Health as a social concept is very important in medical sociology, perhaps even the central concept in the field. Definitions of health and the concept are not limited to medical sociology alone; all fields that deal with health, illness and health care have to comprise some ideas and conceptualizations of what they mean by health. More complicated conceptions of health as a multi-dimensional concept have been discussed both in the social sciences and in the medical and public health literature over past decades. Often, these approaches have emphasized not only physical health status, but mental health status and aspects of overall well-being.

**Burden of chronic diseases**

India is experiencing a rapid health transition, with large and rising burdens of chronic diseases, which are estimated to account for 53% of all deaths and 44% of disability-adjusted life-years (DALYs) lost in 2005. Earlier estimates, from the Global Burden of Disease Study, projected that the number of deaths attributable to chronic diseases would rise from 3.78 million in 1990 (40.4% of all deaths) to 7.63 million in 2020 (66.7% of all deaths). (Sahni, 2006)

India also has the largest number of people with diabetes in the world, with an estimated 19.3 million in 1995 and projected 57.2 million in 2025. The prevalence of type 2 diabetes in urban Indian adults has been reported to have increased from less than 3.0% in 1970 to about 12.0% in 2000. On the basis of recent surveys, the ICMR (Indian Council for Medical Research) estimates the prevalence of diabetes in adults to be 3.8% in rural areas and 11.8% in urban areas. (Reddy, 2005).
The prevalence of hypertension has been reported to range between 20–40% in urban adults and 12–17% among rural adults. The number of people with hypertension is expected to increase from 118.2 million in 2000 to 213.5 million in 2025, with nearly equal numbers of men and women. (Reddy, 2005).

These advancing epidemics are propelled by demographic, economic, and social factors, of which urbanisation, industrialisation, and globalisation, are the main determinants. Urbanisation and industrialisation are changing the patterns of living in ways that increase behavioural and biological risk factor levels in the population. Substantial variations exist between different regions, but risk levels are rising across the country, most notably in urban areas of demographically and economically more advanced states of India.

The second half of the twentieth century witnessed major health transitions in the world, propelled by socio-economic and technological changes which profoundly altered life expectancy and ways of living while creating an unprecedented human capacity to use science to both prolong and enhance life. Among these health transitions, the most globally pervasive change has been the rising burden of non-communicable diseases (NCDs).

One change that has occurred over the past 100 years is the concentration of life-threatening conditions into later ages. In the early 1900s, there were still many important, life-threatening illnesses that occurred early in life or throughout childhood such as typhoid, diphtheria and whooping cough as well as threats to the life of adult women through maternal mortality and to adult men (and to a lesser
extent women) through occupational injuries. Now in the 21st century, improved housing, nutrition, sanitation and better safety on jobs and the presence of immunizations and improved medical care mean that the primary causes of death and disability are chronic conditions such as heart disease, cancer, stroke, diabetes, hypertension and chronic obstructive pulmonary diseases. All these conditions are much more common among the elderly than among the young. As it is well known from a variety of medical sociological and epidemiological studies (Kronenfeld, 2006) as people age, chronic health problems become more common and mobility and sensory limitations also increase.

It is evident from the WHO report (2005), that the impact of chronic diseases in many low and middle income countries is steadily growing. It is vital that the increasing importance of chronic disease is anticipated, understood and acted upon urgently. For understanding the effects of chronic disease in a better manner, earlier research methods and findings are helpful to us. In this chapter, the researcher has brought in some insight of that kind.

**Diabetes in India: Current Status**

Diabetes has emerged as a major healthcare problem in India. According to Diabetes Atlas published by the International Diabetes Federation (IDF), there were an estimated 40 million persons with diabetes in India in 2007 and this number is predicted to rise to almost 70 million people by 2025 (2006). The countries with the largest number of diabetic people will be India, China and USA by 2030 (IDF, Diabetes Atlas, 4th edition). It is estimated that every fifth person with diabetes will
be an Indian. Due to these sheer numbers, the economic burden due to diabetes in India is amongst the highest in the world. The real burden of the disease is, however, due to its associated complications which lead to increased morbidity and mortality. WHO estimates that mortality from diabetes, heart disease and stroke costs about $210 billion in India in the year 2005. Much of the heart disease and stroke in these estimates was linked to diabetes. WHO(2005) estimates that diabetes, heart disease and stroke together will cost about $ 333.6 billion over the next 10 years in India alone.

Rapid urbanisation and industrialisation have produced advancement on the social and economic front in countries such as India which are transitioning between agrarian and industrial capitalism and this transition has resulted in dramatic lifestyle changes leading to lifestyle related diseases. The transition from a rural to an urban lifestyle, consumption of diets rich in fat and calories combined with a high level of mental stress has compounded the problem further. There are several studies from various parts of India which reveal a rising trend in the prevalence of type II diabetes in the urban areas (1999). A National Urban Survey in 2000 observed that the prevalence of diabetes in urban India in adults was 12.1 percent. Recent has illustrated the impact of socio-economic transition occurring in rural India. The transition has occurred in the last 15 years and the prevalence has risen from 2.4 per cent to 6.4 per cent. (Ramachandran, 2001)
The Risk Factors for Diabetes in Indians Are:

Age—Indians develop diabetes at a very young age, at least 10 to 15 years earlier than the western population. An early occurrence of diabetes gives ample time for development of the chronic complications of diabetes. The incidence of diabetes increases with age. In India, the life span has increased, hence more number of people with diabetes are being detected.

Family History—The prevalence of diabetes increases with a family history of diabetes. The risk of a child developing diabetes with a parental history increases above 50 per cent. A high incidence of diabetes is seen among the first degree relatives. Indians have a high genetic risk for diabetes as observed in Asian Indians who have migrated to other countries. They have been found to have a higher rate of diabetes as compared to the local population.

Central Obesity—The association of obesity with Type II Diabetes is well known. Even with an acceptable body weight range, weight gain could increase the risk of diabetes. An excess of body fat specially concentrated within the abdomen has an increased risk of diabetes. The cut-off limit for waist circumference for Indians have been recommended to be 90 cm for males and 80 cm for females. Abdominal obesity is defined by waist circumference above these limits.

In the next section I will highlight some of the risk factors for diabetes. These include such things as:
Physical Inactivity and Sedentary Living—There is enough evidence to demonstrate that physical inactivity as a independent factor for the development of type II diabetes. The availability of motorised transport and a shift in occupations combined with the plethora of television programmes has reduced the physical activity in all groups of populations.

Insulin Resistance—Asian Indians have been found to be more insulin resistant as compared to the white population source???. They have a higher level of insulin to achieve the same the blood glucose control. A cluster of factors consisting of abnormal fats (Dyslipidemia), high blood pressure, obesity, and abnormal glucose levels known as metabolic syndrome is highly prevalent in Asian Indians. You began by noting “asian” now you are saying “asian Indians” be consistent and clear with your terminology and cite the source.

Urbanisation—The developing countries like India are undergoing rapid urbanisation. Urbanisation is associated with increasing obesity, decreasing physical activity due to changes in lifestyle, diet and a change from manual work to less physical occupations.

Stress—The impact of stress both physical and mental along with lifestyle changes has a strong effect of increasing incidence of type II Diabetes amongst persons is a strong genetic background.

In a recent study in Chennai, nearly 25 per cent of the population studied was unaware of a condition called diabetes. Only 40 per cent of the participants felt
that prevalence of diabetes was increasing and only 22 per cent of the population felt that diabetes could be prevented. Though the awareness levels increased with education, only 42.6 per cent of postgraduates and professionals including doctors knew that diabetes was preventable. The knowledge of risk factors was even lower, only 11.9 per cent of the study subjects reported obesity and physical inactivity as risk factors. Even amongst the known diabetics, only 40.6 per cent were aware that diabetes could lead to some organ damage and complications. Many people (46 per cent) with diabetes felt that it was a temporary phenomenon (Diabetes Voice, 2005).

In 1998, a major study was undertaken to quantify (x, y and z). In this study it was observed that of all the patients with diabetes taking treatment from specialised centres, more than 50 per cent of patients had poor control of diabetes as per the criteria of American Diabetes Association. The Study showed that four per cent of patients were on diet therapy alone, 53.9 per cent were receiving oral antidiabetic agents, 22 per cent of the patients were taking insulin and another 19 per cent were on both insulin and oral drugs. This Study confirmed that diabetes care in India leaves much to be desired.

In two other studies carried out in Bangalore and South India (dates of the studies?), it was observed that majority of patients (70 per cent) were diagnosed by their general practitioners (GP) and 70 per cent of them had approached the GP for some other problem. 90 per cent of them underwent only Fasting and Post Meal Blood Sugar and Urine Sugar Tests. Specialised tests such as Glycosylated Haemoglobin (HbA1C), lipid profile, kidney Function test were undertaken by only
four-six percent of patients. Even simple measurement of blood pressure, weight and examination of feet were not done for majority of patients.

In India, due to less importance to proper healthcare infrastructure, and absence of clear cut guidelines mean that approach to the management of diabetes is ad hoc. The lack of awareness among patients and General Practitioners (GPs) is a key factor in the poor care. There are practically no nurse educators or diabetic counselors, no podiatrists (foot experts) and very few dieticians which means that the treating doctor has no support and has to take the entire burden of caring for these patients. The patients' inability/unwillingness to pay for this additional support also hinders the treatment.

Even after the diagnosis, monitoring of diabetes is very poor. Most of the patients initially visit a doctor and then discontinue their therapy once their symptoms and controlled. A majority of the patients abandon modern allopathic treatment in favour of indigenous treatments (Dr. Rajiv Gupta, 2006) Further, more patients with poor control avoid insulin for fear of injection and belief of addiction of insulin. Hence they keep changing doctors and hop from one system of treatment to another leading to further complications and early death. Lack of resources, medical reimbursement and poor state funding for diabetes is a barrier to quality care often because the patient is unable to afford the high cost of treatment.

There is ample evidence to suggest that preventive measures to reduce the burden of diabetes are needed. The US Diabetes Prevention Programme and the Finnish Diabetes Prevention Programme and the Chinese Study have conclusively
proved that lifestyle modification including weight loss, increased physical activity and dietary changes can prevent or delay the onset of diabetes. The need of the hour is direct public education and mass media campaigns, awareness about diabetes and its complications. There is a need to spread the message that diabetes is preventable and we need to have a behavioral change to adopt a healthy lifestyle.

