



SOCIAL REPRESENTATIONS OF MEN ABOUT SELF-CARE AND HIGH BLOOD PRESSURE

Cristina Arreguy-Sena*
Jéssica de Castro Santos**
Thayrine Silva Marcelo***
Paulo Ferreira Pinto****
Hérica Silva Dutra*****
Laércio Deleon de Melo*****
Marcos Antônio Gomes Brandão*****

ABSTRACT

Objective: to understand the social representations of men about self-care and high blood pressure. **Method:** it is a qualitative research based on the Social Representations Theory (procedural and structural approaches) and on Orem's concept of Self-Care Deficit. It was held in a public place in a city in Zona da Mata, Minas Gerais, with 118 men (age ≥ 18 years-old). Sociodemographic characterization data, free word evocation techniques and individual in-depth interview with audio recording guided by guiding questions were collected. The data were consolidated with the support of the software: EVOC®, SPSS24, NvivoPro11 and Iramuteq. Content analysis (theoretical density - Pearson's coefficient) was performed. Ethical and legal aspects are met. **Results:** the predominant age group is 18-29 years-old (41.5%). The emerging categories were: 1) adherence to preventive actions in self-care of hypertension (it demonstrated knowledge and insertion of participants) and 2) neglect of self-care in preventive actions of hypertension (doubts or justifications were evident for men not taking care of themselves). **Final considerations:** the group considers that self-care is the responsibility to have healthy habits (food and physical activity) for disease prevention; and high blood pressure is influenced by: unruly food, physical inactivity and stress, requiring self-care to control and maintain health.

Keywords: Nursing. Chronic Disease. Hypertension. Men's Health. Self-care. Nursing Models.

INTRODUCTION

The Brazilian population is composed of 210,147,125 inhabitants, out of them 48.2% are men⁽¹⁾, whose gender stereotypes are rooted in society, ways of coping with diseases, curative and hospital-centered health models weaken the care of their specificities in the context of the health-disease process, as a vulnerable group that has a defined public policy⁽²⁾, justifying its low adherence to personal care and access to health services⁽³⁾.

In order to explain the specificities of man's demands, the National Policy for Integral Attention to Men's Health (PNAISH) prioritizes

care in the age group of 20-59 years-old, proposing health guidelines and actions that contributed to the understanding of the reality and uniqueness of men, and rescuing their social, cultural, political and economic role in the social context. It focuses on health promotion actions, prevention of diseases and injuries, in order to avoid the occurrence of advanced/acute stages of non-communicable conical diseases (NCDs), which may reduce the need for complex interventions/burdensome to users and the health system⁽⁴⁾.

The morbidity and mortality indicators that underpin the need for the policy show that 75% of illnesses and injuries related to men's health affect

*Nurse. Doctor. Federal University of Juiz de Fora - UFJF. Professor of the Graduate Program at FACENF. Juiz de Fora, Minas Gerais - MG - Brazil. E-mail: cristina.arreguy@gmail.com
ORCID iD: 0000-0002-5928-0495.

**Nurse. PhD student at the Anna Nery School of Nursing at the Federal University of Rio de Janeiro (UFRJ). Rio de Janeiro, RJ - Brazil. E-mail: jessicacastroenf@gmail.com ORCID iD: 0000-0002-8336-156X.

***Nurse. Adult Health Specialist with Emphasis on Chronic-Degenerative Diseases at the Federal University of Juiz de Fora. Juiz de Fora, Minas Gerais - MG - Brazil. E-mail: thayrine.ufjf@gmail.com ORCID iD: 0000-0003-1460-6399

****Physical educator. PhD, Professor at FAEFID School of Physical Education and Sports, Federal University of Juiz de Fora - UFJF. Juiz de Fora, Minas Gerais - MG - Brazil. E-mail: paulo.ferpinto@gmail.com ORCID iD: 0000-0001-7321-3160.

*****Nurse. Doctor. Federal University of Juiz de Fora - UFJF. Professor of the Graduate Program at FACENF. Juiz de Fora, Minas Gerais - MG - Brazil. E-mail: enherica@gmail.com ORCID iD: 0000-0003-2338-3043

*****Nurse. Teacher. College professor at Centro Universitário Estácio JF. Juiz de Fora, Minas Gerais - MG - Brazil. E-mail: laerciodl28@hotmail.com ORCID iD: 0000-0002-8470-7040.

*****Nurse. PhD, Professor of the Graduate Program at EEAN. Anna Nery School of Nursing (EEAN) at the Federal University of Rio de Janeiro (UFRJ). Rio de Janeiro, RJ - Brazil. E-mail: marcosantonioogbrandao@gmail.com ORCID iD: 0000-0002-8368-8343.

five areas: external causes portrayed by transport accidents, assaults and self-harm (deaths: 19.32%); circulatory diseases (deaths: 28.23%); oncological (deaths: 15.86%); respiratory (deaths: 10.7%) and digestive⁽⁵⁻⁶⁾. There are 4.57% of deaths attributed to parasitic infectious diseases and it is worth mentioning that external causes are the first cause of mortality among men aged 15-40 years-old, surpassed in number only by circulatory diseases in men aged ≥ 45 years-old⁽⁵⁾.

Systemic Arterial Hypertension (SAH) is considered a NCD directly responsible (in) for the occurrence of 335,213 cases of death in 2011, of which 175,254 were men (50,877 due to cerebrovascular diseases, 60,158 due to ischemic heart diseases and 64,219 due to other diseases of the device circulatory system)⁽⁶⁾. It is multifactorial and complex, conceived as a stratified clinical condition in five stages (elevated, stage 1 hypertension, stage 2, hypertensive urgency and hypertensive emergency) in which blood pressure levels remain systematically elevated (systolic values ≥ 120 mmHg and/or diastolic values < 80 mmHg) observed by more than three different measurements⁽⁷⁾.

