside from what biomedicine prescribes? What about folk remedies such as...(some will be suggested which have been mentioned by patients).

10. What is a patient seeking when he or she comes to the clinic? What do they expect?

11. Is there anyone besides biomedically trained persons who might help in the control of hypertension? Have you ever heard of gaith healers, spiritualists, or root doctors? Have you ever met a person like this? What do they do? Do you think they help? Do you think they cause harm?

12. In general, why do people get sick? Why do they get sick when they do?

13. What happens when someone gets sick, how do they feel?

14. What should someone do if he feels sick? How can you tell if someone is sick?

15. Is hypertension a sickness?

16. In general, is the world a good safe place? Should people be worried or frightened?

17. In general, do people have control of their lives, or do things happen because of fate or chance? Because of God's will? What about people's health? Do people have control over their health?

18. How would you describe the patients you treat here?

APPENDIX B: Frequencies of Responses Describing Illness Models

CHARACTERISTICS OF "HIGH BLOOD"
(From interviews with informants recognizing two* folk illnesses)
n = 32 informants

Variable (Category underlined)	Yes	No	Not Sure	No Response
Cause				
Heredity of Disease	19	0	4	9
Heredity of Personality	0	6	1	25
Personality (not inherited)	1	0	0	31
Red Meat	2	1	0	29
Pork	10	2	0	20
Salt	22	1	0	9
Sweets	4	1	1	26
Seasoning	12	1	0	19
"Wrong" Foods	26	1	0	5
Grease	10	1	0	21
Overweight	4	2	0	26
Alcohol	4	1	0	27
Heat	3	1	0	28
Aging	4	0	0	28
Menopause/ Hysterectomy	4	0	0	28

* Six informants did not know whether there were one or two illnesses involved. They had minimal opinions on their health and their answers were consistently "don't know". Since their observations do not constitute an illness model their responses are not included in the appendix.

High-pertension (continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Cause				
Grandchildren	1	1	1	29
Spouse	4	1	1	26
Stress	14	1	1	16
Worry	13	1	Ø	18
Crime	2	Ø	1	29
Money	3	1	Ø	28
"Pertension"	8	1	Ø	23
Fighting	5	Ø	1	26
Anger	12	Ø	1	19
Nerves	30	Ø	Ø	2
Coping (Holding in/ Letting go of feelings)	9	Ø	1	22
Fatigue	1	Ø	1	32
Anxiety	12	Ø	1	19
Exacerbating Factors				
Red Meat	5	1	Ø	26
Pork	Ø	7	1	24
Salt	2	6	3	9
Sweets	Ø	4	1	27
Seasoning	1	4	1	26
Wrong food	2	5	1	24
Grease	Ø	5	1	26
Overweight	1	5	1	25
Alcohol	Ø	5	1	26

High Blood (continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Exacerbating Factors				
Grease	14	1	Ø	17
Overweight	9	Ø	Ø	23
Alcohol	6	1	Ø	26
Heat	8	1	Ø	23
Aging	12	2	Ø	18
Marriage	1	1	Ø	30
Hysterectomy/ Menopause	7	1	Ø	24
Family	Ø	4	Ø	28
Children	2	4	Ø	26
Grandchildren	1	3	Ø	28
Spouse	2	4	Ø	26
Stress	10	6	1	15
Worry	5	6	Ø	21
Crime	Ø	4	Ø	28
Money	1	4	Ø	27
"Pertension"	Ø	4	Ø	28
Fighting	2	4	Ø	26
Anger	Ø	5	Ø	27
Nerves	Ø	8	Ø	24
Coping	Ø	4	Ø	28
Fatigue	2	4	Ø	26
Anxiety	Ø	6	Ø	26

High-pertension (continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
<u>Pathophysiology</u>				
Blood moves up	16	Ø	2	14
Blood moves up suddenly	30	1	Ø	1
Blood goes to head	30	Ø	Ø	2
Blood clogs	2	6	1	23
Blood stays up	Ø	15	1	16
Heart works too hard	1	Ø	1	30
<u>Symptoms</u>				
Heart beats too fast	8	Ø	1	23
Weakness	7	1	1	23
Dizziness	13	1	1	17
"Blind staggers"	7	1	Ø	24
"Falling out"	6	1	3	22
Visual disturbance	4	1	Ø	27
Nasal disturbance	6	1	Ø	25
Auditory disturbance	4	Ø	4	24
Feeling hot/cold	3	1	Ø	28
Fatigue	4	1	Ø	27
Disorientation	13	Ø	Ø	19
Headaches	22	1	Ø	9
Chest pains/ heaviness	4	2	1	25

High Blood (continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Symptoms				
Headaches	23	4	Ø	5
Chest pains/ heaviness	3	4	Ø	25
Course of Illness				
Will not go away	30	1	1	
Will be cured	1	22	7	2
Is fatal	Ø	11	19	Ø
Will get worse	1	9	20	2
Has symptoms	23	3	2	9
Episodic	3	27	Ø	2
Predictable	29	1	Ø	2
Treatment				
Prescribed medication	24	3	3	2
Garlic	19	1	2	10
Vinegar	10	1	2	19
Lemon	15	1	3	13
Other	11	Ø	Ø	21
Diet	29	Ø	Ø	3
Weight loss	11	Ø	Ø	21
Temperature change	11	Ø	Ø	21
Rest	22	Ø	Ø	10
Relax	9	3	Ø	20
Don't worry	2	3	Ø	27
Quiet	4	1	Ø	27