**Trends in hypertension epidemiology in India.**

Cardiovascular diseases caused 2.3 million deaths in India in the year 1990; this is projected to double by the year 2020. (2004). Hypertension is directly responsible for 57% of all stroke deaths and 24% of all coronary heart disease deaths in India. Indian urban population studies in the mid-1950s used older WHO guidelines for diagnosis (BP > or =160 and/or 95 mmHg) and reported hypertension prevalence of 1.2-4.0%. Subsequent studies report steadily increasing prevalence from 5% in 1960s to 12-15% in 1990s. Hypertension prevalence is lower in the rural Indian population, although there has been a steady increase over time here as well. Recent studies using revised criteria (BP > or =140 and/or 90 mmHg) have shown a high prevalence of hypertension among urban adults: men 30%, women 33% in Jaipur (1995), men 44%, women 45% in Mumbai (1999), men 31%, women 36% in Thiruvananthapuram (2000), 14% in Chennai (2001), and men 36%, women 37% in Jaipur (2002). Among the rural populations, hypertension prevalence is men 24%, women 17% in Rajasthan (1994). Hypertension diagnosed by multiple examinations has been reported in 27% male and 28% female executives in Mumbai (2000) and 4.5% rural subjects in Haryana (1999). There is a strong correlation between changing lifestyle factors and increase in hypertension in India.
The nature of genetic contribution and gene-environment interaction in accelerating the hypertension epidemic in India needs more studies. Pooling of epidemiological studies shows that hypertension is present in 25% urban and 10% rural subjects in India. At an underestimate, there are 31.5 million hypertensives in rural and 34 million in urban populations. A total of 70% of these would be Stage I hypertension (systolic BP 140-159 and/or diastolic BP 90-99 mmHg). Recent reports show that borderline hypertension (systolic BP 130-139 and/or diastolic BP 85-89 mmHg) and Stage I hypertension carry a significant cardiovascular risk and there is a need to reduce this blood pressure. Population-based cost-effective hypertension control strategies should be developed.(Gupta 2004)

Further this chapter will try to bring out the research work done in this area of chronic disease in general and Diabetes and Hypertension in particular.

Ahern M.M. and Hendryx M.S.(2005) employed an ecological social capital model to represent progressive social influences in an individual’s life in their study of chronic illness. They tested the model in a preliminary way to examine the relationship between individual and aggregate components of the social environment and people’s health status. To measure health, they used the presence of two chronic diseases, hypertension and diabetes type 2, because these diseases are prevalent and increasing, and because they are chronic illnesses that have strong, documented behavioural foundations.

Social capital refers to the stock of trust, civic engagement and norms of reciprocity existing in a community that allow collective actions to occur.
Communities are higher in social capital when their residents are generally more trusting, more co-operative, and more engaged in community life.

The model argues that the ecological progression then extends from family relationships and personal social support to larger community-level norms of reciprocity and engagement. The community or aggregate collection of social relationships leads to the levels of trust that exist in a community and then to collaborative actions that may improve the health of communities. The progression from relationships to networks, norms and trust proceeds from personal connections at the family level to collective social characteristics. The authors examine both the personal and collective aspects of social support and social capital. They hypothesize that personal levels of social support should be relatively more important correlates of health outcomes than collective levels of social support, because social support is inherently a personal construct. In contrast, collective levels of social capital variables should be relatively more important correlates of health outcomes than personal levels of these variables, because they are inherently aggregate constructs.

Ahern and Hendryx’s study contributes to the theoretical understanding of social capital based on an ecological model subjected to empirical testing, that initially supports this model. The personal and community level variables correlated with disease as hypothesized by the theoretical model. People with better personal social support reported less diabetes. Collective generalized reciprocity was associated with lower risk for both diabetes and hypertension. It was found that collective measures of social support were not associated with hypertension or
diabetes. Also as expected by the author, personal measures of reciprocity and trust were not related to dependent variables in three of four cases. The areas where the model didn’t work out are also noted. One personal-level independent variable, neighbourhood trust, was related to diabetes. However, it was related to diabetes in an unexpected direction; that is, persons in better neighbourhoods reported higher risk of diabetes. This was the only occasion on which a significant effect was found that ran directly contrary to the model. The authors speculate that this effect may be due to: (1) the weakness of the measure — the alpha reliability was marginal at best; or (2) some unmeasured characteristic of the sample that was related to both diabetes and neighbourhood trust. In addition, there were multiple instances where the expected significant effects were simply not present, which could be due to weaknesses in the model or to weaknesses in the measures or data. (Melissa 2005)

However, this study makes a contribution by specifying a more nuanced theoretical model of the production of social capital than has been previously proposed, and by beginning to test this model, although with limited data. They also contributed to the social capital literature by establishing links between social capital and chronic disease, specifically diabetes and hypertension.

Bradley and Puoane (2007) in their project *Prevention of Hypertension and Diabetes in an Urban setting in South Africa: Participatory Action Research* with Community Health Workers aimed to identify factors that contribute to hypertension and diabetes and to design and implement appropriate local interventions to prevent these noncommunicable diseases and promote healthy
lifestyles. This was a community-based participatory action research project in which researchers and community health workers (CHWs) were the main participants. The triple A approach to planning interventions was used, that is, the process of assessing the situation, analyzing the findings, and taking action based on this analysis. Both qualitative and quantitative methods were employed. Twenty-two CHWs working in site C, Khayelitsha, a deprived urban area of Cape Town, South Africa, participated in the study.

This research provided considerable information on the problem of increasing prevalence of hypertension and diabetes in this particular community. It identified a wide range of factors that affect these diseases and illustrated ways in which CHWs could be involved in addressing the problem. The findings of the CHW and community assessments indicated that, while individual knowledge about hypertension and diabetes and risk factors was poor, both social and cultural influences about food and body size, as well as the socioeconomic and environmental context, were important contributory factors to the problem in this community.

Findings from the situational assessment indicated a lack of knowledge among CHWs and the community about hypertension and diabetes and the risk factors for these noncommunicable diseases. Economic constraints and cultural beliefs and practices influenced the community’s food choices and participation in physical activity. On the basis of these findings, a training program was proposed that would provide CHWs with the skills to prevent hypertension and diabetes in their community. A program was developed and piloted by the project team. A
health club that focuses on promoting healthy lifestyles is currently being piloted. This project illustrates the unique involvement of CHWs in a successful participatory action research project on the prevention of hypertension and diabetes and promotion of health in a deprived urban setting. The project emphasized the importance of involving local people in community-based initiatives to promote health and identifies that the primary role of health services is to develop appropriate skills in the local community, monitor activities, and facilitate a link with primary health services.

HosikMin et al (2010) study on *Sociodemographic Risk Factors of Diabetes and Hypertension Prevalence in Republic of Korea* examined the relationships between SES and diabetes and hypertension for Korean adults using the Korean National Health and Nutritional Examination Survey. Four dummy dependent variables were utilized in the study. These were: Diabetes and Hypertension, Diabetes alone, Hypertension alone, and Diabetes or Hypertension, four different logistic models were conducted by the authors. The descriptive statistics showed a considerable amount of comorbidity between the combined dependent variable of diabetes and hypertension. To gauge more realistic measures of SES, education and income were combined together as four dummy categories. The SES factor indeed had significant impacts on diabetes and hypertension. Socioeconomically disadvantaged groups demonstrated to have increased likelihood of having these diseases. However, they could not find the strong compensating effect between education and income; the higher level of education but lower income variable was only significant in having both diseases, and the higher income but lower level of education variable was only significant in having hypertension alone and either one
of the diseases. Only the highest SES one, the one with a higher level of education and a higher income, was significantly lowering the likelihood of having these diseases in all models. Therefore, public policy and intervention programs should focus on individuals matching these socioeconomic characteristics.

The goal was to examine the relationships between SES and diabetes and hypertension in Republic of Korea. As expected by the authors, the combined dependent variable of diabetes and hypertension shows a considerable amount of comorbidity, particularly in diabetes; more than 50% of people diagnosed as having diabetes also have hypertension, on the contrary, only 20% of people with hypertension also have diabetes.

Tamara Poljičanin and et al study on Diabetes mellitus and hypertension have comparable adverse effects on health-related quality of life assessed health-related quality of life (HRQoL) among people with diabetes or hypertension, estimate the effect of cardiovascular comorbidities on HRQoL as well as compare HRQoL in these groups with that of healthy individuals. In chronic conditions such as hypertension and diabetes, HRQoL is an especially important outcome, given their lifelong nature and the need for daily self-management. HRQoL has been found to be poorer in diabetic participants than in the general population, especially in the domains of self perceived physical health, while findings on domains of psychosocial functioning vary between studies. Hypertension has also been shown to be associated with negative outcomes in HRQoL, especially in the domain of subjectively perceived general health, although its impact on HRQoL is usually less adverse than that of other chronic diseases.
The results suggested that diabetes and hypertension have comparably negative effects on HRQoL, which supports the conclusion that both conditions impose similar self perceived limitations in physical and mental functioning.

It is likely that some individuals who had been classified into the groups without cardiovascular comorbidities of hypertension or diabetes had other comorbidities that potentially reduced their HRQoL. On the other hand, even in the absence of any comorbidities, a mere perception of being chronically ill and thus frailer than a healthy person may also detrimentally affect participant’s HRQoL.

They also observed that cardiovascular comorbidities had a particularly negative impact on HRQoL in these two chronic diseases. This is in line with previous research which has found that the presence of macro vascular complications was a very important factor that comparably limited participants’ HRQoL to a clinically significant extent in both hypertension and diabetes. Cardiovascular comorbidities are thought to debilitate physical functioning to a higher degree than hypertension or diabetes alone. This can be substantiated by profiles of particular SF-36 scales, as self reported well-being in participants with comorbidities has been shown to be poorest with respect to physical functioning.

Diabetes and hypertension seem to comparably impair HRQoL. Cardiovascular comorbidities further reduce HRQoL in participants with both chronic conditions. Future research of interventions aimed at improving these participants’ HRQoL is needed. (Tamara Poljičanin, 2010)
Rajaram’s (1997) explores the biographical disruption that occurs as a result of a hypoglycemic episode (or insulin reaction) among people with insulin dependent diabetes. It focuses on the process of biographical reconstruction that sufferers and their spouses go through, while striving to maintain a positive selfworth in the 'world of health'. This paper is a qualitative study of twenty-three people with diabetes in the stable phase of the illness and their spouses.

The findings of Rajaram’s study indicate that the illness experience calls forth a redefinition of the personal and social identities of the sufferer. Chronic illness is more than just the functional adaptation to the physical demands of the illness. It is the expression of a person's selfworth through bodily conduct in day-to-day life. 'The body is not merely the location of the disease, but is that through which one continues to apprehend the world and oneself in it'. While managing the illness, sufferers strive to project an image that is acceptable within socially and ideologically defined standards of moral virtue. Management of an illness episode such as an insulin reaction involves an ongoing discourse between: (a) patients' relationships with their illness, (b) patients' relationships with their intimates, (c) patients' relationships with the medical profession, and (d) the relationship of couples to the world at large. A chronic illness such as diabetes is primarily managed at home within the personal arena, away from health care facilities. Spouses play a key role in the negotiation of meaning, in the face of a biographical disruption within the social and cultural milieu. Five aspects of an insulin reaction contribute to the complexity of the biographical disruption for the patient and intimates: (1) the uncertainty and unpredictability of a hypoglycemic episode, (2)
the suddenness and intensity of the onset of an insulin reaction, (3) the disorientation and loss of cognitive-motor functioning, (4) the risk for physical harm to themselves and others, and (5) the possibility of death due to an accident or failure to take timely corrective medical action.