The increase in blood pressure levels can be motivated by: metabolic disorders, functional changes in target organs and stresses and worsen in the presence of obesity, dyslipidemia and Diabetes Mellitus (DM). It is worth mentioning that there are conditions considered modifiable, which refer to the need for self-care in terms of health promotion, prevention, disease control, treatment and rehabilitation⁽⁷⁻⁸⁾.

In this sense, the nurse can help men to identify what are the potentialities of self-care, demands for total or partial care and at what level this care provision should occur⁽⁸⁻⁹⁾.

In this investigation, self-care is conceived as the concepts, actions, basic conditioning factors and therapeutic demand that express how men take care of themselves⁽¹⁰⁾, it allows portraying how the male social actors in this investigation behave, act, know, inform themselves, value and portray self-care and increased blood pressure⁽¹⁰⁻¹¹⁾.

Capture human responses of how men in their daily lives deal with situations of the health-disease process, risky circumstances, vulnerability, health promotion and disease prevention, constitute evidence capable of

supporting the structuring of care and decision-making of actions therapies in line with the PNAISH⁽⁴⁾. It is believed that men form a group socially constituted by health demands related to male specificity and that SAH and self-care are representational objects that can be captured by "common sense".

Given the above, the following research question emerged: how do men, as social actors, represent self-care and high blood pressure regarding the specificity of male health care? This essay aimed to understand the social representations of men about self-care and high blood pressure.

MATERIAL AND METHOD

This essay is a qualitative research outlined in the Social Representations Theory (TRS)⁽¹²⁾ according to the triangulation of the structural⁽¹³⁾ and procedural⁽¹⁴⁾ approaches described according to the Consolidated Criteria For Reporting Qualitative Research (COREQ)⁽¹⁵⁾ criteria.

The Social Representation Theory (SRT), used as a methodological framework, is suitable for nursing research, as it allows the identification of behaviors, attitudes, knowledge, information, values and objects used to represent what was built (anchored and objectified) in a socially contextualized conception⁽¹⁴⁾ about the representations of self-care and SAH.

The choice of the concept of self-care proposed by Orem⁽¹⁶⁾, as it allows accessing the conception of how men behave and conceive high blood pressure and practice with themselves, justified the choice of this theoretical framework as a component for data analysis.

The scene of the investigation was the public road (bus stop) located near a public higher education institution and a Basic Health Unit (BHU) in a municipality in Minas Gerais, where the participants were recruited.

Men aged ≥ 18 years-old with coherent speech were included, and those ones who did not complete data collection or who did not wish to interrupt their participation were excluded. It is a typical sample. The sample design met the criteria recommended for the structural ($n > 100$)⁽¹⁷⁾ and procedural ($n > 22$)⁽¹⁸⁾ approaches and the accessibility criteria for passers-by and their availability, totaling 150 participants after applying the inclusion criteria and exclusion,

totaling 32 losses due to interruption or refusal.

The data collection instrument was composed of: 1) sociodemographic characterization; 2) free word association technique triggered by verbally pronounced inducing term; 3) individual in-depth interview based on guiding questions; and 4) field diary records.

The data collection was carried out by a researcher who approached passers-by on public roads (May-September/2016), at times of greater flow (Mondays, Wednesdays and Fridays from 11:30 am to 12:30 pm and from 6:00 pm to 7:00 pm - commuting hours to lunch and return home), using the Open Data Kit (ODK®) application on Android® operating system to record information. The characterization variables were consolidated in software Statistical Package for the Social Sciences (SPSS) version 24 and analyzed according to descriptive statistics (trends of centrality and dispersion).

In the structural approach of SRT, the technique of free association of words was used, which consists of obtaining up to five words/expression from social subjects to designate an object and encourage them to access content about the theme addressed through internalized impressions⁽¹⁹⁾. The inducing terms were: “take care of yourself” and “high blood pressure”.

The cognemas, that is, the words or expressions issued verbally by the participants in the evocation technique (structural approach) were consolidated in the Excel for Windows 2016 program and submitted to the dictionary technique or equivalent terms technique (meeting of consensual terms according to gender, number, tense, approximated by hyphen and prepositions, conjunctions and articles removed). For this, lexicographic and semantic criteria were used. The substitution of raw (original) contents with those obtained with the dictionary technique made it possible to homogenize evocations, reduce dispersion of contents, bringing together the cognemas under the same designation of common meanings⁽¹²⁻¹³⁾. This homogenized content was introduced in the EVOC® software (Ensemble of Programs PermettantL'analysedes Évocations) to operationalize the prototypical analysis (Four boxes matrix table).

There were 438 and 455 cognemas evoked for “high blood pressure” and “taking care” with 98 and 91 distinct words, respectively, obtained

using the following parameters: corpus composed of 31.1% and 25.1% of cognemas, respectively, frequency minimum of 28, intermediate of 34 and Average Order of Evocation (OME or rangé the position that each cognema was mentioned after being accessed mentally) of 2.5. These parameters allowed obtaining a table with four quadrants where the cognemas were allocated according to the frequency and order in which they were mentioned.

The quadrants in the four boxes matrix tables make it possible to identify nuclear and peripheral contents that portray: 1) Upper Left Quadrant (ULQ) - possible central nucleus allocates the cognemas emitted more frequently and mentioned more readily (high frequency and low OME). Depict consensual content; 2) Lower Left Quadrant (LLQ) - contrast area, the cognemas mentioned are more readily allocated, but emitted less frequently (low OME and low frequency); 3) Upper Right Quadrant (URQ) - first periphery, the mentioned cognemas are allocated more frequently and later (high OME and high frequency); and 4) Lower Right Quadrant (LRQ) - second periphery, the cognemas mentioned later and less frequently (high OME and low frequency), portraying content from personal experiences whose purpose is to stabilize shared content⁽¹²⁻¹³⁾.

In order to verify the stability character of the most prominent elements identified in the four boxes matrix table (allocated in the possible central nucleus), the entire corpus, treated by the dictionary technique, was introduced in the software IRAMUTEQ version 0.7 alpha 2, to validate this content by similarity analysis. We sought to highlight the co-occurrences and connectedness of the cognemas that were mentioned concurrently and more frequently by the social actors, using the proximity index (variability: 0-1) as an analysis parameter. We chose to present the results in a dynamic tree graph with community grouping and focus and connections according to the Fruchterman-Reinglode layout⁽²⁰⁾.

