ABSTRACT. Individual illness belief systems form a cognitive structure which lies beneath the cultural and social aspect of health care in a community. Popular belief systems are different from, yet linked to, expert belief systems. Popular illness terms often help support a stable cultural milieu by linking concepts of causes and significance of types of illness problems with a set of health care seeking choices; as well as linking typical physical and psychological symptoms with associated social problems. This study presents an example of how illness beliefs perform these functions in urban, mainstream America.

One hundred and seventeen people with biomedically defined hypertension were interviewed following the Explanatory Models format. The belief held by 72% of this sample was that they had 'Hyper-Tension,' a physical illness characterized by excessive nervousness caused by untoward social stress. The data are used to derive a composite diagram of the cognitive domain of 'Hyper-Tension' in America which demonstrates the various options people have for interpreting their experiences and choosing appropriate therapeutic actions. They use this illness belief system to justify otherwise unwarranted social behavior and to assume various aspects of the sick role. This popular model is compared and contrasted with the professional model of the disease 'hypertension' and with other less frequent models which were observed in this sample.

INTRODUCTION

It is generally accepted that all cultures have some sort of healing tradition. How these differing healing systems function to maintain a stable cultural milieu is a matter of much wider debate. Frequently healing systems are divided into categories such as: local (primitive, folk) medical system; regional (Ayurvedic, Unani, Chinese) medical systems and the cosmopolitan (modern, Western, scientific) medical system. This type of classification relies on differences in geographic spread, degree of professionalization, and underlying theories of health, disease and healing. Since this type of analysis tends to stress differences rather than commonalities, functional equivalents which occur across medical systems are more difficult to determine (Press 1980). The type of problem that develops is illustrated by Press who defines a folk medical system as being (1) any health system at variance with Western, scientific medicine; (2) any health system at variance with a codified, formal and literate medical tradition (Western, scientific, Ayurvedic, classical Chinese, etc.); (3) any system of health practice at variance with the official health practice of the community or nation (Press 1978). This type of theoretical muddle arises because researchers allow themselves to be distracted by differences in healing theory (e.g., biomedical vs. Ayurvedic) or in ritual practices (naturalistic vs. spiritualistic) or in apparent complexity (cosmopolitan vs. local). Horton has documented that, in fact, these

differences may be more apparent than real, even when African traditional thought and Western science are contrasted (1967). Perhaps a more fruitful way to approach a theoretical understanding of health care systems is to look at the distribution of healing knowledge in a culture, and then examine how this knowledge is used to shape both social and personal realities.

One of the characteristics of nearly all health care systems is that there is a division of knowledge into practitioner (or professional) and popular realms. While this is shown in complex, urban environments, it probably also applies to most small scale societies as well. Thus, despite Lewis' claim that the Gnau "do not have clearly recognized medical experts" (1975:196), elsewhere he admits that "men who have acquired this knowledge are thus the experts in healing and diagnosis" (p. 170).

It is also important to recognize that in almost every culture there are a variety of healers among whom a lay person can choose. The individual interpretations of illness that each practitioner makes are sufficiently distinct in most cases to offer a real choice of healing technique. This does not merely apply in those settings where a variety of healing traditions intersect, such as Taiwan (Kleinman 1980), but also occurs in the urban West where most healers may bear the name "physician." The concept that healing styles differ markedly even within a tightly controlled, highly professionalized system like Biomedicine is also not well accepted in the literature, despite Helman's (1978) and Freidson's (1970) work. Press, for example, states that in Bogota "no two curers are alike ... each is a distinct and stylistic specialist. It is easy, in comparison, to view the physician [sic] monolithically" (1969). One has only to listen to the violent arguments that occur, for example, between nephrologists and cardiologists as they discuss the care of a critically ill person to realize that such a "monolithic" view is untenable. This occurs even though both are considered to be members of the same speciality (internal medicine).

The important thing to note here is that as we attempt to work through the interaction of individual belief systems and expert belief systems, we cannot assume that either is a uniform structure, unaffected by the individuals themselves. Instead we must look at how a particular layman interacts with a particular expert, and from these interactions draw conclusions about the larger system.

INDIVIDUAL BELIEF SYSTEMS

Sickness is a ubiquitous human experience. By its very nature, sickness is a profound threat to the social and personal existence of the individual. Individuals must therefore have some way of interpreting the nature of the threat that illness poses as well as avenues which may be taken to mitigate these effects. In