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SOCIAL – CULTURAL INTERPRETATIVE DIMENSIONS OF HEALTH AND ILLNESS

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Abstract: *The conclusions which can be important for research in psychosomatics are the ones obtained following an opened vision on the health issues which experience the interference of political, economic, moral and medical issue. The culturally “tailored” perceptions, the types of communication and the coping mechanisms of the patient are examined within the illness experience of the patient and of the family, but they are also understood by taking into consideration the possible effect on the practice of the clinician and researcher. Elisabeth Miller and Margaret Lock^[2] researchers in Sociosomatics, which combines medicine and anthropology within the didactical and research activity, demonstrated in their studies the fact that the experience of the illness and its diagnosis are “socially constructed”. From the sociosomatics and ethnographic point of view, the moral, political and medical landmarks are inseparable.*

Keywords: *anthropology, coping, communication, beliefs, prophylaxis*

It is well known that the individual perception on health and illness differ, “the cross –cultural variables making the difference between collectivism and individualism. The individual’s mental representation of illness is highly influenced by the dominant medical models of their particular culture. The medical models known and investigated are: biomedical, Traditional Chinese, Ayurvedic”.^[3]

The beliefs on illness are derived from the social and cultural beliefs, known as “popular knowledge on illness”. The patients have beliefs on illness corresponding to the dominant medical model of their particular culture. Most of the studies from the field of the cultural differences at the level of perceptions on illness focused on the causal contributions of health and illness.

The cultural differences which occur within the therapeutic goals and the variable in their cognitions and significances are also known. Within this contextual frame, we noticed the interferences occurring between the social – cultural interpretive dimensions of health and illness, so that their recognition, understanding and “translation” by an anthropologist would be beneficial in the prophylactic and curative medical activities.

Knowing the health “folklore”, the cultural factors associated with the health and illness condition is important in order to find out the significances assigned by the patient to his pathology. Subsequently, knowing the information the patient acquires from family, friends and neighbours regarding the nature of a health issue is definitely a key to solve certain cases which sometimes seemed to have minimum chances of therapeutic success. Anthropology helps to decode the local culture

related to health and illness. In certain cases, illness is explained and associated with other personal experiences, its significances being negotiated in a manner in which it would comply both to the context and personal expectations, and to the social – cultural regulations shared at the community level. “In the description or interpretation of health and illness related events, the individual always uses a preset frame of values and attitudes, established in his particular culture and society. Starting from the simple description of symptoms and up to the evaluation of the consequences of illness, each nation is guided by the dominant speeches present in the context where the patient is positioned.”^[4]

The possibility of a proximity relationship with the patient and with his social – cultural environment, the interdisciplinary coordination and the course of his pathology, as well as the establishment of an efficient medical communication created the favourable background for the observation and study of these types of relationships by the family doctors. They are the most accessible individuals, called the “gatekeepers” of the system, they perform their activity in the same place where the patients live, being familiar to their social – cultural environment. The patient seeks information related to his personal illness and to its treatment from the individuals around him, this is why the knowledge of the local social – cultural specific character is so important in order to understand the significances of the illness attributed by the patient and to prevent the eventual mistakes in following the therapeutic, diet and life style recommendations.

In addition, most of the theories related to the adjustment to the illness converge on the fact that the manner in which people “see” their illness represents the basis for the following coping mechanisms Stanton and co. in *Health Psychology: Psychological Adjustment to Chronic Disease*, focusing on neoplasias, cardio – vascular and rheumatism diseases, conduct a review on the distal mechanisms constituted in social – economic, ethno – cultural variables and the gender – related and proximal variables: interpersonal relations, personality attributes, cognitive evaluations and coping processes studies as

risk and protection factors to adjustment throughout time. Lazarus stress and coping theory (Lazarus & Folkman, 1984) represents the basis for most of the current researches on the mechanisms of adjustment to the illness.

The coping strategies are classified in two categories: of acceptance or pro-active and of avoidance; *of acceptance*, which includes seeking information and social support, solution of problems, actively attempting to identify benefits in his experience and creation of commodity markets for the emotional expression; *of avoidance*, contrasting with the first one, which involves cognitive strategies, as denial and suppression and behavioural strategies, as disengagement.

The other adjustment efforts, as the spiritual coping, can be useful for both strategies.

Mecanic (1978) presents a simple model of individual health – related decisions which suggest the individual reporting to the number and persistency of the symptoms, if they are easier to recognize or familiar, the possible debilitating aspects, to all being applicable our cultural and social definitions of the illness. “The beliefs of the patients in terms of the causes of the symptoms will directly influence their decisions about the medical treatment. These beliefs indirectly affect the manner in which the information and treatment suggested by the doctor will be received”.^[5]

Each of these aspects are encountered in practice, the multiple significances of the illness attributed by the patient and the coping mechanisms he tends to use varying on a daily basis, which gives a particular character to the specialization. Thus, the necessity of the psychosomatic approach appears in a physiological manner. For a family doctor trained according to the classical curriculum it is more difficult to correctly and efficiently approach the “pathology” and the current expectations of the individuals requesting the medical services. We can also investigate the utility of a multidisciplinary team which could include: the doctor, psychologist, sociologist within “the qualified re-humanization of medical activities by involving other specialists from the humanistic sciences”^[6] and optimization of the therapeutic process. Deciphering the psychosomatic particularities,



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correctly using the instruments of the other specialists from the team would shorten the patient's road to healing. However, the most important desideratum would be the primary prophylaxis – equally achieved in the spirit of a proper knowledge of the local social – cultural specific character and also through a psychosomatic approach of the patients. The improvement of the communication competences and techniques is part of an efficient bio – psycho-social approach of the patient, with important application in the family medicine.