In the procedural approach, in-depth interviews with audio recording took place from the guiding questions: How do you do or should someone do to avoid having high blood pressure? What do you do or should someone do to control the pressure? Tell a case that happened to you or someone you know who drew your attention to

how a man takes care of his own health or how to take care of himself.

The result of the in-depth interview was fully transcribed and registered in the Word for Windows program, being subjected to content analysis (pre-analysis, material exploration and treatment of results, inference and interpretation)⁽²¹⁾. The data were processed using the Nvivo Pro 11® program, the content of which underwent thematic-categorical content analysis⁽²²⁾ operated in analysis and registration units until categories were obtained. The following criteria were adopted: relevance, representativeness, homogeneity and completeness⁽²¹⁾. The units of analysis were structured by “nodes” previously defined according to the representational dimensions (behavioral-attitudinal, informative-cognitive, evaluative and objective) and representational origins (own, family, friends, neighbors, health professionals, institutional, and others) and the axes that portray the concept of adopted self-care (self-care, activities, requirements and therapeutic demands of self-care).

The criterion adopted for the meeting of the analysis and registration units in categorical format was based on the theoretical density measured by Pearson's coefficient (values

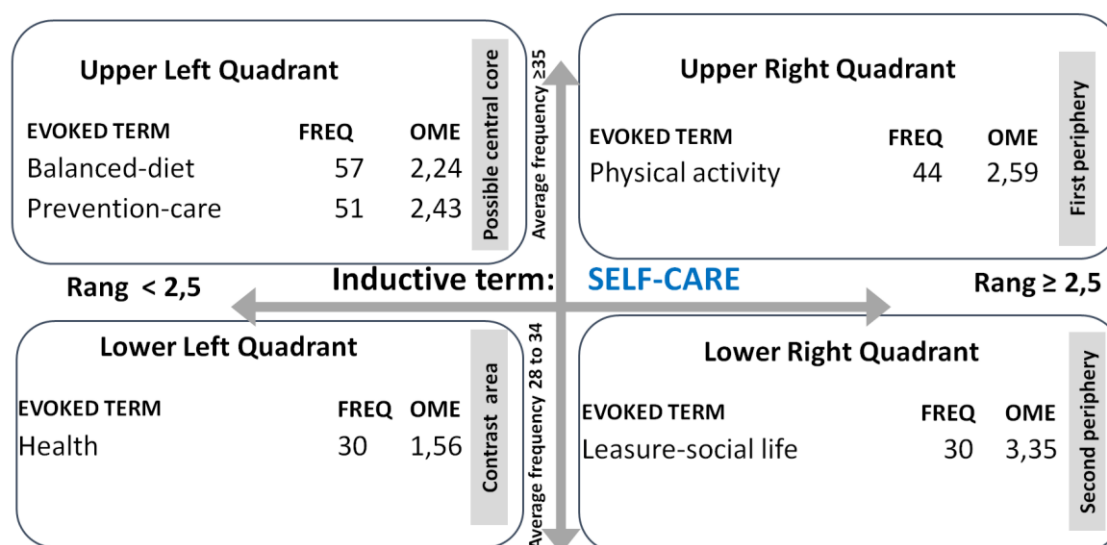
between 0.97 and 0.72), reconciling the balance of the contents with the SRT and the concept of self-care proposed by Orem. The results were presented in two categories whose content was discussed in the light of the adopted theoretical frameworks and evidence from the literature.

All ethical and legal requirements for research involving human beings were met (opinion no.: 1,466,399 of 03/28/2016). This research integrated a matrix investigation entitled "Social representations of men about health, illness, treatment, self-care, prevention and seeking care". To maintain the anonymity of the participants, codes were used to portray them (PA01 to PA50).

RESULTS AND DISCUSSIONS

118 men participated in the research, characterized by: being adults - 18 to 59 years-old (82.2%); singles (54.2%); without children (52.5%); declared themselves white (53.4%); study time ≥ 12 years (65.2%); average personal income of 2.2 minimum wages; not retired (83.1%); they resort to public services for assistance (58.5%) motivated by diseases: infectious (28%); cardiovascular (22%); respiratory diseases (12.7%), 27.1% of which are known to be hypertensive.

Figure 1: Four boxesmatrix table for “self-care” and “high pressure” inducers and their similarity tests (n=118). Juiz de Fora, August/2020.



Source: Data generated by the EVOC software.

Authors' note: OME- Average Order of Evocation. Rang - Average OME value.

The profile of the participants can be explained by the fact that the research scenario is

located in the vicinity of a higher education institution. The construction of the concept of “being a man” arises from the hegemonic idea of masculinity, as a social construction rooted in a social context governed by the presence of gender stereotypes that recognize men as being strong and invulnerable, reproducing an idea that illness and care they are female characteristics⁽²³⁾.

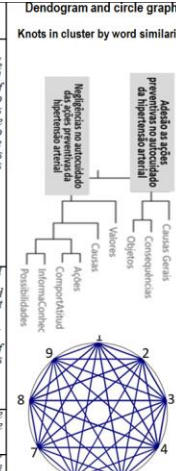
Self-care is when the individual develops actions for his own benefit in order to preserve his health, through the development of activities to promote health and prevent diseases and

injuries^(16; 24). It should be stimulated and practiced by everyone, regardless of variables such as gender, age or education level.

Figure 1 shows the result of the structural approach, explained by the four boxes matrix table for the inductive terms “taking care” and “high pressure” and the similarity analysis.

Two categories were identified in the procedural approach: 1) Adherence to preventive actions in the self-care of arterial hypertension and 2) Negligence in the self-care of preventive actions of arterial hypertension (Figure 2).

Figure 2: Fragments of speeches on self-care and arterial hypertension.