A qualitative analysis approach enabled the author to gain valuable insights into some of the issues that patients and families grapple with in relation to hypoglycemia, and clearly demonstrates the key role that spouses play in the legitimating the self-worth in the management of a chronic illness. From a clinical perspective, the health-care team would do well to involve both the patient and the family in the decision-making process relating to management of the illness. Patients and families should be given full information on the physiological and psychosocial issues involved in different treatment strategies. As Lawson and Rajaram (1994) have recommended, several different approaches can be used to provide necessary information and support to patients and families of diabetics - support groups (in person or via telephone or computer networks), access to diabetes educational material (print, computer on-line, home video tapes, or through outreach health workers) with information presented in a lucid and interesting manner. This information will provide patients and families with the necessary knowledge to make informed decisions about their diabetes regimen and may also provide a sufficient base of knowledge to facilitate the biographical reconstruction process. The drawback in this study is that it is restricted to patients in the stable phase of the illness devoid of long-term diabetic complications, and, hence, is not representative of diabetes mellitus sufferers in general. Different stages of the illness will no doubt present different psychosocial issues for the patient and spouse. Also gender
differences in illness management were not addressed. Further research will do well to investigate class, gender, and race differences in the experience of hypoglycaemia among patients and their families.

Higginbottom (2006) to present findings from a study which explored hypertension amongst African Caribbean people residing in England, providing a comprehensive and detailed account of the meaning and consequences of hypertension and the factors that mediate chronic illness experience. Ethnicity, cultural adaptation and migration are postulated as significant mediators of the chronic illness experience. Hypertension (commonly described in lay terms as ‘high blood pressure’) is a condition that is associated with older age. Within the African Caribbean population in England, hypertension is four times the national average and is becoming more prevalent amongst people considered to be in mid-life rather than old age. A number of epidemiological studies have mapped out the increased prevalence of hypertension and its sequelae in African Caribbean communities in the UK.

The findings of this study may in fact provide evidence of greater commonality with individuals in the wider population who experience hypertension, rather than suggest that this experience is determined by culture or ethnicity. This commonality may be associated with social class dimensions. Although the participants in this study were not exclusively ‘working class’. Individuals who experience chronic illness of different forms, e.g. diabetes, arthritis, hypertension, regardless of their ethnic origin, frequently share similar responses to the diagnosis and management of a chronic illness. In respect of
hypertension, ethnicity appears to mediate the experience further in relation to migration, cultural adaptation including the socio-economic dimensions of migrant status, reception in the host community and propensity towards self-care.

The study maps out how ethnicity, migration and cultural adaptation impact upon and mediate the chronic illness experience of the mid-life and older people of African Caribbean origin. Many of the participants viewed self-care and resourcefulness as an important dimension in the response to a chronic illness such as hypertension. The findings of this study further elaborates and extend understandings of the meaning of hypertension for African Caribbean people residing in England. Stress was said to arise from both internal and external factors such as relationship problems, financial worries, racism, occupational stress, the stress of migration and adaptation. Many participants accepted this stress as a dimension of their lives, referring to the pressure or stress of life as being characteristic of life in England. Notwithstanding all of these issues, gender, age and social class further mediated the experience of hypertension for the people in this study. The extent to which the findings are generalisable to all African Caribbean people in England is not clear. Principles, however, may be extracted in relation to how migrant communities accept and make sense of systems of Western medicine, the demands of migration and cultural adaptation; additionally, the influence of wider structural issues on health status such as racism and acceptance by the host community.

Morgan and Watkins (2008) determine the distribution of beliefs which are hypothesized to influence patients' responses to drug therapy in their study of
hypertension. The reasons for non-compliance are then inferred from these associations, with little attempt being made to assess the significance of particular beliefs and concerns for individual behaviours or the variations which may occur across social and cultural groups. In contrast, this study aims to elicit hypertensive patients' own beliefs, concerns and patterns of behaviour, rather than seeking to test specific hypotheses or to determine the distribution of particular beliefs.

The study was conducted in the London borough of Lambeth, an inner London area with a predominantly working class population. A notable characteristic of the area is the high proportion of ethnic minorities, who comprise about 23% of the population. West Indians form the largest ethnic minority and account for 12% of the population. West Indians are also of particular interest as they appear to have a high prevalence of hypertension compared with 'white' and Asian populations. The authors compare the beliefs and responses to hypertension of a small group of 'white' and West Indian patients of similar socio-economic status.

A notable feature of both the white and West Indian respondents' beliefs about their high blood pressure was the identification of worry, stress, and tension as a cause. Patients' misunderstanding of the term 'hypertension' may in a few cases have contributed to a belief in stress or tension as a cause of high blood pressure, this does not appear to be responsible for the widespread emphasis on worry, stress and tension as a cause among the present group of general practice patients.
West Indians appear to have a relatively high incidence of hypertension, and differences in salt intake or salt retention have been identified as possible risk factors. However, the higher blood pressure levels of hypertensive blacks than hypertensive whites found in a study by Sever et al. and the larger numbers of West Indian patients with uncontrolled blood pressure among the present group of respondents may also be associated with the observed variations in adherence to the prescribed medication, as well as with possible differences in rates of drop-out from treatment. The use of folk remedies in Britain is probably currently most common among ethnic minorities and especially among immigrants from rural areas with less access to modern scientific medicine. The grandmothers' generation frequently used folk remedies for a range of illnesses, whereas their daughters relied more heavily on proprietary medicines brought from the chemist. In recent years there has been a trend towards the increasing use of homeopathy, yoga, acupuncture and other healing systems, which form a large and growing 'hidden health care system', and is often sought when conventional medicine is unable to provide an effective cure. However, recourse to these systems may be more common among middle class than working class people. Responses to illness are affected by a complex interplay between class and culture.

Numerous studies have shown that certain unhealthy lifestyles, such as smoking, excessive use of alcohol, and lack of physical activity, could aggravate or worsen different chronic diseases, such as lung disease, cardiovascular disease, diabetes, osteoarthritis and/or rheumatic arthritis. On the other hand, healthy lifestyles, such as not smoking, moderate alcohol use, and daily physical activity,
may preserve physical function and reduce the risk of disease worsening in patients with chronic diseases.

Coen H. van Gool et al the association between course of chronic disease and lifestyle in their study of chronic disease. They examine the differences in unhealthy lifestyles—smoking, excessive alcohol use, being sedentary and transitions herein after six years in prevalent and incident chronic disease categories - lung and cardiovascular disease, diabetes, and osteoarthritis and/or rheumatic arthritis - among 2,184 respondents aged 55 years and older from the Netherlands. They also examine if transitions in lifestyle co-occurred with changes in disease-related symptomatology. Results of the study show that proportions of respondents who smoked decreased over time, whereas proportions of respondents who were sedentary increased. Respondents with incident cardiovascular disease demonstrated more lifestyle transitions than respondents from other disease categories. Respondents demonstrating healthy lifestyle transitions did not differ from those persisting in unhealthy lifestyles in change in disease-related symptoms. Health promotion may benefit from these findings in a way that patient groups at risk for not initiating healthy lifestyles might be identified sooner. This is the first study among late middle-aged and older respondents that explicitly quantifies (a) the prevalence of several lifestyle domains across different chronic diseases, (b) the categorical and continuous changes in these domains across different chronic diseases during a six year period, and (c) the effect of these categorical changes on change in disease-related symptomatology across different chronic diseases during a six -year period.
This chapter also tries to examine chronic disease in general not limiting itself to specific disease. This is because of the studies carried out in social aspects of people living with diabetes and hypertension is limited and more of biological studies have been carried out in this area. Therefore, the researcher tries to bring out the various studies carried out on other chronic conditions like heart disease, which is caused by hypertension and diabetes and the studies on chronic disease in general pertaining to various social aspects.

Mcwilliam C.L.(2009) made an extensive study on Self-care management that is essential for effective chronic disease management. It is yet prevailing approaches of healthcare practitioners often undermine the efforts of those who require on-going medical attention for chronic conditions, emphasizing their status as patients, failing to consider their larger life experience as people, and most importantly, failing to consider them as people with the potential to be partners in their care. The author tries to explores two approaches for professional–patient interaction in chronic disease management, namely, patient-centred care and empowering partnering, illuminating how professionals might better interact with chronically ill individuals who seek their care. The opportunities, challenges, theory and research evidence associated with each approach are explored. The advantages of moving beyond patient-centred care to the empowering partnering approach are elaborated. For people with chronic disease, having the opportunity to engage in the social construction of their own health as a resource for everyday living, the opportunity to experience interdependence rather than dependence/independence throughout on-going healthcare, and the opportunity to optimize their potential for self-care management of chronic disease are important justifications for being
involved in an empowering partnering approach to their chronic disease management. From the perspective of individuals with chronic disease, the diagnosis of incurable illness means the loss and re-creation of one’s previous sense of self and self-care management.

In 1954 the Minnesota Heart Association undertook a study to determine the attitudes and practices of employers toward cardiac workers. Following this study, the Heart Association sponsored an exploratory project to determine the impact of heart disease on the occupational and economic standing of the patient and his family. This paper is a report of the second of these studies. The design of the study called for the purposive selection of between 40 and 60 heart disease victims, all male adults between the ages of 30 and 60 and living in Minneapolis. The reasons for limiting the study to heart patients in this group were: (a) heart disease is the leading cause of death among males after the age of 30; (b) it is predominantly a male disease; and (c) although the disease is rather common among males in the seventh decade of life, it was not advisable to include men in that age category for purposes of this study because withdrawal from the labor force usually occurs at that time. Two hospitals were asked to cooperate in furnishing a list of male patients who had been hospitalized for cardiac treatment during the period from July 1, 1953, to June 30, 1954. Upon securing the names of the patients, their physicians were contacted and permission was requested to interview the patients. With few exceptions, the physicians were very cooperative. The patients were then contacted and arrangements were made for interviews. Most of the interviews took place in the home of the respondent, but some were held in the respondent's place of business. The data were gathered by use of the directed type of interview. A total of
47 cases are included in the study. The respondents were initially categorized into the usual occupational status groups, but because of the small number of cases, these groups were combined into nonmanual and manual occupations, comprising 53 and 47 per cent of the sample, respectively. It should be noted that the occupational distribution of the sample deviated from the occupational distribution of the general population of Minneapolis. Two groups were over-represented, the white-collar and the skilled manual; one was under-represented, he combined category of semi-skilled and unskilled. Judging from medical estimates of the incidence in the general population of the various types of heart disease - such as aortic and mitral valve, coronary, and hypertensive - the interview group was slightly over-represented in the coronary heart disease category.