High Blood (continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Treatment				
Away from people	0	2	0	30
Pray	27	0	0	5
Root Doctors	7	13	8	4
Faith Healers	7	13	8	4

High-pertension (continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Course of Illness				
Will not go away	28	0	2	2
Will be cured	0	23	7	2
Is fatal	0	2	26	2
Will get worse	2	4	22	4
Has symptoms	24	1	2	5
Episodic	27	1	2	2
Predictable	4	24	2	2
Treatment Prescribed medication	10	11	10	1
Garlic	7	6	3	16
Vinegar	1	4	2	25
Lemon	3	4	2	23
Other	6	5	1	20
Diet	1	6	1	24
Weight loss	1	5	1	25
Temperature change	4	4	1	23
Rest	24	1	1	6
Relax	30	0	0	2
Don't worry	31	0	0	1
Quiet	18	2	1	11
Away from people	10	4	1	17

High-pertension (continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
<u>Treatment</u>				
Pray	25	Ø	1	6
Root Doctors	5	12	9	6
Faith Healers	4	12	10	6

CHARACTERISTICS OF HIGH BLOOD PRESSURE/HYPERTENSION
(From interviews with informants
recognizing only one illness)
n = 22 informants

Variable (Category underlined)	Yes	No	Not Sure	No Response
Cause				
Heredity of Disease	10	0	0	12
Heredity of Personality	0	0	0	22
Personality (not inherited)	0	5	0	17
Red Meat	1	2	1	18
Pork	3	3	0	16
Salt	5	1	0	16
Sweets	0	2	0	22
Seasoning	2	2	0	18
"Wrong" Foods	5	3	0	14
Grease	2	2	0	18
Overweight	1	2	1	18
Alcohol	0	2	0	20
Heat	1	3	0	18
Aging	1	2	0	19
Marriage	1	3	0	18
Menopause/ Hysterectomy	1	2	0	19
Family	1	3	0	18
Children	1	3	0	18
Grandchildren	0	3	0	19

High Blood Pressure/Hypertension (Continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Cause				
Spouse	1	3	Ø	18
Stress	3	3	1	15
Worry	2	3	2	15
Crime	1	3	1	17
Money	1	3	Ø	28
"Pertension"	Ø	Ø	Ø	22
Fighting	Ø	3	Ø	19
Anger	Ø	3	Ø	19
Nerves	1	3	Ø	18
Coping (Holding in/ Letting go of feelings)	Ø	3	Ø	19
Fatigue	1	3	2	16
Anxiety	Ø	3	1	18
Exacerbating Factors				
Red Meat	1	1	Ø	20
Pork	6	2	Ø	14
Salt	10	1	Ø	11
Sweets	2	2	Ø	18
Seasoning	5	1	Ø	16
Wrong food	6	2	Ø	14
Grease	5	1	Ø	16
Overweight	1	2	1	18

High Blood Pressure/Hypertension (Continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Exacerbating Factors				
Alcohol	Ø	1	Ø	21
Heat	1	1	Ø	20
Aging	3	Ø	Ø	19
Marriage	1	1	Ø	20
Hysterectomy/ Menopause	4	1	Ø	17
Children	1	2	Ø	19
Grandchildren	1	2	Ø	19
Spouse	1	2	Ø	19
Stress	7	1	1	13
Worry	5	2	1	14
Crime	1	2	Ø	19
Money	2	2	Ø	18
"Pertension"	Ø	Ø	Ø	22
Fighting	1	1	Ø	20
Anger	Ø	2	Ø	20
Nerves	1	4	Ø	17
Coping	Ø	2	Ø	20
Fatigue	2	3	1	16
Anxiety	1	3	Ø	18
Pathophysiology				
Hot/Rich blood	3	Ø	Ø	18
Thick blood	1	4	Ø	17

High Blood Pressure/Hypertension (Continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
<u>Pathophysiology</u>				
Blood boils	0	0	0	22
Blood moves up	7	0	3	14
Blood moves up suddenly	1	2	1	18
Blood goes to head	6	0	1	15
Blood clogs	4	0	1	17
Blood stays up	4	0	1	17
Heart works too hard	3	1	1	18
<u>Symptoms</u>				
Heart beats too fast	2	1	1	18
Weakness	3	1	0	18
Dizziness	10	1	0	11
"Blind staggers"	3	2	0	17
"Falling out"	2	2	0	18
Visual disturbance	6	1	0	15
Nasal disturbance	2	4	0	16
Auditory disturbance	3	3	0	16
Feeling hot/cold	4	2	0	16
Fatigue	4	1	0	17
Disorientation	0	2	0	20
Headaches	10	0	1	11
Chest pains/ heaviness	1	3	0	18

High Blood Pressure/Hypertension (Continued)

Variable (Category underlined)	Yes	No	Not Sure	No Response
Course of Illness				
Will not go away	9	1	1	11
Will be cured	1	7	2	12
Is fatal	0	5	5	12
Will get worse	1	3	6	12
Has symptoms	10	0	0	12
Episodic	0	9	0	13
Predictable	10	0	0	12
Treatment				
Prescribed medication	12	4	2	4
Garlic	7	2	1	12
Vinegar	5	2	2	13
Lemon	3	2	1	16
Other	1	2	0	19
Diet	8	1	0	13
Weight loss	3	1	0	18
Temperature change	1	2	0	19
Rest	9	2	0	11
Relax	6	2	0	14
Don't worry	2	2	0	18
Quiet	2	2	0	20
Away from people	1	2	0	19
Pray	9	2	0	11
Root Doctors	1	9	0	12
Faith Healers	1	8	0	13