Adherence to preventive actions in self-care of hypertension			Neglect in self-care in preventive actions of arterial hypertension			Dendrogram and circle graph Knots in cluster by word similarity		
Representational dimensions	ATTITUDINAL AND BEHAVIORAL: I have a more balanced diet, currently I don't do physical exercises, but I know its importance to control high blood pressure. PA15 I eat a special type of salt. PA8 My wife has high blood pressure, so she takes medicine regularly. COGNITIVE AND INFORMATIV: the control of pressure is more complicated, it's important to eat less salt in the food, in the right amount and also in practicing physical exercise a little [...]. I think that in the reduction of salt, a good food, more fruits than industrialized food that has more sodium, isn't it? VALUATION: it is important to have less salt in the food, in the right amount and, also, to do physical exercises a little. PA18 they are usually disorganized with medicine, with food and do not take much precaution. PA26 OBJECTIVE: I'm taking medicine, am I? The doctor prescribed me because I have health problems. PA10 To avoid high blood pressure we must avoid salty food, drink a lot of liquid and take care [...] eat more vegetables, it's basically this. PA17. ante líquidos e cuidar [...] comer alimentos mais vegetais; é basicamente isso! PA17.			ATTITUDINAL AND BEHAVIORAL: gymnastics and weight control, but I am not sure if determined care will solve it [...]. I advise someone who ask me to look for a doctor. I think he can advise better. PA01 COGNITIVE AND INFORMATIV: He (uncle) drinks and eat salty food. I'm in the salty food. Even healthy food, he also puts salt. It's not using to talk to him. VALUATION: it is essential to do physical exercise and food. It's basic for everything; But I smoke, drink and eat salty food. I'm in the middle, huh? Preventing... for the people who already has problem. So it's necessary to see the doctor and take the medicine. OBJECTIVE: He (father) is a little stubborn in seeing the doctor, until the day that he was very bad with blood pressure and said me, Oh, I can die today. He was hospitalized and after what happened he still doesn't control food.				
	ATHLETE ORIGIN: some famous people, because of their age, take care of themselves a lot, and more because they are athletes [...] Some people live more, a little bit more because they care their health. PA04. OWN ORIGIN: to keep an stable weight, a good food, to avoid smoking habits [...] I do this kind of things. PA05. DOCTOR: I had a medical check-up and everything was perfect! The doctor even praised my physical condition, he was surprised when I said I smoke, and he said: so, stop. PA06 Now he (father) takes the medicine that he should take and see the doctor when he feels something. PA08. FAMILY: he (father) started to take care of himself. He changed his diet, doesn't eat salt anymore. My mom has to cook his food in olive oil. [...] after a bad situation, my father takes care of himself periodically, not the food, but himself. PA48.			Own: I don't have control! Currently I don't do physical exercises, but I know its importance. PA02. Family: My father died of stroke. He was stressed and anxious. He had two strokes and take medicine to control blood pressure every day, but it didn't help, because he died. PA06. Health professional: the doctor said it is genetic. I think there is no way. We were born with this. PA05. Friend: A friend of mine has high blood pressure and doesn't take care of himself. He doesn't care! He thinks it's better to have the same habits than getting a better quality of life. PA27.				
Self-care	I'm afraid with psychological question. For sure, stress causes high blood pressure, also food question. PA12 [...] I think that we should know that what can happen with others may happen with us too, and preventing, practicing physical activities, eat well, avoid stress. PA16			Own origin: I don't control it. I think I don't need because I don't have health problem. PA15. So, I don't have to control it so much, because the most that will happen to me is I fall and pass out. PA25				
	Sometimes, I check it, when I think I am a little accelerated or feeling sick, I go to the drugstore and check it (blood pressure), avoid salt, alcoholic beverage and medicine. PA11. I do physical exercise, take care my food and take care of relax exercises. I'm afraid with psychological question. Stress, for sure, causes high blood pressure and there is the question of food. PA12.			I think this is hopeless. You are born with high blood pressure, right? PA19 I don't do anything special because my blood pressure is normal [...] to control it when we already have (high blood pressure). So, we have to avoid salty food, alcoholic beverage and take medicine. PA11. I do not prevent myself, even though I have a lot of stress at work and family. PA42				
Requisitos	Origin in the home stuff. It is necessary the doctor follow-up, sometimes we take medicine, but physical exercises and food are essential. It's the basis of everything. PA13. I think we should know. If it can happen with others, it may happen with us too. We should prevent it, practice physical activity, eat well and avoid stress. PA16.			Own: I have bradycardia and I don't feel any changes, any kind of dizziness. That's why I don't take care of myself. PA14 My blood pressure is high anyway! Even taking medicine, it doesn't go down anyway, so I let it go. PA23				
	Health professional: I am taking medicine, huh? I didn't have high blood pressure, the doctor wants that I take the medicine independently of my blood pressure [...] So I am taking the medicine that the doctor prescribed. PA01. The control is what the person must have			Health professionals: although they speak, I don't take medication, I don't exercise and I still eat fat food. I like it. PA16				
Exigências terapêuticas							LEGENDA (Fonte/Fragments)	
							1: Ações (49/134)	
							2: Causas específicas (34/48)	
							3: Causas gerais (36/50)	
							4: Dimensões comportamental e atitudinal (46/121)	
							5: Consequências (16/17)	
							6: Dimensões informativa e cognitiva (35/58)	
							7: Dimensão objetiva (39/50)	
							8: Possibilidades (31/44)	
							9: Dimensões valorativas e afetivas (14/21)	

Source: Data generated by the NVivo PRO 11 software.

By bringing the category “Adherence to preventive actions in self-care of SAH” (procedural approach) closer to the evoked cognema (structural approach), it was possible to identify that the social actors mentioned the need to adhere to preventive measures, what are a component of self-care. These are conducts that contribute to the integrality, functioning and development of the being, corroborating the understanding about self-care as behaviors and conducts carried out autonomously by the person on their own initiative with the purpose of adding health benefits, quality to the years lived and feeling of integral well-being⁽¹⁶⁾.