It is evident from the Minnesota study that there is a differential impact of heart disease on the occupational and economic standing of the person, according to his occupational status. The differential impact is apparently due more to the nature of employment than to the nature of work performed. Those individuals employed on a salary and occupying a relatively high occupational status were affected the least, occupationally and economically. In those cases where the cardiac in a lower-ranking occupation had been a long-time employee, or his skills had become important to the enterprise, the employer usually made adjustments in order to keep the cardiac worker on the staff.

One of the distinctive features of heart disease as a chronic illness is its disabling impact upon the individual. The cardiac may be totally disabled for one to two months; he may not be able to return to work on a full-time basis for a much
longer period of time. In some cases, the cardiac is advised to change his job or occupation by his physician. More often, it appears that industry is very reluctant to re-employ a cardiac in a manual occupation. This point was frequently mentioned by the respondents in this study and was a major finding of the study of employer's attitudes towards hiring cardiacs mentioned above. The result is that cardiacs of lower-ranking occupational status tend to have the greatest problems: long-term disability, reduction or loss of income, the necessity of changing job or occupation.

Based upon an exploratory study of the effect of heart disease upon the occupational and economic standing of the person, it is more suggestive of hypotheses for further research and testing than it is analytical. It is hoped that more research will provide us with greater understanding of the social effects of illness.

Fiona Ross and Ruth Harris (2005) identify that in recent years, there has been an increasing policy focus on the role of interprofessional education (IPE) in healthcare. IPE is occasions when two or more professions (or disciplines) learn with, from and about each other to improve collaboration. However, the literature emphasizes process rather than outcomes, with little that specifically relates interprofessional educational interventions to the care of people with long-term conditions. In this study the author questions what we know about interprofessional interventions in the care of people with chronic disease, examines the evidence for and potential of interprofessional education in changing practice, and makes suggestions for further research.
Interventions to improve chronic disease management need to be embedded in effective collaborative relationships between health and social care through teamwork. Growing evidence from the USA suggests that team-based interventions in chronic disease are associated with better patient outcomes, and the involvement of nurses in assessment, treatment, self-management support and follow-up has been linked to improved professional adherence to guidelines, patient satisfaction, clinical health status, and use of health services. Earlier researchers and reviews show that team-based interventions are effective in the prevention of falls in older people; and in relation to stroke care, it is established that multidisciplinary collaboration does improve outcomes for patients. IPE has been shown to be effective in enhancing the understanding of different professional roles, increasing the knowledge of teamwork, improving collaborative practice, and enhancing the quality of care. This is based on a programme of systematic reviews that have been conducted over the last seven years by an interprofessional review team. The first systematic review of research conducted by this group in 2000 to evaluate the effect of IPE on professional practice and healthcare outcomes failed to identify any articles that met the methodological inclusion criteria set by the Effective Practice and Organization of Care Group of the Cochrane Collaboration (EPOC). Most of the studies examined employed a before-and-after research design; a few of these included a control group, but none used validated measures. Some of the authors concluded that a more methodologically inclusive review would be useful to increase understanding of the form, process and evaluation of IPE. Not surprisingly, this review found studies of variable quality. The higher-quality studies tended to be North American, from both hospital and community settings, and reflecting both acute and chronic health conditions. The majority involved evaluation of a formal
learning experience, usually involving nurses and doctors, and used a before-and-after or longitudinal research design. The most commonly used outcome measure was the participants’ evaluation of the IPE. Acquisition of knowledge and changes in organizational practice were also commonly measured, usually by participant questionnaire. Far fewer studies measured changes in attitude of participants and changes in practitioner behaviour, although the least used outcome measure was benefits to patients/clients. It was found no articles that reported wholly negative outcomes, although they suggest that publication bias is likely to explain this in part. Positive outcomes reported included a well-rated educational experience, changes in attitude towards teamwork, e.g. the importance of teams and satisfaction with team accomplishment, and improved knowledge and understanding of roles and responsibilities of other professionals and teamwork skills. It was also found that studies evaluating changes in behaviour as a result of IPE difficult to interpret.

Improved communication and co-operation between professionals was reported, although studies tended to be anecdotal in the absence of the definition and operationalization of this outcome. Positive benefits to patients/clients tended to be in terms of improved satisfaction with care, although changes in patient behaviour, biochemical parameters and length of stay were also identified. Therefore, there is some evidence of the benefit of IPE over a range of outcomes and within a range of health services, including those for people with chronic disease.

However, this evidence is small in scale, of variable quality, and needs to take account of the prevailing view that IPE is difficult to implement, because of political, organizational, educational and cultural barriers that are often cited as factors influencing lack of success, the slow pace of change, or failure to move
beyond a pilot initiative into mainstream educational provision. In this chapter, we have set out to clarify the boundaries between the education that promotes teamwork and the extent to which there is evidence of improvement in collaborative practice and patient outcomes. Clearly, the evidence base is weak, perhaps because this kind of research is difficult to do, as it straddles disciplinary boundaries. However, it is important to overcome these challenges in order to exploit the potential for generating explanation of multiple perspectives, and understanding the impact of non-linear models on effecting change. In conclusion, IPE may be seen as a component part of a ‘complex intervention’ that requires systematic exploration and investigation to identify and describe its many components, before evaluation of the effectiveness of different models of IPE can provide robust evidence to guide healthcare and social-care development. (Ross, F., & Harris, R., 2005)

Barbara K. Redman (2005) study focuses on how to build a necessary level of accountability for management of chronic conditions through one important practice, patient self-management (PSM), defined as patient ability to detect and manage symptoms, treatments and their consequences. Redman argues that, ethically, such an initiative is necessary because of the goods that can flow from it and the harms that can be prevented, and will caution that issues of social justice need to be addressed.

PSM of varying portions of therapy for chronic illness is expanding. However, several current conditions of practice are ethically problematic. Standards remain process-oriented, and accountability for patient outcomes and quality of practice of both patient and provider is diffuse. PSM carries important benefits but
largely unmonitored potential harms. Also, access to preparation for safe PSM appears to be skewed in favour of high socio-economic classes. This condition persists even though available evidence supports the conclusion that less advantaged patients with poor disease outcomes can be taught to self-manage, albeit they require more intensive and prolonged interventions. Routine clinical use of well-validated measurement instruments could serve to develop evidence-based standards of PSM, quality improvement and effective public policy. Development of a standard dataset would facilitate description of the effectiveness of existing programmes and comparison across programmes. Such reform will require investment in the development of instruments that measure patient ability to make sound clinical judgements and sustain PSM over changed disease and social conditions. It will take advantage of modern psychometric theory, which is increasingly necessary for building the empirical base for evidence-based healthcare.

Mary Elizabeth Bowen (2010) examines the ways in which childhood deprivation (low parental education and father’s manual occupation) may be associated with coronary heart disease (CHD) in her longitudinal study. Multilevel modeling techniques and a nationally representative sample of Americans above age 50 from the Health and Retirement Study (HRS; N = 18,465) were used to examine childhood and CHD relationships over the course of 6 years (1998-2004). Date: page. Having a father with ≤8 years of education was associated with 11% higher odds of CHD, accounting for demographic characteristics, adult socioeconomic status (SES; education, income, and wealth), CHD risks (diabetes,
hypertension, cigarette smoking, and obesity), and other factors (childhood health, exercise, stroke, and marital status). Policies and programs aimed at improving the conditions of poor children and their families may effectively reduce the prevalence of CHD in later life.

The findings from this study suggest that childhood deprivation may set the stage for future socioeconomic and behavioural risks. Policies improving educational access and promoting healthy behaviours across the life course may attenuate some of the adverse affects of childhood deprivation. However, the affects of early deprivation are not restricted to the continuity of social and behavioral disadvantages; these policies and programs should be coupled with those aiming to improve the well-being of children and their families. At-risk families may benefit from programs that provide healthy foods, education, and early prenatal care. One such program is the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Based on medical professional recommendations and socioeconomic need, WIC has been shown to be effective in reducing the risk for preterm delivery, infant mortality, and low birthweight. Programs such as this may effectively prevent permanent damage to developing cardiovascular, endocrine, and metabolic systems, thus decreasing the risk for CHD and related conditions in later life.

Poverty and illness are nearly inseparable. Poor living and working conditions impair health and shorten lives. The association between low socioeconomic status (SES) and poor health is well established; the poorer the SES, the worse prospects for health development. Evidence confirms that this correlation
persists even when universal health care is accessible as WHO Commission on the Social Determinants of Health states. Health as a social concept is very important in medical sociology. More complicated conceptions of health as a multi-dimensional concept have emphasized not only physical health status, but aspects of overall wellbeing. This article continues in the tradition of a multi-dimensional concept of health, but adds in the complexity of variation over the life course. As people grow older, chronic health problems become more common. Mobility and sensory limitations also increase. How does this impact how people view their health? How do more complicated understandings of the life course and variation by social factors link to an expanded model of health.

The psychological adjustment of people suffering from chronic diseases is an area of research in which a series of hospital studies were conducted by Dalal and his colleagues at Allahabad University (2000). These studies were conducted on hospitalised patients who were seeking treatment for various types of chronic diseases. The major objective of this research is to examine the causal attributions which patients make for their illness, and the way in which such attributions are related to their health behaviour. The relationship between cultural beliefs about illness and psychological adjustment is explored. General conclusions based on the findings of five studies are presented. The prevalence of chronic diseases has increased rapidly in last two or three decades. Increase in life expectancy, lifestyle, dietary habits, occupational and environmental stresses along with a host of other factors have led to a fourfold increase in the occurrence of chronic diseases in the twentieth century.
Some of the findings clearly stand out, providing useful insights into the way Indian rural, poor, uneducated patients deal with their own health problems. First, all these patients are actively engaged in constructing the meaning and causality of their problems. Many of their explanatory models are rooted in the cultural belief system, which clearly determines how they will deal with the crisis. Second, the patients’ own representation of the disease is not only contingent on its medical aspects, but also on the cultural meaning of the illness experience. They rarely attributed their health problems to factors like virus, heredity, or environmental pollution, as was observed in Western studies, but viewed it as a transcending experience. Third, it is against this backdrop that the traditional healers play an important role in the psychological well-being of patients. India has more than five million faith healers and their services in providing relief to people suffering from chronic diseases cannot be overlooked. Faith healing in combination with biomedical treatment can be a potent treatment regimen for chronic diseases. However, it remains to be seen how medical services and traditional medicinal/healing services can be integrated into a unified health care system.

Dave Sells and et al (2009) examine experiences of people with multiple chronic illnesses. Approaching this subject via a temporal framework that parallels the ‘unfolding’ character of illness experience—i.e., onset and accrual, loss and corresponding efforts to adapt to these experiences, the authors notably through personal determination and the salutary effects of the social support received both from, and given to, family and friends.
Dave Sells et al (2009) conducted a longitudinal study involving three qualitative interviews with each participant over 1 year, at approximately 4-month intervals. They reported from the first qualitative interview in this article. While in a previous study, they analysed the difference between high and low users of medical services, this study focuses upon participants’ experiences irrespective of their healthcare utilization or cost.

