CHAPTER - 4
CONCEPTUAL AND THEORETICAL FRAMEWORK

The foundation of a theory involves the making of a model, which shows some likeness to reality. While making a model essential features are looked at as well as the inter-relationships between them. This becomes important since science inspects only a part of a much larger reality which must be conceptualised. This conceptualisation helps to limit this reality to aspects that interest the investigator. Concepts also help in communication. Concepts are abstractions and of necessity portray only one aspect of a reality. Concepts are used as a symbolisation, they are logical constructs created from impressions, perceptions or even fairly complex expressions. Concepts bring order and coherence into an abstraction of the phenomena which would have been otherwise impossible.

We know that to be able to identify a problem, the researcher must be well equipped to experience some difficulty or challenge. This in turn would depend upon the researcher being well conversant with the relevant theories in the field, reports, records, etc. This would help the researcher to know if there are certain gaps in the theories or whether the prevailing theories applicable to the problem are inconsistent with each other or whether the findings of different studies do not follow a pattern consistent with theoretical expectations and so on. All these will afford occasions for institution of research problems. This is also an aspect of exploration.

In this chapter researcher has discussed some important concepts, models and theories related to the present study.

4.1 HEALTH

Health is a broad concept which can embody a huge range of meanings, from the narrowly technical to the all-embracing or philosophical. To a layperson, health would mean a sound physical body. It is more so, a condition of a body that helps a person to perform his day-to-day activities to the expectation of others (Mehta, 1992). Webster’s New Twentieth Century
Dictionary of Indian Language (1977) defines health as:

(a) Physical and mental well-being; soundness; freedom from defect, pain or disease; normality of mental and physical functions.

(b) A condition of body or mind; as good or bad health.

(c) Power to heal, restore, or purify.

In the Oxford dictionary, health means ‘the state of being well in body or mind; a person’s mental or physical condition’ (The Concise Oxford Dictionary, 1996).

To some people, health is a general sense of well-being and “feeling good.” For others, health includes the expectations that they will not become ill or will be able to recover quickly. For most, health involves the ability to do what they want to do, with one’s body not presenting difficulty in normal activities. For some, health has moral connotations, with disease the consequence of immorality. People’s prominent concerns with health generally encompass physical, psychological, emotional, and spiritual dimensions of well-being. The word health is derived from the old English word for heal which means ‘whole’, signalling that health concerns the whole person and his or her integrity, soundness or well-being. Only physical well-being no longer stands relevant in present context, a new conception of health has emerged within a broader state of complete physical, mental, social and spiritual well-being and not just the absence of disease and illness. Conceptions of what constitutes health vary widely. In the context of medical anthropology, Landy (1977) defined a state of health as “the condition of an organism that permits it to adapt to its environmental situation with relative minimal pain and discomfort, achieve at least some physical and psychic gratification and possess a reasonable probability of survival”. While on the other hand, a state of disease according to Landy “is a condition of the organism that seriously obtrudes against these adaptive requirements and causes behavioural dysfunction”. Rao (1992) maintained that the aim and objective of health and medical science is to help achieve such a well-being that one can function at his choice not only as an individual, but also as a useful member of the family, social groups and community.
Health has two common meanings in everyday use, one negative and one positive. The negative definition of health is the absence of disease or illness. The positive definition of health is a state of well-being, interpreted by the World Health Organisation (WHO) in its Constitution as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. Assuring physical well-being by preventing disease, disability, dysfunction, and premature death has been the primary focus of modern medical care. However, secondary social and psychological factors have also been recognised as having major influences on general health status (De La Carcela and Chin, 1998). Warren (1999) is of opinion that a more broadened description of the parameters of health may prove helpful and in that regard, health may be described as a relationship, a synergistic interplay between the physical, social, psychological and spiritual elements that create the well-being of individuals and/or groups in their physical and social environment.

4.1.1 The different views/concepts of health

The different views and concepts of health such as etymological views, biomedical views, WHO's concept of health, critical medical anthropology concept of health, public health concept of health, cultural and organisational concepts of health, and cultural systems approaches to health, biological rhythms and health, holistic concept of health, and ayurvedic concept of health; help to comprehensively and holistically understand the concept of health.

4.1.1.1 Etymological views of health: These wider concerns of health are reflected in ancient root meanings of “heal”, “disease”, “sickness”, and “illness”. Heal means “To restore to health..... To set right, amend..... To rid of sin, anxiety or the like..... To become whole and sound”. Heal is derived from the Indo-European root kailo, which means “whole”, “holy”, and “good omen”; Old English derivative forms include “holy”, “hallowed”, and “whole”. Disease has its root meaning in “ease” and means a reversal of ease. Sick, meaning “ailing, ill, unwell”, “mentally ill or disturbed”, also refers to suffering or deeply affected by emotions, mental affliction, or corruption. Sick is derived from the
Indo-European root *seug-* meaning “troubled” or “sad.” The linguistic roots of ill in the Middle English ill (e) mean “bad” or “sickness of body or mind”; older meanings emphasised evil and wickedness, still reflected in its use to refer to evil, hostile intentions, wrongdoing, wickedness, sin, and disaster. The responses to health maladies represented in the concepts of medicine and care also reflect broader concerns. Medicine derives from the Latin *medicina* and the Indo-European root *med-*, which means “to take appropriate measures”. Cure means “restoration of health” from the Indo-European root *cura*, “care”. Cure also has ecclesiastical or religious significance, meaning “spiritual charge or care of souls, as of a priest for his congregation,” from the Medieval Latin *curatus*, “one having spiritual cure or charge” (Morris, 1981).