The balanced-food cognema, allocated in the

possible central nucleus, shows the behavioral dimension valued in a positive way to the point of portraying the concept of self-care mentioned by the social actors. This cognema brings together the functions: 1) to know, by referring to information and knowledge that food is a fundamental element to be incorporated into the habits of a person who craves health; 2) advisor, insofar as it directs the way of acting, valuing and conducting socially; 3) justification, which makes it possible to explain the behaviors and positions of those who take care of themselves and 4) identity, which characterizes a pattern of behavior to which the values, concepts and

norms of conduct adopted by the social group are incorporated.

In the procedural approach, a balanced diet was mentioned as a fundamental point to health and stemming from a behavior of self-determination in the way of eating. Stable weight, abstaining from some foods, restriction in the use of salt and increased consumption of fruits and vegetables were markers, as mentioned by some participants (PA05, PA08, and PA18).

Another cognema allocated in the possible central nucleus was prevention-care, which portrays the behavioral-attitudinal and objective dimension and the functions of knowledge, identity, guidance and justification similar to the balanced-food cognemas. The presence of these two cognemas in the possible central nucleus, when approached to the concept of self-care, reinforces the concept that taking care is linked to an act that requires persistence and the creation of habits inserted in daily life⁽¹⁶⁾.

On the other hand, the health cognema is located in the contrast area, since although it was mentioned promptly, it did not have the necessary adhesion to allow it to ascend to the central nucleus. These cognemas are linked to the central nucleus, since a balanced diet is valued as a condition to obtain health. The concern with health, which is part of the LLQ, justifies the adoption of prevention-care as a lifestyle to be incorporated into everyday life that is covered with intentionality⁽¹⁶⁾. This fact can be exemplified with the experience of participant PA16 in the procedural approach.

In the ULQ, the first periphery, the physical activity cognema is allocated, which refers to the objective and behavioral dimension; it is the component that is linked to a balanced diet and refers to a prevention-care conduct (cognemas allocated in the ULQ). Physical activity refers to the functions: 1) guiding the behavior of social actors, 2) knowing - since they recognize its importance from information and knowledge learned from social sharing, 3) identity - characterizing a social group that it values it in accordance with a social system and context, and 4) justification - insofar as it explains the connection between the search for well-being based on a behavior of concern and care for you.

In the procedural approach, physical activity

is conceived as a behavior to be cultivated and valued as a way of taking care (PA13), as something neglected (PA02) or used in cases of extreme need.

The leisure-convivial-social cognema, located in the second periphery (LRQ), refers to the behavioral/attitudinal dimension and the justification function that values the interpersonal relationship as a stress reduction strategy. This fact was corroborated by the participants (PA03 and PA12) and is linked to the prevention-care and health behavior allocated in the ULQ and LLQ, respectively.

In the validation of the content allocated in the ULQ for the inductive term “to take care”, it was possible to identify that the food-unbalanced and prevention-care cognemas derived for different cognemas, whose co-occurrences allowed to identify that: 1) the unbalanced food derived for use of medicine, sleep and physical activity and 2) prevention-care derived for health, doctor, exam, well-being, responsibility, love, discipline, study and self-esteem.

The graph derived from the inductive term “high pressure” allows the identification of two complementary situations that are linked to the act of taking care and involve the commitment, decision and resources available for the prevention of diseases and treatment when blood pressure levels rise.

In the category “Adherence to preventive actions in the self-care of SAH”, self-care addressed by social actors through healthy eating, the necessary restrictions and choices for healthy foods, the regular practice of physical activities, the control of stress and abstaining from smoking and alcohol use.

Healthy eating, physical activity practices, daily stress control and abstinence from drug use (legal), such as smoking and alcohol consumption, represent the main self-care actions in adhering to preventive measures of SAH and other NCDs. Therefore, “the regulated diet with restriction of components such as salt, preservatives, sugars and fats; regular physical activity to control overweight and clinical and pharmacological treatment essential pillars for the control of SAH and the prevention of health problems”⁽²⁴⁻²⁵⁾.

Behaviors, attitudes, knowledge, information, values and the way the social

actors perceived the pressure and the way they take care were mentioned. They mentioned the need to adhere to preventive measures and self-care through healthy eating and with restrictions on some components, regular physical activity, stress control and abstention from smoking and alcohol use.

By bringing the category “Negligence to self-care in SAH preventive actions” closer to the content of the four boxes matrix table, it was possible to identify that the participants mentioned the problem-health cognema, aiming at and explaining the information and knowledge they access about high blood pressure and that they were incorporated into the cognitive and evaluative perspective to the point of being a content shared by social actors. This explains that SAH is a close event and inserted in their daily lives, which portrays the role of knowledge and justification of social representation.

Among chronic diseases, SAH is one of the most prevalent, having as main causes overweight, obesity and physical inactivity, being the main risk factor for the appearance of more severe CVD. Adherence to treatment is essential for the prevention of health problems and maintenance of health, but the adoption of healthy practices and the coping with factors that hinder adherence to self-care, and the recommendations of health professionals are perceived as a challenge⁽²⁶⁾.

In the contrast area (LLQ), the unbalanced food-unbalanced cognema, of an evaluative dimension, explains and justifies why a person may have high blood pressure and explains the filter by which they become vulnerable to high blood pressure or allow it to rise from of your incorrect eating behavior. Food was mentioned in the procedural approach as something neglected by the participants, even in situations in which they recognize its harm and the consequences that may arise on the state of health (PA12). Salt, frying, alcoholic drinks and the use of processed foods were forms of objectification that portrayed unbalanced food (PA12 and PA17).

Healthy eating has a fundamental role in maintaining health and preventing and treating NCDs, including CVDs. Therefore, the identification of eating habits becomes extremely important in order to implement

measures and strategies for the prevention and control of SAH (24; 27).

There is an association between excessive sodium consumption and the development of NCDs, including SAH and CVD, thus requiring actions aimed at reducing salt consumption aiming at the prevention/control of NCDs related to food^(11,20).