Participant narratives revealed shared patterns of experience in the onset and accrual, loss and adaptation with respect to multiple chronic conditions. For most, the defining moment of physical crisis portended a series of medical difficulties—often in relatively quick succession—experienced as a virtual cascade of problems. In some instances, the limitations imposed by treatments led to further crises, such as the loss of mobility following amputation of a limb due to arterial disease. For all participants, the culmination of chronic problems and burdensome treatments imposed significant limits upon their social and vocational lives. Among the myriad consequences heralded by illness were job and subsequent income loss, restriction of personal activities such as attending church and breakdown of marital and social relations. As illnesses progressed, these losses were in addition to more direct corporeal insults such as visual impairments, reduced mobility and loss of teeth and other body parts. Given the magnitude of such trials, participants showed great resolve in reclaiming aspects of their former lives and strength of spirit in pursuing new lives integrated within the dimensions of illness. For some, resolve showed through work to regain physical capacities or in the willingness to do things differently. The abilities to both receive and provide social support evinced as invaluable resources to daily life and more broadly towards maintaining and/ or
reclaiming a sense of personal value. The findings are consistent with this assertion, suggesting a model linking resilience in the face of great personal challenge with supportive interpersonal relationships outside of those with providers.

Moreover, the findings lead towards a promising source of participant strength through the notion of providing support to others. While current psychological discourse in medicine emphasizes the virtues of patient agency through the application of varied clinical strategies and techniques to counter the effects of chronic medical illness, the patient’s personal recognition of experiential and selfworth — intrinsic to caring for others — may yet prove an even more potent means towards personal empowerment.

Linda L. Eddy and Alexis J. Walker examined the impact of having a child with a chronic illness or handicapping condition on marital quality and on perceived marital stability (1999). Using data from the National Study of Families and Households (NSFH), married parents caring for a child with a chronic illness or disability (n = 94) were contrasted with married parents of well children (n = 3,693). Data were analyzed using ordinary least squares regression. Neither marital quality nor perceived marital stability differed between the two groups. These results call into question assumptions that children with special needs irreparably harm marriages.

There is a general belief that having a child who is chronically ill or handicapped increases the likelihood that parents will be less happy in their marriages and thus more prone to dissolve them. There is no straightforward link
between marital quality and marital stability, however. Marriages are stable for many reasons, and having a chronically ill or handicapped child should be associated both with reasons for breaking up and reasons for staying together. Marital quality and marital stability are products, not only of perceived net outcomes (i.e., rewards minus costs), but also of barriers to leaving the relationship as well as alternative attractions that affect marital quality and subsequently marital stability (Lewis & Spanier, 1979; Sabatelli & Shehan, 1993). As social exchange theory posits, unhappy marriages with low rewards and high costs may be stable. The role of children with chronic health problems in marital quality and marital stability is still a puzzle. Not all families are seriously harmed and some may actually be strengthened by this crisis (Kazak & Marvin, 1984).

Kazak and Mavin’s study provides information previously unavailable from a representative sample and raises some questions of theoretical and clinical significance. For instance, how does having a child with special needs affect marriage for persons in the general population not involved in clinical services? Should we continue to examine these important issues entirely in small clinical samples? Although potentially valuable information is gained through these convenience samples, use of data sets based on representative samples would give a less biased picture of these families. Families of children with chronic health problems might benefit if clinicians approached them from a strength rather than a deficit stance. Family stress does not necessarily equal marital problems or family disruption. This study provides some evidence that the stress of having a child with a chronic health problem may not affect marriage negatively. In the current climate of scarce resources available for family support, clinicians should center their
attention on actual rather than presumed family needs. Future research might focus on within-group variability in families with chronically ill or handicapped children. If clinicians are to focus on family strengths rather than weaknesses or deficits, more information is needed about factors associated with positive outcomes in these families. Factors to be investigated might include the meaning of the diagnosis to the family, the meaning of marriage and commitment, the role of partner support, social support, division of family work, and formal support services for families caring for children with special needs in influencing marital and family outcomes.

The authors examined the impact of children with chronic health problems on marriage using a representative sample. The results indicated that neither marital quality nor perceived marital stability differed for parents of children with chronic illnesses and disabilities and parents with well children. The results provide evidence that having a child with a chronic illness or disability may not have the uniformly negative association with marital quality and stability that is often suggested.

Here is another study which deals with overweight and obesity which are considered to be the main cause for diabetes and hypertension. Therefore this study has some relevance in with this topic of research. Gunnel Bostromi and Mats Eliasson (2006) outlined some of the major public health problems such as overweight and obesity sees it as a growing threat to health for survival, humans must have a certain quantity of fat in their bodies. Adipose tissue is necessary, among other things, for storing energy, for insulation and for the production of hormones. Women require a larger proportion of fatty tissues in their bodies than
men do; as a rough estimate, a woman of normal weight has about 25–30% fat in her body and a man of normal weight about 15%.

When adiposity increases far above what is normal, a number of health problems ensue. Obesity is a growing public health problem in the Western world. In Sweden, too, the proportion of overweight people is increasing steadily and the development among children is disquieting. Direct medical care costs for obesity and its accompanying diseases have been calculated in a report from the Swedish Council on Technology Assessment in Health Care (SBU) from 2002. These costs represent about 2% of total expenditure for medical care in Sweden, approximately 3,000 million Swedish crowns.

While analyzing the cause of the increasing bodyweight, some contradictory trends can be noted. First and foremost, changes in genes can be excluded since the period in question is very short. In Sweden the production of energy-rich foods increased between 1990 and 2002, according to Swedish Board of Agriculture statistics, by about 5% of the energy intake. The largest increase consisted of bread and cereal products, meat and meat products, chocolate, confectionery, ice cream, soft drinks and alcohol, while the consumption of white sugar, milk and edible fat decreased. For the body to be able to consume this increased energy intake, an extra daily walk of 23 minutes is needed for a person who weighs 65 kilos. However, there is no indication that average daily activity has increased this much. Some of the increase in overweight may be because fewer people are smokers.
This, however, is beneficial and the gains in health achieved through smoking cessation are probably greater than the increase in risk associated with weight increase. The proportion of smokers has declined most among men and it is also among men that the proportion of overweight people has increased most. People use less energy than formerly, since physically light and sedentary jobs, for example, have become increasingly common and people cycle and walk less. Physical activity is now largely only a leisure-time occupation. Increased car driving, increased television, the introduction of personal computers and growing automation in working life during the twentieth century underlie this development.

The trend is thus implacably towards increasingly sedentary lives, which must be compensated for through deliberate daily and leisure-time activity. If the consumption of high-energy foods and sweets continues to increase at the same rate as during the past 10 years, however, it will hardly be possible to counteract this with physical activity: we will also have to reduce our intake of energy-rich foods.

Technological development during the past few decades has meant that people need to move about less and less. Many people spend a large part of their work in front of a computer screen and their leisure time in front of computers and television. Taken together this probably means that people’s total energy consumption, despite increased activity during leisure time, is lower than formerly. Calorie intakes among large sections of the population, however, have not been adapted to a more sedentary style of life.
Aikins (2003) highlights that current chronic illness research in Africa neglects the social psychological dimensions of illness experiences that present more appropriate frameworks for intervention. Informed by social representations theory, links between social knowledge of diabetes, illness experience and illness action were examined through semi-structured individual interviews with rural and urban Ghanaians with diabetes. All respondents drew interchangeably from commonsense, scientized, and religious knowledge modalities in defining health, illness and diabetes. Diabetes caused disruption to: body-self, social identity, family/social relationships, economic circumstance and nutrition. Commonsense and scientized notions of health, illness and diabetes framed illness action goals that merged with biomedical goals, specifically drug and diet management. The goals were compromised by the nature, severity and duration of disruption(s) and emotional responses evoked. The author of this paper discusses the implication of Living with diabetes in rural and urban Ghana and outlines recommendations for interventions that span individual/group, community and structural dimensions.

The discussion will situate the main findings within the current regional literature on chronic illness, work on diabetes in African and non-African settings and within critical health discourse. A strong link has been made between illness inaction and disruption to economic circumstance and social identity. Within the rural communities where uncontrolled diabetes symptoms are misconstrued as AIDS symptoms, the impact of stigmatization and ostracism on social identities and personal agency of sufferers should constitute a key area for attention. Here, lessons can be drawn from community intervention work on epilepsy and HIV/AIDS in the
region, which suggest that sustainable results are more feasibly realized if community education is prioritized alongside psychosocial support.

Charlene Winters et al (2006) tried to examine the rural context and describe its influence on the self-management of chronic illness by women living in a rural setting. The Women to Women (WTW) project is a research-based computer intervention that provides health education and peer support to rural women with chronic health conditions. Messages posted to the online support and health education chat rooms were examined to determine the characteristics of the rural context in relation to the women’s illness self-management. ‘Distance’ was the overarching characteristic of the rural context that influenced the women’s ability to self-manage their chronic health problems. The effect of distance was woven throughout each of the four predominant themes that emerged from the data as having influence — physical setting, social/cultural/economic environment, nature of women’s work, and accessibility/quality of healthcare. These influences affected the women’s self-management abilities both negatively and positively. The rural context profoundly influenced the ability of rural women to self-manage their chronic conditions. From the data, health professionals and policy-makers can glean information about the barriers to healthcare faced by rural women who are trying to manage their chronic health problems in comparative isolation.

How underserved women experience their chronic illnesses, seek health services and manage their conditions in the rural context has significant implications for education, public policy, clinical practice, and research. Often, health professionals are educated without regard to the rural context. Distance,
physical setting, social/cultural/ economic environment, nature of rural women’s work, and accessibility/quality of healthcare, had both negative and positive influences on the women’s self-management abilities. Specialized education that focuses on the influences of the rural context should be provided for health professionals and students who are interested in rural practice.

Some of the problems in rural healthcare utilization that must be addressed in public policy are indicated by these results. Steps to attend to these concerns should ensure that the policies are tailored to meet particular needs of the community and will be acceptable to them. According to Mueller and MacKinney (2001), healthcare delivery systems for rural dwellers that provide seamless and coordinated transitions across the continuum of care — wellness, prevention of illness, disease management, and return to wellness — require a conceptualization of care with the rural context in mind. Research is needed to operationalize this vision. In the area of clinical practice, the data provide healthcare professionals with information to deepen their sensitivity to the needs of rural women for social support and education in self-management skills to successfully manage and adapt to living with their illnesses. It will also assist them in planning and designing interventions that are appropriate and acceptable.