Traditionalism vs. modernism, social structuring, fulfilment and social positions in the community, representation of the important social actors, knowing the unwritten law, all allow deciphering the factors which can influence the medical act by recognizing their importance within the holistic medicine. The late visit to the doctor, the prophylactic attitude, the attitude towards the disease, the adherence to the treatment – can be better deciphered and extracted from the cultural pattern following their "translation" by the anthropologist. The structure of the patients from a list of a family doctor is heterogeneous and subsequently the doctor has to hold anthropological information.

All the cultures have belief systems in terms of health, in order to explain the causes of the disease, how it can be healed or treated. The modernists, present especially in the urban area and to a lesser extent in the rural environment, attribute to the disease a scientific cause and require state of the art diagnosis and therapy methods. The traditionalist patients, belonging to the rural areas – in Romania, the percentage of the rural amounting to almost 70% of the population – can attribute to the disease supernatural causes, invoking religious rigors (i.e., the food

Lent) at the diet or prophylactic recommendations of the doctor, factors which directly affect the therapeutic compliance.

In the conservatory, traditionalist societies, it is important to know the composition of the entire enlarged family and the family "head", who is frequently "the one who talks". The family elders are observed, their authority being frequently questioned. Usually, a key member of the family is consulted in the important health cases. The family interests and honour are more important than the ones of the individual family members, subsequently the genetically transmitted diseases (i.e., epilepsy) are refused to be diagnosed and treated, in order to be "hidden", with the motivation not do diminish the chances to marriage of the other family members (especially of the girls within the family, potentially carriers of genes with pathology).

Up to present, the classical approach predominates. In Romania, the psychosomatic approach is in the tendency stage. The anthropologisation of medicine is also developing within the anthropologisation process of social and humanistic sciences. The structure of patients from a doctor's lists is heterogeneous from the point of view of their particular cultures and subsequently the doctor has to hold anthropological information.

"Medical anthropology studies the indigene or "folk" beliefs on health and illness in various cultures; it studies the ideas and behaviours of health practitioners in various cultural spaces. In certain cases, the medical anthropology even assumed the role and mission to reveal, through a sort of an ethno – epistemology, the ideological presumptions underlying the biomedical model (A.Young 1993). For instance, the approach of the symptom as subject of anthropology was

possible exactly because the biomedicine neglected the social and cultural dimensions of illness. Within this context, the medical anthropology developed a special strategy expressly to include this discursive dimension and to interpret it. The purpose is to understand the illness and its expressions (symptoms) as symbolical constructions which do not exclusively make reference to biological disorders, but also to a local world of significances and experiences. In this case, the task of the anthropology is to open towards the cultural, social and political dimensions where the individuals displaying the symptoms live, as well as understanding and interpreting these dimensions".^[7] In this field there are medical anthropology studies based on evidenced – MBD.

The anthropologist helps to decipher the culture, he is the one who has the data necessary to identify and eliminate the cultural factors disturbing the adequate performance of the medical process. The late visit to the doctor, the prophylactic attitude, the attitude towards the disease, the adherence to the treatment – can be better deciphered and extracted from the cultural pattern following their "translation" by the anthropologist. The multicultural structure of the patients is a continuous challenge. All cultures have systems of beliefs in terms of health, in order to explain the cause of the disease, how it can be healed or treated.

The social – cultural interpretative dimensions of health and illness, with the results of the medical activity, varies according to the progress of health or illness stages.

The integrative approach of healthy or sick individual has a conclusion in practice, in the following manner: the improvement of quality of medical act, the implicit increase of satisfaction degree of patients within the concept of patient –focused medical communication – PFC, all these being obtained with reduced medical costs for the sanitary system.

The modern concept of "PATIENT – FOCUSED COMMUNICATION – PFC" is widely approved as a high quality central component of health services (Committee on Quality of Health Care in America, 2001)

"Stewart (2001) described the PFC as a holistic concept whose components interact and uniquely reunite within every doctor – patient meeting."^[8] PFC includes four communication fields: patient perspective, psychosocial context, joint understanding and change of power and responsibility.

Using the multiple regression analysis, the authors D'Angelo și Dimatteo demonstrate (page 80) the fact that "only three variables were predictive for the satisfaction degree of overall patients, and these were: the affective behaviour of family doctor, discussion about the psychosocial subjects and references to other medical specializations. This later element had a negative impact on the satisfaction of patients. Another negative element is represented by the occurrence of a significant discrepancy between the various expectations within the doctor – patient meeting. In particular, there is a discrepancy when the patient's expectations are highly discrepant correlated to the lack of existence of an efficient treatment. Examples are the chronic patients, especially oncology patients. In terms of "care and cure" concept, it is known that most of the times there is a "care deficiency in providing efficient psychological and social interventions". (Marian Pitts, Keith Phillips 1998, pages 80-82).

However, the most important desideratum would be the primary prophylaxis – equally achieved in the spirit of a proper knowledge of the local social – cultural specific character and also through a psychosomatic approach of the patients.

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