In the first periphery (URQ) two cognemas were mentioned: stress-anxieties and linked to the problem-disease cognema, which is located in the possible central nucleus. It refers to the behavioral/attitudinal dimension and the functions of knowledge, justification, and identity to the extent that it informs one of the modifiable causes of arterial hypertension, explains why a person can develop changes in blood pressure levels and allows identifying adopted behaviors and positions that may have as an outcome the increase in pressure.

Stress has been considered one of the most important risk factors for the development of diseases, and can be defined as a state of pathogenic tension. It generates bodily responses that can influence metabolic, cardiovascular and autonomic nervous systems, leading to tachycardia and hypertension⁽¹⁹⁾.

The other cognema mentioned was the medication, an element of the objective dimension that emerges as a marker of the disease - identity function (linked by the cognemas allocated in the possible central nucleus - problem-disease) and an orientation function in directing how the social actors who have pressure act and conduct themselves therapeutically. This fact was mentioned in the procedural approach by the participant (PA10) and consists of a confirmation of the recognition of the disease already installed.

It can be observed that, in most cases, the reasons for seeking care referred to the treatment of installed diseases, which indicates that the participants seek care in situations of aggravation. This is due to the fact that they believe they are invulnerable, not having the perception that the disease is something they are exposed to. In addition, to intensify this search for assistance, there is the prevalent biomedical and curative model, which makes many men not believe that health promotion and disease prevention actions are effective⁽²⁸⁾.

Physical inactivity, cognemas allocated in

the second periphery, is another cause identified by the social actors that can trigger the change in blood pressure levels. This cognema refers to the behavioral dimension with a negative value for physical well-being, sometimes portrays a behavior of neglect with one's own health (PA02) and refers to the problem-disease cognema allocated in the possible central nucleus.

The presence of the fear-death cognema allocated in the second periphery constitutes an example of a justifying function of the representational content originated from the personal, family and acquaintances' experience of some social actors when they have contact with hypertensive crises and when they see these people evolve to severity pictures who required hospitalization or who had death as an outcome (PA05). This experience generated reflections on the connection between personal conduct and health status, portraying the guiding function, a guiding filter of the behavior and shape of people facing life.

The category "Neglect to self-care in SAH preventive actions" when showing that blood pressure is linked to non-adherence to preventive and self-care measures justified by doubts about the success of preventive care, the prioritization of habits and routines, and when aware of the that it would be necessary to do this neglect it, justified by a social view that only when hypertensive would they need to adopt healthy habits that include eating and practicing physical activities. Regular use of medication and professional follow-up emerged as a marker of behavior change. Such conceptions, values, information, behaviors, attitudes were corroborated by triangulating the structural and procedural approach.

Men does not perceive health care as something inherent to masculinity, which means that they do not believe that health promotion and disease prevention actions are relevant⁽²⁹⁾.

To make it more difficult, health services, as they are available nowadays, intimidate and distance men, a fact that intensifies their vulnerability of preventable situations, as the hours available for care coincide with work hours. This makes it difficult for them to attend health units. They become resistant to access services⁽⁴⁾.

In the validation of the representational content by the similitude technique, it was possible to identify the centrality of the problem-health cognema and its connection with stress-anxiety and the remedy (URQ) and with physical inactivity (LRQ). It is worth mentioning that in the similitude tree it is identified that: 1) the health problem was linked to fear-death, the consumption of salt, the use of fat, the need for treatment, the appearance of manifestations such as dizziness and tremor, among others; 2) stress-anxiety is linked to unbalanced eating, the genetic factor, the behavior of not smoking and drinking, blood pressure levels, the appearance of boredom and the need to take care of yourself (have-to-take care); 3) physical inactivity derived from the cognemas sleeping, obesity and family, portraying the influence of these factors on the functionality of the body (obesity and sleeping) and the impact of possible stressors originating in the family context; and 4) the cognema remedy was derived for a physician (professional who prescribes it), care (act of recognizing the need for adherence to medication therapy) and tranquility (arising from the certainty of the medication's therapeutic effect in controlling blood pressure levels).

As it is an asymptomatic disease in most cases, SAH is neglected, but it is noteworthy that it does not only include the use of medications, there is also a need for changes in habits and lifestyle. It is necessary to adopt a healthy diet, cease smoking, alcohol consumption and the adoption of physical activity⁽²⁾. These changes in habits can be accompanied by resistance, since they are considered difficult tasks, as they involve changes in the way of life and the person's own conceptions of health and how that change can impact their life⁽⁴⁾.

Resistance to seek health care is multifactorial and may include: the coincidence between the opening hours of health services and the working hours of this segment (makes access difficult); absenteeism, although justified, can compromise their employment relationship and the maintenance of their home; the service is predominantly provided by women; the fear of being ill or the inability to self-care, among others⁽²⁴⁾.

When bringing the category "Neglect to self-care in SAH preventive actions" closer to the content of the four boxes matrix table, the participants mentioned behaviors, attitudes, knowledge, information, values linked to non-adherence to preventive and self-care measures justified by doubts about their success preventive care, the prioritization of habits and routines, and when aware of what would be necessary to do, they neglect it justified by a social view that only when hypertensive would they need to adopt healthy habits that include eating and practicing physical activities. Regular use of medication and professional follow-up emerged as a marker of behavior change.

FINAL THOUGHTS

The significant grouping of the two representational analysis indicated a typical way of thinking of the social group regarding self-care and hypertension: "Self-care is the responsibility of the individual, whose practice of healthy eating and physical activity exists to maintain health and prevent diseases"; and "SAH is caused by unruly nutrition, physical inactivity and stress, and needs to be taken care

of and controlled to maintain health, as it can trigger other diseases".

Resistance and postponement for seeking care are not only associated with social conditions, but also based on a culture that men are strong beings, that they do not get sick and that disease is synonymous with fragility.