The WTW project is currently moving into Phase Three and is testing the impact of a simplified computer-based intervention on psychosocial adaptation, chronic illness self-management and the quality of life among rural women with chronic illness. The Agency for Health Research and Quality (AHRQ) has identified telehealth as having tremendous potential as a tool for improving access
to healthcare, particularly in rural populations and the chronically ill. The AHRQ National Telehealth Nursing Research Agenda includes several questions to be answered in future health nursing studies. Of these, three are most pertinent to discussion: (1) what are the patient problems and needs that the nurse in telehealth addresses? (e.g. need to manage own chronic illness; symptom management); (2) which interventions that nurses employ in telehealth practice show the highest potential for demonstrating the clinical efficacy of this practice model? (e.g. chronic disease management, patient empowerment, and teaching self-management using technology); and (3) what telehealth interventions show the highest potential for creating evidence-based future practice directives (e.g. for altering how patients access care or breaking down barriers that deter desired outcomes)? In addition to this research agenda, additional research is needed to further define both the common and unique components and characteristics of rural populations. Continued research can provide a more solid basis for providing acceptable and effective healthcare to the rural chronically ill that is focused on a chronic illness self-management model.

The Sociology of Chronic Disease

Bury (2010) provides a review of research and debate in the field of chronic illness first by outlining some general features of a sociological approach, and then drawing upon recent empirical studies of chronic illness to illustrate some of the main stages involved. These include: onset and the problems of explanation and legitimation, the impact of treatment, and the development of adaptive responses. An attempt is made to distinguish the use of the terms 'coping', 'strategy' and 'style'
in describing adaptation. The paper argues that a sociological approach needs to recognize the positive actions people take, as well as the problems they face. In this way, diversity in managing chronic illness, and the continuing need for a person-based approach to sociological work, are underlined.

Herbert Blumer, made the comment, often repeated since, “that sociological interest in social problems follows in the wake of societal definitions” (1971). What he might have added is that sociologists also tend to be more interested in problems than in people’s responses to tackling them. In the field of chronic illness, the documentation of problems faced by patients, and to a lesser extent their families, has usually dominated the research agenda, including sociological research, highlighting the hidden burden of work and social relationships (Blaxter 1976) for example, or the extent of poverty associated with disabling illness (Townsend 1979) has, of course, been an important corrective to a narrow medical view preoccupied by disease and its clinical (or, at best, functional) sequelae. However, the emphasis on such difficulties and disadvantages has been at the expenses of studying the responses and positive actions of those affected.

Alongside descriptions of the burden of chronic illness, however, research findings have also appeared documenting the steps people take to manage, mitigate, or adapt to it, and the meanings attached to these actions. Part of this change in emphasis has come out through the development and application of more theoretically informed approaches to chronic illness. Interpretive sociology, in particular, has developed a view of people as agents, rather than being merely the products of the contexts in which they live, interactionist and phenomenological
models of illness have been explicated, as a means of understanding better the social basis of the meanings of symptoms, and the negotiated reality actors fashion in response to them (Gerhardt 1989).

Chronic illness is, by definition, a long-term, and perhaps permanent, condition in a person's life. In the classical functionalist framework, illness is characterised by dependency, regression and, through encounters with qualified practitioners, hopefully recovery. In chronic illness these features are often only partially characteristic of experience, overlaid as they are with poor or limited recovery prospects. The time-scale involved makes it important to bring into the picture a view of the illness in terms of both the stages it passes through and their interaction with the individual's age and position in the life course. This 'unfolding' or "emergent" character of chronic illness makes it imperative that a sociological perspective places experience within a temporal framework.

As is now widely recognised, the onset of chronic illness represents an assault not only on the person's physical self, but also on the person's sense of identity, calling into doubt the person's self-worth. Loss of confidence in the body leads to loss of confidence in social interaction. More broadly, Bury has described this experience, of the onset of chronic illness, as "biographical disruption" (Bury 1982). This idea brings into focus the meaning of illness as well as the setting in which it occurs, including in the latter case, the resources available to the individual. The notion of biography suggests that meaning and context in chronic illness cannot easily be separated.
Second, the meaning of chronic illness may be seen in terms of its significance. It means that different conditions carry with them different connotations and imagery, these differences may have a profound influence on how individuals regard themselves, and how they think others see them. Chronic conditions vary markedly in terms of their symbolic significance within segments of the cultural order, and these are bound to affect adaptation. Whilst these may combine into stereotypes (e.g. of 'epileptics' or 'arthritics'), meanings surrounding illness often change as they interact with different stages of the life course. The impact of such categories on individuals and social interaction may not always be a reflection of negative associations. Disguising and disclosing diagnosis and symptoms, for example, depends not only on their physical intrusiveness within social contexts, but also on their positive and negative meanings within a specific set of social relationships, changes in symptoms over time may affect social responses, and these in turn will influence experience. This interactive process can also be seen in the changing perceptions of disease in historical time; the complex interaction between disease and the social meanings which surround, or 'frame' it (Rosenberg 1989).

In everyday life, chronic illness also creates what the author has termed as a situation of "meanings at risk" (1988). In responding to chronic illness, individuals constantly test the meanings attached to their altered situation against the reality of everyday experience. It is a situation of risk because individuals cannot be sure that their own developing perceptions and definition of the situation will be shared by others, whether in the informal setting or in interactions with professional caregivers.
Calls for help may turn out to produce unwanted dependence and calls for sympathy run the risk of rejection. Only the passage of time and trial and error can provide guidelines as to the nature of the risks involved in living with a particular condition, though a degree of unpredictability will always remain. Robinson (1988) for example, shows that patients with multiple sclerosis report being at risk of having their symptoms misunderstood as signs of mental illness, malingering or even being drunk by those not in the know. Even with those in the know, "any claims which allow people social exemptions are likely to be scrutinised by others" (Robinson 1988: 113).

Sociological work on chronic illness has done more than simply document the problems of uncertainty, doctor-patient conflicts and difficulties in managing symptoms and their treatment. Important though these issues are, an interpretive approach to illness brings into view changes over time and the positive actions people adopt to counter the effects of symptoms and treatment, though firmly wedded to a person oriented approach, this approach also recognizes the range of resources drawn upon in adaptation. Including medical resources, in order to improve the quality of life.

In considering long term adaptation to chronic illness, Bury would like to suggest that the terms "coping strategy" and 'style' be distinguished more dearly, at least for analytic purposes, even though they may be difficult to distinguish empirically, "the problem is that these terms are sometimes used synonymously, and at other times they are used In a combined form. For example, "coping' may be
used to refer to the overall process of adaptation, or as a way of describing particular practices, as in "coping strategies'. At the same time this overlap in usage is perhaps inevitable.

The results of recent interpretive sociological studies of chronic illness suggest the need for a multidimensional view of its impact on everyday life. Not only is a biomedical model of disease inadequate on its own, but so, too, are one-dimensional sociological models which emphasize isolation, stigma, or the "master status" of illness and disabilities labels. Though these features may be dominant in some individuals’ experiences, research has shown considerable diversity in the ways in which people actively attempt to mitigate biographical disruption and enhance adaptation. In Geertz’ terms, the research task involves taking 'experience-near" concepts and placing them in 'illuminating connection with experience-distant concepts" (Geertz 1983: 58). It is with this aim that the author have employed terms such as biographical disruption and legitimation, and distinguished between coping, strategy and style.

Future research will not only need, however, to pursue greater conceptual consistency and methodological rigour, it will also have to tackle the changes. The interpretivist approach is often critiqued for concentrating too much on meanings, and not enough on wider structural factors. Concentrating on the positive actions people take, need not be counter posed to considering the impact of the social position and resources of the individual on chronic illness. The need to consider the wider context is important at a time of rapid change in the health held. For example, changes in the culture surrounding health, may have important implications for our
understanding - As Blaxter (1990) has pointed out the current emphasis on 'healthy lifestyles' may have a negative effect in chronic illness, where symptoms can limit their adoption. While such changes in the cultural climate may be attractive to some groups and individuals, they may be new sources of concern to others (Anderson and Bury 1988: 250-352),

How far such developments represent a positive challenge to professional (especially medical) power, and what effects such changes might have on adaptation in chronic illness is open to question. In particular, it is necessary to ask whether these changes will benefit the articulate and better-off at the expense of those in more marginal groupings, or whether they will provide a generally more "enabling" context for responding and adapting to illness. At the least, it is important that future sociological work in chronic illness recognise and assess the impact of these changes, particularly with respect to the interaction between individual experience and social position. If it does it may go some way towards reconciling interpretive and structural approaches.

Sociological Theory and Chronic Illness

Three different sociological perspectives can be applied to understand chronic illness. They are:

1. a structural perspective in which the occurrence of chronic disorders is seen to be socially patterned and related to social divisions;
2. an interactionist perspective in which chronic illness is seen as an emergent and disruptive experience shaped by cultural expectations and interactional difficulties;

3. a postmodern perspective in which personal experience and chronic illness narratives are characterised by discourses which emphasise opportunities for personal growth and change. Each of these perspectives, drawing as they do on different theoretical traditions of social order and action, have both strengths and weaknesses. Each may be relevant to specific practical and research needs, but a more integrated view is likely to provide the fullest sociological picture of chronic illness (Bury, 2002)

The structural perspective

While examining the “structural approach to chronic illness”, several studies have drawn attention to the social patterning of chronic illness. Studies were examining that the social character of chronic disorders were contingent upon whether social conditions (especially inequalities) could be held responsible for their occurrence or were more significantly implicated in their consequences. Some of them attempted to show that in modern societies such as the US, structural factors such as social class had diminished as key social determinants. Some disagreed and argued that poverty could play a major role in the occurrence of chronic illness as well as influencing its effects in terms of income and quality of life. Some research gave the conclusion that social class did indeed have an effect on the occurrence of chronic illness and not just on its outcome.
However, in recent years there has been a noticeable shift in attention among sociologists and epidemiologists concerning health inequalities. Work is now focusing on what is called a ‘lifecourse’ perspective on health and illness, bringing with it fresh evidence of structural influences on chronic illness as well as on life threatening conditions.

Sociologists such as Vagero and Illsley (1995) have taken issue with what they see as an overly biologically deterministic perspective, arguing that ‘biological and social influences are not mutually exclusive’. Wadsworth (2002) has developed this approach by arguing that ‘health capital’ may in one sense be seen as fixed at birth. However, the development of ‘social capital’ which may reinforce or mitigate early influences, though developing ‘more gradually... becomes in later life the key to maximising the benefits of health capital’ (Wadsworth 1996). Thus with the passage of time and the ageing process social influences on health become relatively more important (Bury and Wadsworth 2002).

This more developmental approach to the lifecourse argues for a shift away from an epidemiological and essentially biological view to one emphasizing structural and sociological issues, especially those related to social inequalities in later life where chronic illness has increased salience. At the least it suggests that there are complex interactions between biology and social structural influences across the lifecourse.

First, a life course perspective inevitably deals with the ageing process and thus is drawn towards dealing with chronic disorders as well as life threatening
ones. Secondly, a life course perspective shows how social structural factors and health outcomes may have complex causal pathways. ‘Outcome’ measures such as low weight at birth or adult height for example, may not only reflect social as well as biological influences, but may in turn have implications for social functioning as well as health in later life. Restrictions in height correlate with structural features such as unemployment, and can influence life chances through their interaction with social and cultural institutions such as marriage. In one recent study, it was found that not only did unmarried men have higher rates of cardiovascular disease, but that ‘men that are smaller at birth are less likely to marry’. Thus the study of health disorders, including chronic disorders, in a life course perspective, can show the importance of health in shaping key features of the social structure (through its influence on social mobility, family formation and soon) as well as show how social structure influences health outcomes. However, that there is considerable debate about the tendency towards reductionism in these explanations, and how far the effects of biological and structural determinants can explain events later in life. Factors affecting such issues as marriage clearly involve complex processes at the level of the individual, group and society. Though these are beyond the scope of the present research they are important to the development of theory at the structural level.

However valuable structural approaches to chronic illness may be, especially in their capacity to reveal links between chronic illness, inequalities and public health more generally, the lived experience of illness remains virtually silent in such accounts. Mortality and morbidity data can map the contours of the problems created by chronic illnesses, but they can say nothing about what they
mean in everyday settings. In so far as the experience of illness has been tackled, structural approaches have emphasised its socially dysfunctional character rather than its meaning. In the US the dominant structural functionalist approach in sociology, especially in the work of Parsons, approached the experience of illness (even chronic illness, Parsons 1975) in terms of deviance and an elaborated ‘sick role’. Structural sociology assumed that the occurrence and experience of illness were, by definition, socially undesirable, and in need of prevention and control. This form of structuralism emphasized role performance, the control of deviance, and symmetrical if unequal relationships between the sick and the medical profession.

*The interactionist perspective*

In reaction to structural approaches, whether of an inequalities or social role kind, sociologists of a more interactionist persuasion began to study specific chronic illnesses in more depth, using qualitative methods of inquiry, rather than employing survey methods or relying on epidemiological data. Here the question of ‘agency’ was raised; how did people manage everyday life in the face of chronic disorders which would not respond to curative medicine (and were not in the main preventable) but which interfered significantly with both private and public worlds? And how did such people manage in circumstances where the ‘sick role’ was only intermittently relevant, if at all, and where medical care was not always central to their daily concerns?
Perhaps one of the most influential studies in this period, which helped to set out a new agenda for sociological research was that of Strauss and his colleagues, published initially in Strauss and Glaser’s 1975 book Chronic Illness and the Quality of Life, containing a long introductory essay, and a series of empirical studies by others on such illnesses as rheumatoid arthritis and emphysema. Rather than summarise this body of well known work, it is preferable, perhaps, to draw out one or two of the more theoretically significant issues contained in Strauss’ approach. The first of these is, of course, the oft cited ‘grounded’ character of this form of interactionist sociology. Employing an inductive approach, the investigator is encouraged to enter the field with as few preconceptions as possible, and to build up a picture of the lived reality found, as the study proceeds. While it is true that Strauss and Glaser begin their discussion of chronic illness with a note of its public health significance in modern America, and suggest that the horizons of health care professionals wedded to curative medicine and preoccupied by acute disease, were too limited, their call to sociologists was to enter the everyday world of patients and report on the ways in which they manage both their symptoms and their ‘treatment regimens’.

This ‘management of symptoms’ is at the core of Strauss and Glaser’s approach. As Gerhardt has pointed out, the interactionist perspective does not treat the social structure as given or ‘sui generis’ (as in the structural approach) but as ‘negotiated’ (Gerhardt 1989: 123). Social order is thus maintained by bargaining processes in everyday settings. This applies to illness as well. For Strauss, illness and its outcomes are a function of the decisions, tactics and, organisation of work’ carried out over the ‘trajectory’ of the illness (Gerhardt 1989: 147). Whilst a
medical or physiological view of chronic illness would seek to establish its ‘natural history’ or ‘sequelae’, and an epidemiological view its recurrent pattern in populations, an interactionist sociological view would stress its uncertainty (within broad ‘trajectories’) and the contingencies surrounding its emergence, diagnosis and course. What holds true for illness holds true for the social order more generally. To repeat, both chronic illness and the social order from this viewpoint are emergent in character and are produced by the constant interplay of circumstance and action.

In subsequent work on chronic illness, sociologists employing an interactionist perspective have established a series of empirical and theoretically informed studies. Bury’s own approach, much influenced initially by Strauss, has been to document the ‘disruptive’ character of chronic illness, the issues involved in the active responses people fashion in social interaction, together with the meanings attached to such illnesses when set against the often ambiguous cultural settings in which they occur.

In an early paper on ‘biographical disruption’ Bury (1982) attempted to examine the ‘emergent’ character of chronic illness (in this case rheumatoid arthritis) in a group of relatively young men and women. The study found that respondents had begun to reconstruct their lives into two halves, before and after the onset of the illness. This sense of a fundamental fracturing of biography was not always set in train by receiving a diagnosis, but was nearly always reinforced by doing so. Modern medical categories, the medical understanding of the disease and the treatments it could offer, were appropriated by patients as containing complex symbolic properties. On the one hand, the diagnosis and attendant medical
information could act as form of ‘legitimation’ in dealing with their altered physical and emotional state, on the other, it confirmed that they were suffering from a disabling illness associated with later life, for which there was no cure, and from which there was in all probability no escape.

In subsequent writings this approach was developed by examining the interactional difficulties (and successes) people experience in living with chronic illness. It was argued that especially in family and work settings, everyday meanings are put ‘at risk’ by the ‘performance’ involved in managing illness (Bury 1988). Not only do taken for granted aspects of life need rethinking, requiring ‘endless work and care’ (Corbin and Strauss 1988) but the meaning of the illness itself involves two sets of constantly negotiated elements. In the first place, of course, are the practical problems of disruptive symptoms on everyday tasks, especially those concerning self care, but extending to wider issues of dexterity, mobility and orientation.

But, in addition, interfacing with these practical issues in complex ways are the ‘significances’ attached to specific illnesses and their effects in particular cultural contexts. Much depends on the nature of the disorder, the cultural imagery surrounding it, its visibility and implications for social interaction. As Kelly and Field have argued (1996) an altered body disrupts a sense of self-identity (an issue less in evidence, perhaps, in Strauss’ work) through alterations in appearance and action. Identity, in particular, is constructed and maintained through ‘public and shared’ performances of the self, and is dependent on equally shared cultural expectations of what is appropriate behaviour. Disruptive symptoms, or visible
changes in the appearance of the body have to be managed with care. Such disruptions can, of course, lead to social isolation as individuals restrict their exposure to such ‘risks’, or are openly rejected by others. Kelly and Field’s argument is that in order to be judged as competent social performers, it is necessary to ‘be able to give the impression of some degree of the control, use and presentation of our bodies’ (Kelly and Field 1996: 246). In attempting to meet these expectations, those living with chronic illness must endlessly judge the ‘limits of tolerance’ of others, in making demand for practical help and assistance. They must also try to read what others think about their altered state, especially its significance for proper conduct and appearance in social interaction.

In a review paper published in 1991 Bury it attempted to summarise what at that date had become a substantial body of work on the sociology of chronic illness, employing a broadly interactionist perspective. The paper suggested that the findings of studies pointed out three types of response by the chronically ill, dealing with related but analytically separate issues. The first of these concerned ‘coping’. It was argued that though this was a term frequently employed in social studies of chronic illness, it had been transferred from psychology, rather than being a strictly sociological concept. The paper suggested that coping refers to a cognitive process through which the person ‘manages the illness internally’, so to speak. It refers to attempts by the individual to maintain a sense of self worth and value, and involves trying to come to terms with the altered situation and its effects on both the body and the self. This will, of course, depend in part on the reaction of others and the degree of emotional support and reinforcement the person receives. But coping with
chronic illness has a psychological dimension which begins and ends with the individual.

In terms of the social action taken by individuals in their relations with others, it was argued that a second term, ‘strategy’ or the ‘strategic management’ of chronic illness, was more appropriately at the centre of the interactionist perspective. The term ‘strategy’, here, refers to the different ways people mobilise resources to meet the situation in which they find themselves. Though this may overlap with coping mechanisms, it involves all the day to day tactics employed to circumvent, mitigate or disguise the effects of disruptive symptoms. It also refers to the conscious or unconscious ‘trade offs’ people must make in carrying through daily activities or pursuing valued goals. Such strategic management of chronic illness will also involve decisions about medication and medical treatment. Crucially, it was suggested, strategies in chronic illness will be directed to dealing with material resources and their maximization, a matter which interactionist sociology has often been charged with neglecting. The idea of strategic management suggests that issues of social division and social structure cannot be satisfactorily left out of the picture, even in an interactionist account (Williams 2000).

Finally, the review paper argued that different responses to chronic illness may be frequently characterised by different ‘styles’. By this we mean that, depending on circumstance and outlook, the solutions people find to the problem of self presentation and ‘competent social performance’ take on very different forms. The emphasis on shared values and meanings, within which people must fashion
their active responses should not blind us to the fact that cultures are themselves often fragmented, contradictory and open to challenge and change. Some studies have indicated that people adopt quite different ‘styles’ of living with chronic illness, some preferring, or accepting the need to disguise their problems as much as possible, while others might be quite open about their altered identity and appearance. Here ‘biographical reinforcement’ as much as ‘biographical disruption’ may be at work (Carricaburu and Pierret 1995). This final emphasis on different styles of managing chronic illness has become a significant motif in recent research and writing on the sociology of chronic illness, and takes us from an interactionist perspective to a more ‘postmodern’ one; the subject of the third and final section of this paper.

**The postmodern perspective**

Bury’s analysis is also instructive in understanding the contribution that interactionist sociology has set out an alternative vision of chronic illness – one concerned with the meaning and cultural shaping of illness as social action, rather than its structural origins or effects – it has still addressed matters that might be considered broadly ‘modernist’ in nature. By this it means that interactionism, like structural sociology, is concerned with social order and its formal properties, albeit at the more micro, everyday, problematic level. The disruption brought about by chronic illness is seen to be in need of management, and, if possible, repair. The sources of concern about the limits of the medical model, and of health care when applied to chronic disorders are broadly reformist in character. Many interactionist
studies suggest that people as patients do not reject ‘modernist’ explanations of, or actions for their troubles, however ambivalent they may sometimes feel about both, or however conflictual patient-practitioner relationships may become (Williams and Calnan 1996).

Bury has stressed in his own work, as others have done, that health care, despite its difficulties, is an essential if limited resource for the chronically ill. The order patients strive to maintain, through processes of ‘normalisation’ and the like, are understandable responses to the threatening character of pain and suffering. Carrying out such ‘work’ is an everyday reality, not one confined to interactions and decision in a clinic. However, the limitations of modern medicine for the chronically ill should not be read as reason for even less being offered. Much of the interactionist research has been joined to a call for health care to become more responsive to the needs of the chronically ill (Corbin and Strauss 1988).