Man must be considered a unique being with his particularities, with his feelings, values and experiences. Understanding these conditions is essential for the development of measures to promote individuals' access to health services, especially in primary care, in order to guarantee disease prevention and health promotion. Therefore, in order for qualified nursing assistance to occur, it is essential to use a reflexive and participative communication technique, which facilitates dialogue and understanding by the user, facilitating the promotion of educational actions.

It is hoped that the findings of this research may add subsidies to the organization of services and the implementation and planning of health actions aimed at the male population, so that PNAISH can be implemented and changes in the male morbidity and mortality profile occur.

REPRESENTAÇÕES SOCIAIS DE HOMENS SOBRE AUTOCUIDADO E PRESSÃO ALTA

RESUMO

Objetivo: compreender as representações sociais de homens sobre autocuidado e pressão alta. **Método:** pesquisa qualitativa alicerçada na Teoria das Representações Sociais (abordagens processual e estrutural) e no conceito de Déficit de autocuidado de Orem. Realizada em via pública em uma cidade da Zona da Mata mineira com 118 homens (idade ≥ 18 anos). Coletados os dados de caracterização sociodemográficas, as técnicas de evocação livre das palavras e a entrevista individual em profundidade com gravação de áudio guiada por questões norteadoras. Os dados foram consolidados com apoio dos *softwares*: EVOC®, SPSS24, NvivoPro11 e Iramuteq. Realizada análise de conteúdo (adensamento teórico - coeficiente de Pearson). Atendidos os aspectos ético-legais. **Resultados:** faixa etária predominante 18-29 anos (41,5%). Foram categorias emergentes: 1) adesão às ações preventivas no autocuidado da hipertensão (demonstraram conhecimento e inserção dos participantes) e; 2) negligências ao autocuidado nas ações preventivas da hipertensão (evidenciou-se dúvidas ou justificativas para os homens não se cuidarem). **Considerações finais:** o grupo considera que o autocuidado é a responsabilidade em ter hábitos saudáveis (alimentação e atividade física) para prevenção de doenças; e a pressão alta é influenciada por: alimentação desregrada, sedentarismo e estresse, sendo necessário o autocuidado para o controle e manutenção da saúde.

Palavras-chave: Enfermagem. Doença Crônica. Hipertensão. Saúde do Homem. Autocuidado. Modelos de Enfermagem.

REPRESENTACIONES SOCIALES DE HOMBRES SOBRE EL AUTOCUIDADO Y LA PRESIÓN ARTERIAL ALTA

RESUMEN

Objetivo: comprender las representaciones sociales de hombres sobre el autocuidado y la presión arterial alta. **Método:** investigación cualitativa basada en la Teoría de las Representaciones Sociales (abordajes procesual y estructural) y en el concepto de Déficit de autocuidado de Orem. Realizada en vía pública en una ciudad de la Zona da Mata Mineira-Minas Gerais-Brasil con 118 hombres (edad ≥ 18 años). Fueron recolectados los datos de caracterización sociodemográficas, las técnicas de evocación libre de las palabras y la entrevista individual en profundidad con

grabación de audio conducida por cuestiones orientadoras. Los datos fueron consolidados con el apoyo de los softwares: EVOC®, SPSS24, NvivoPro11 y Iramuteq. Fue realizado análisis de contenido (densificación teórica - coeficiente de Pearson). Fueron atendidos los aspectos ético-legales. **Resultados:** franja de edad predominante 18-29 años (41,5%). Las categorías resultantes encontradas fueron: 1) adhesión a las acciones preventivas en el autocuidado de la hipertensión (demostraron conocimiento e inserción de los participantes) y; 2) negligencias al autocuidado en las acciones preventivas de la hipertensión (se evidenciaron dudas o justificativas para que los hombres no se cuiden). **Consideraciones finales:** el grupo considera que el autocuidado es la responsabilidad de tener hábitos saludables (alimentación y actividad física) para la prevención de enfermedades; y la presión alta es afectada por: alimentación desordenada, sedentarismo y estrés, siendo necesario el autocuidado para el control y el mantenimiento de la salud.

Palabras clave: Enfermería. Enfermedad Crónica. Hipertensión. Salud del Hombre. Autocuidado. Modelos de Enfermería.

REFERENCES

1. Instituto Brasileiro de Geografia e Estatística (IBGE). Fonte para dados olímpicos. [Internet] Brasil: IBGE, 2019. [citado 2020 Jul. 21] Disponível em: <https://www.ibge.gov.br/apps/populacao/projecao/>
2. Mendonça FA da C, Moreira TMM, Sampaio LRL, Brasil BMBL, Arruda CN de, Diogenes KCBM, et al. Associações entre o estilo de vida masculino e ações de promoção de saúde. *Motricidade. SciELOpt*, 2018; 14: 355-61. Disponível em: <http://www.scielo.mec.pt/pdf/mot/v14n1/v14n1a55.pdf>
3. Moura EC, Gomes R, Pereira GMC. Percepções sobre a saúde dos homens numa perspectiva relacional de gênero. *Cienc e Saúde Coletiva*. 2017;22(1):291-300. DOI: 10.1590/1413-81232017221.17482015.
4. Brasil. Política Nacional de Atenção Integral à Saúde do Homem: princípios e diretrizes. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas e Estratégicas - Brasília: Ministério da Saúde, 2009.92 p.: il. - (Série B. Textos Básicos de Saúde). Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_atencao_saude_homem.pdf
5. Tabnet-DATASUS. Proporção de óbitos (%) por Grupo de Causas segundo sexo. Brasil: Ministério da Saúde/SVS - Sistema de Informações sobre Mortalidade(SIM); 2011. Disponível em: <http://tabnet.datasus.gov.br/cgi/tabcgi.exe?idb2012/c04.def>
6. Tabnet-DATASUS. Taxa de mortalidade específica por doenças do aparelho circulatório. Brasil: Ministério da Saúde/SVS - Sistema de Informações sobre Mortalidade (SIM); 2011. Disponível em: <http://tabnet.datasus.gov.br/cgi/defhtdm.exe?idb2012/c08.def>
7. American Heart Association. American Stroke Association. 2017. Detail Guideline for the prevention, detection, evaluation and management of high blood pressure in adults. 2017;1-20. American College of Cardiology Foundation.
8. Malachias MVB, Souza WKS, Plavnik FL, Rodrigues CIS, Brandão AA, Neves MFT, et al. 7ª Diretriz Brasileira de Hipertensão Arterial. *Rev Bras Hipertens* 2017; Vol.24(1):12-7 ISSN 1519-7522
9. Carey RM, Whelton PK. Prevenção, detecção, avaliação e tratamento da pressão arterial alta em adultos: sinopse 2017 American College of Cardiology/American Heart Association Guidelines da hipertensão. *Ann Intern Med*, 2018; 168(5): 351-358. DOI: 10.7326/M17-3203.
10. Cortez MM, Trindade ZA, Menandro MCS. Rationality and suffering: men and healthcare practices. *Psicol Saúde Doença*. 2017;18(2):556-66. Disponível em: https://www.researchgate.net/publication/318693930_Rationality_and_suffering_men_and_healthcare_practices
11. Silva MLB, Bousfield ABS. Representações sociais da hipertensão arterial. *Temas Psicol*. 2016;24(3):895-909. DOI: 10.9788/TP2016.3-07.
12. Sá, CP. Estudos de psicologia social: história, comportamento, representações e memória. 1 ed. Rio de Janeiro: EdUERJ. 2015; 458p. ISBN: 978-85-7511-394-3.
13. Abric JC, editeur. Pratiques sociales et représentations. Paris: Presses Universitaires de France; 1994. ISBN-10: 2130730264.
14. Moscovici S. Representações Sociais: investigações em psicologia Social. 11 ed. Petrópolis: Vozes; 2015. 408p. ISBN: 8532628966.
15. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care*, 19(6), 349-357. Doi: 10.1093/intqhc/mzm042
16. Orem DE, Fawcett J, Trust FH. Dorothea Orem: self-care framework. Athens, OH: FITNE; 2005.
17. Wachelke J, Wolter R, Rodrigues Matos, F. Efeito do tamanho da amostra na análise de evocações para representações sociais. *liber*. 2016; 22(2):153-60. DOI:10.24265/liberabit.2016.v22n2.03
18. Minayo MCS. Sampling and saturation in qualitative research: consensuses and controversies. *Revista Pesquisa Qualitativa*. São Paulo (SP), v. 5, n. 7, p. 01-12, abril. 2017. ISSN 2525-8222
19. Santos JC, Arreguy-Sena C, Pinto PF, Pereira EP, Alves MS, Loures FB. Social representation of elderly people on falls: structural analysis and in the light of Neuman. *Rev Bras Enferm*. 2018;71(2):851-9. DOI: 10.1590/0034-7167-2017-0258.
20. Donato SP, Ens RT, Favoreto EDA, Pullin EMMP. "Abordagem estrutural das representações sociais: da análise de similitude ao grupo focal, uma proposta metodológica." *Revista Educação e Cultura Contemporânea*. 2017;14(37):367-394. Doi: 10.5935/2238-1279.20170053.
21. Bardin L. Análise de conteúdo. Trad. Luís Antero Reto e Augusto Pinheiro. Lisboa: Edições 70; 2011. 223p. ISBN: 9788562938047. Trocar por Bardin L. Análise de Conteúdo. Reimpressão da Edição revista e atualizada de 2009. Lisboa, Portugal ou São Paulo?: Edições 70; 2018. 288p.
22. Oliveira DC. Análise de conteúdo temático-categorial: uma técnica maior nas pesquisas qualitativas in: metodologias de pesquisa para a enfermagem e saúde: da teoria para a prática. 1 ed. Porto Alegre: Moria, 2016; p.481-511.
23. Pereira J, Klein C, Meyer DE. PNAISH: uma análise de sua dimensão educativa na perspectiva de gênero. *Saúde e Soc*. 2019; 28(2):132-46. DOI: 10.1590/s0104-12902019170836.
24. Bidinotto DNPB, Simonetti JP, Bocchi SCM. A saúde do homem: Doenças crônicas não transmissíveis e vulnerabilidade social. *Rev Lat Am Enfermagem*. 2016; 24:e2756 DOI: 10.1590/1518-8345.0735.2756.
25. Santos FNP, Baldissera VDA, Toledo RF. Pub Talk: participation, education and men's health promotion. *Esc Anna Nery*. 2019;23(3): 1-7. DOI: 10.1590/2177-9465-ean-2019-0006.
26. Portela PP, Mussi FC, Gama GGG, Santos CAST. Factors associated with lack of blood pressure control in men. *ACTA Paul Enferm*. 2016; 29(3):307-15. DOI: 10.1590/1982-0194201600043.
27. Costa DO, Araújo FA, Xavier ASG, Araújo LDS, Silva UB, Santos EA, et al. Self-care of men with priapism and sickle cell disease. *Rev Bras Enferm*. 2018;71(5):2418-24. DOI: 10.1590/0034-7167-2017-0464.
28. Gois ÉCP; Santos JVO; Araújo LF. "Representações Sociais sobre a Velhice Masculina: Abordagens de Homens Idosos Participantes de Grupo de Convivência." *Revista Subjetividades*

20.Esp (2020): 20-05. DOI:

<https://doi.org/10.5020/23590777.rs.v20iEsp1.e9140>

29. Barros CT, Gontijo DT, Lyra J, De Lima LS, Monteiro EMLM. If the man takes care of his own health, it

will seem contradictory to the work: The

relation between masculinities and health care for young men in vocational training. Saude e Soc. 2018; 27(2):423-34. DOI: 10.1590/s0104-12902018166057.

Corresponding author: Jéssica de Castro Santos R. Afonso Cavalcanti, 275 - Cidade Nova, Rio de Janeiro - RJ, Brasil. Telephone: 021 9 9804-4324. E-mail: jessicacastroenf@gmail.com.

Submitted: 23/09/2020

Accepted: 03/02/2021