In the last few years, however, this broadly ‘reformist’ sociology has been supplemented, if not displaced, by an apparently more radical vision. This shift in emphasis is signalled in a number of recent writings. Kathy Charmaz has stated, for example, that the interactionist literature has delineated ‘patients’ perspectives instead of practitioners’ views that dominate both medicine and social scientific research’ (Charmaz 2000: 277). She also stresses that normalisation processes involve attempts to ‘contain’ the impact of illness on everyday interactions. Significantly, though, she goes on to argue that ‘experiencing chronic illness can mean embarking on an odyssey...to integrate the self on a different level... facing such losses moves them (the chronically ill) toward transcending loss.’ (Charmaz
In this argument ‘biographical reinforcement’ is taken a step further, towards a new conception of self through illness.

As Bury notes, this shift in tone is, of some significance because it marks a move away from the interactionist critique of structural sociology and from modernist concerns, be they medical or social in character. In its place a new kind of cultural frame obtains. The postmodern perspective begins by asserting that modern social structures and their cultural form are already in decline, or are being superseded by a culture of a very different nature. Sociology, including that concerned with chronic illness needs, therefore, has to pursue a quite different agenda, one where personal lifestyle and ‘agency’ take on new meanings. Space permits an outline of only a few of the items from this theoretical agenda as they might relate to chronic illness.

Bury’s remedy for this is to investigate the disruption of chronic illness and the question of identity. Whilst the need to respond actively to the disruptive character of illness is difficult to deny, the postmodern emphasis is on continuity and development, but where one might see not so much ‘biographical reinforcement’ as ‘biographical reinvention’. Here, the ‘reflexive’ nature of postmodern identity and biography can be seen to involve ‘a never-ending cycle of biographical appraisals, revisions and improvements, health related or otherwise’ (Williams 2000: 61). What was earlier seen as an attempt to stabilise and normalise is now seen to be a ceaseless and nomadic journey with no end point. At its limits this signals the development of ‘pathologies of reflective self control’ (Williams 2000) but in its most positive forms, chronic illness is seen to open up of
opportunities for self development and personal growth, even if through adversity. Reflexivity, openness about illness, the revelation of experience and the demand that diversity and ‘difference’ be accepted, lie at the heart of this new approach.

The idea that chronic illness should be reconceptualised to take into account these postmodern cultural forms has, perhaps, been most clearly expounded by Arthur Frank (Frank 1991, 1997). Postmodernism, here, points to the waning of categories and structures that have ordered modern life. The separation of different spheres of activity – the public from the private, production from consumption, pathology from normality, and the whole panoply of different divisions of labour – is overtaken by a rise in the importance of personal experience, self consciousness of the body, the emotions, lifestyles and open ended experience.

Following sociological commentators on the postmodern such as Mike Featherstone (1991) Frank suggests that medicine, health and illness are important elements on this shifting cultural terrain. The reduction in ‘medical dominance’ and the rise of patient and consumer influence are but instances of a more general populist culture which is replacing that based on hierarchy and clear cut cultural categories. Frank argues that not only are the chronically ill more likely to challenge their doctors and be more assertive, but that the very distinction between sickness and health is becoming effaced (Frank 1997: 9). In its place, Frank argues that a new form of ‘remission society’ has developed where substantial numbers of people, if not the majority, regard themselves as neither completely well nor ill.
Chronic illness sufferers, together with those who have recovered from acute illness but are not back to their previous health, those with long term disabilities, and those suffering from allergies and a variety of other disorders constitute a new and legitimate realm of lived experience. The ‘discursive formations’, to use Foucault’s phrase, of medicine or sociology, with their categories and classifications, cannot express the diversity of experience now emerging.

It is worth noting here that Foucault’s emphasis on the impact of modern medicine (Foucault 1976) and its tendency to exercise, ‘surveillance’ and control over an increasingly wider range of human experience, was linked to the creation of what he saw as ‘docile bodies’ and the ‘subjugation of populations’ (Foucault 1981: 140). Medicine, for Foucault was part of an insidious process inherent in modernity, one which was centrally based on expert knowledge – on forms of ‘discourse’. For Foucault, however, the growing emphasis on subjective experience of the body (as well as of areas such as sexuality and the emotions) could not properly be seen as a ‘liberating’ move. Rather it was simply another turn in the exercise of an ordering and controlling ‘bio-power’ (ibid). From a Foucauldian viewpoint, today’s culture is saturated with discursive practices, from psychotherapy, to counseling, to media confessionals – from Freud to OprahWinfrey – that deal with personal matters earlier hidden from view. The growth of multifarious forms of subjective ‘truth telling’ marks the transformation of the confession into a new form of public discourse (Foucault 1981: 63).
Bury has characterized it as somewhat ironic therefore, that much contemporary postmodern sociology portrays such subjectivity in an optimistic light, as the basis for celebrating diversity, among people as they ‘reclaim’ their experiences from a ‘colonial’ form of modern medicine (Frank 1997: 13). Postmodernism regards the ‘expressive culture’ as welcome, and tends to celebrate the heterogeneity that it signifies (Bury 1998).

The postmodern view of chronic illness, then, is of it being reinstated as a part of ‘life’s map’ or ‘life’s journey’, rather than as a form of disruption in need of control or repair (Frank 1997: 7). The new expressions of patient power, or at least of subjective experience are seen to challenge existing sociological notions of agency, meaning and social action. These new discourses on chronic illness are, as noted, portrayed as ‘post colonial’ moves to ‘reclaim’ illness from medicine (Frank 1997). The earlier ‘sequestration’ of illness from everyday life by an all powerful medical profession, one that set the terms of illness and the terms of its treatment, and elevated expertise above the ‘life world’, excluded everyday experience in favour of a technocratic rationality. Where modern medicine sought to bring about ‘medical dominance’, and exclude the heterogeneous and emotional worlds of patients and their everyday concerns from the clinic, now medicine (and the wider society) will need to face the multi faceted character of ‘lived experience’ in all its expressive forms.

The implications of this approach for a sociology of chronic illness are fairly clear. It follows from the analysis of these cultural trends that the sociological enterprise should give full expression to heterogeneity and the inherent ‘messiness’
of everyday life including illness, which modernist medicine had previously contained. The benefits of this medicine, especially for the ‘remission society’ are now seen to be highly questionable. Sociology should therefore, it is argued, make personal experience, discourse and illness narratives the centre of its attention. The social character of chronic illness is now to be seen in the radical and reflexive subjectivity brought to the fore by postmodernism. Frank argues for a ‘sociology of witness’ to supersede earlier theoretical traditions (Frank 1997: 24) and in so doing free itself from modernist assumptions and attachments, with their controlling and ordering propensities.

Whilst Foucault’s critiques centered on both the objectification of disease in modern medicine and the ‘subjective turn’ in contemporary culture, postmodern sociology emphasises ‘restitution’ through story telling (Frank 1997:75). The idea that ‘post-colonial’ expressions of illness might themselves be another set of controlling discourses, is set aside in favour of advocating a form of medical sociology that emphasises the ‘moral act’ of listening to the newly found voice of the chronically ill (Frank 1997: 25).

The intention of discussing these perspectives is to show, in brief form, three key theoretical perspectives and their relevance for the sociology of chronic illness. The discussion also attempted to indicate how attention to chronic illness can throw important light, in turn, on cultural forms and sociological theory itself. This two way approach – the relevance of sociology to chronic illness and the relevance of chronic illness to sociology – has hopefully become a little more clear.
In summary, we can say that each of the three perspectives discussed is appropriate to tackling different questions. The structural approach deals with factors that might account for the social patterning of chronic illness, both its occurrence and outcome. Some features of this patterning may be related to biological differences, but social processes may also influence the development of chronic disorders. Questions of inequalities and material influences are best tackled within this perspective. However, when questions of agency, identity and the impact of chronic illness on everyday life are the focus of study, it seems clear that the second, interactionist perspective is most relevant. The ability of people to adapt and live with illness depends on complex issues concerning the body, identity and interaction. The third perspective, that of postmodernism, addresses questions of discourse and narrative in a period of rapid cultural change, where the distinctions between health and illness become blurred and where patient advocacy and subjective experience is the focus of interest.

The delineation of these perspectives is, of course, open to argument, and might itself be interpreted as an attempt to provide an overly ordered account. However, the postmodernist view that we are living in a new form of society and therefore need a new form of sociology, including that of chronic illness, needs to be addressed. Though the challenge to sociology set out by the ‘postmodernists’ points to some significant developments in contemporary cultures, and their expression in areas such as chronic illness, it also has important limitations. Two comments in this regard can suffice by way of a conclusion.
The first of these concerns the question of relativism, which we have discussed elsewhere in greater detail (Bury 1986, 1998). In much postmodern writing all forms of culture and personal expression are treated as carrying equal weight. Despite Foucault’s critique of the emphasis on subjectivity illness narratives are treated as a route to wisdom. Sociology, from this viewpoint, is advocated as a mechanism for heightening attention to ‘stories that are their own truth’ (Frank 1997: 24). However, the difficulties of sociological interpretation (necessarily at the centre of the enterprise) cannot be so easily dispelled. The responsibility of sociology to be interpretive in character, and thus the need to evaluate what is said, is part of the professional responsibility of the sociologist (Riessman 1990, Bury 2001). Otherwise all claims to the truth are given equal weight, no matter how contradictory, ambiguous or socially divisive they may be. The stories people tell about illness, for example, may well contain a variety of ‘truths’, but this is not always a socially benign or positive activity, as is often presumed. Narrative may also contain sentiments made at the expense of others, or express unwarranted claims for social attention or resources. Placing personal narrative at the centre of a sociology of chronic illness means recognising the possibility of social conflict and division, as well as personal development and growth.

Second, and finally, the postmodern emphasis is on contingency, possibility and human diversity. In many ways this can be seen as an understandable reaction to the ordering and control of modernist social institutions such as medicine. But to assume that modernity has run its course is a quite different matter. Modern medical care and medical science may in some ways be in crisis, but they still have enormous power to influence and transform human experience, both for good and
for ill, as even those wedded to a postmodern view often have to recognize (Morris 1998). Developments in human genetics, pharmacology and surgery alone suggest that the ‘waning of medical dominance’ is overstated. Rather, I would argue, medical sociology should be and largely is involved in a more complex situation; one where being a ‘witness to self reflexive experience’ is only part of the story.

The interplay between modern social structures and institutions – in their everyday forms of family, work and community settings as well as areas such as medicine and health care – is, arguably, the terrain on which most chronically ill people live out their lives, and thus where the attention of medical sociology should continue to be directed. It is the tensions found here that helps us understand the accounts and narratives that the chronically ill produce. An approach which combines elements of the structural perspective with its emphasis on material conditions, social division and lifecourse influences, together with an interactional view of experience in everyday settings would help to interpret both narrative forms and chronic illness more fully (Bury, 2002)

This chapter brought in a wide-ranging idea of the prevalence of the chronic diseases Diabetes and Hypertension. It also focused on the existing researches carried out in this area. The related studies and various theoretical approaches which highlighted the significance of the sociological study of chronic illness are also discussed in this part. The next chapter will focus on the methodology adopted for the study and discuss in detail about it.