4.1.1.2 Biomedical views of health: Biomedicine defines health as physical well-being and disease in terms of absence of health. Eisenberg (1977) defined disease as a biological abnormality in the body’s structures, chemistry and functions. The basic biomedical assumptions regarding disease include the following:

- Diseases are basically biological and are indicated in the departure from normal measures of biological functioning.
- The belief that each disease derives from a specific physical cause or etiology.
- The belief that medical practice is culture-free and scientifically neutral and objective.

Doyal and Doyal (1984) described the biomedical views of health as:

- The body is like a machine, in which all the parts are interconnected but capable of being separated and treated separately.
- Health equals all the parts of the body functioning properly.
- Illness equals some malfunction of the parts of body, which is measurable.
• Disease is caused by internal processes such as degeneration through ageing or the failure of self-regulation, or by external processes such as invasions of pathogens into the body.

• Medical treatment aims to restore normal functioning or health to the body system.

This view sees health and disease as linked, as if in a continuum, so that the more disease a person has the further away he or she is from health and normality.

Biomedical practitioners generally presume that their professional practice standards produce scientific, morally neutral and objective “culture free” treatment approaches. Biomedical concerns with health focussed on biological diseases often clash with patients’ conceptions, so much so that effective care is impeded. Even doctors and patients from the same culture have different views of health because professional education socialises doctors into a worldview that patients generally do not share. Health is generally poorly understood by physicians because their medical education emphasises detection, diagnosis, and treatment of disease, rather than health and well-being (Winkelman, 2009).

4.1.1.3 Ecological views of health: Dubos (1965) defined health as “relative absence of pain and discomfort and a continuous adaptation and adjustment to the environment to ensure optimal function”. According to Leavell and Clark (1965) health according to ecological concept is embedded in the ecosystem of man and health is visualised as a state of dynamic equilibrium between man and environment.

Deficiencies in biomedical concept gave rise to other concepts. The ecologists put forward an attractive hypothesis which viewed health as a dynamic equilibrium between man and his environment, and disease a maladjustment of the human organism to environment. A full understanding of health requires that humanity be seen as a part of an ecosystem. The physical ecosystem includes in addition to the natural environment, all the dimensions of the man-made environment – physical, chemical, biological, psychological: in short, our culture and all its products (Park, 2009).
4.1.1.4 World Health Organisation’s concept of health: The World Health Organisation (WHO) characterised health as complete physical, mental, and social well-being and not merely as absence of disease and infirmity. What would a person in a state of complete physical, mental and social well-being be like? Physical well-being means that they would be free of all the physical diseases and free of aches, pains and other symptoms. Their joints, muscles and all their organs would function well. Furthermore, there would be no indication that they were likely to develop any disease or infirmity in the future. Mental well-being means that their mental function would be as good as their physical state. They would be intelligent, well-balanced, resilient and able to cope with the stresses of daily life. They would feel happy and at peace with the world and themselves. Social well-being means that they would function well in society. They would relate well to their family and other members of society. They would have a role in society and would value and be valued by others.

The three important points that can be drawn from WHO’s definition of health are

- There is a lot more to being healthy than just being in good physical shape. There is a need to think of mental and social function.
- Absence of disease and infirmity is a necessary feature of health.
- Health requires the presence of various features which are referred to as positive health.

The WHO definition of health distinguishes a positive and a negative dimension of health. Negative health, or ill-health, has a subjective component expressed in the concepts of illness and discomfort, and an objective component expressed in concepts of disease, injury, handicap, or deformity. These strands are linked via the idea of abnormal, unwanted, or anticipating states of a biological system, which in turn presupposes the idea of a good or flourishing human life. These ideas can be carried over to the spheres of the mental and social. Positive health can be purely subjective, but to be a component of positive health it must arise from and reflect a process of empowerment, which may be enhanced through the development of life skills.
The two concepts or similar ideas have generally taken the form of a continuum (Catford, 1983) with extremes of well-being and ill-health at the positive and negative ends, respectively (Figure 4.1).

**Figure 4.1: Continuum of health**

![Continuum of health diagram](image)

Source: Catford, 1983

Both positive and negative health is to be seen as having interconnected physical, mental and social elements. The representation of these facets as bridges between positive health and ill-health in relation to one particular facet often go hand in hand; physical illness may well be accompanied by a low level of physical well-being or fitness (Misra, 2004).

Some consider the WHO definition to also have problems. Park (2009) criticised it for being too broad. WHO (1984) defined health as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not an object of living; it is a positive concept emphasising social and personal resources, as well as physical capacities. The WHO also emphasised the “highest possible level of health” that allows people to participate in social life and work productively (WHO, 1992). Health involves social and personal resources in addition to physical conditions; a sense of overall well-being derived from work, family and community; and other relations, including psychosocial and spiritual (Durch et al., 1997). Health can be viewed as both a fundamental human right and a sound social investment. This view has been publicly affirmed by Jakarta Declaration which linked health to social and economic development (WHO, 1997). This definition provides a variety of reasons for supporting health, which are likely to meet the concerns of range of groups. It establishes a broad consensus for prioritising health, legitimises a range of activities designed to promote health.
Health is resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities. In keeping with the concept of health as a fundamental human right, the WHO (1986) emphasised certain prerequisites for health which include peace, adequate economic resources, food and shelter, and a stable ecosystem and sustainable resource use. Recognition of these prerequisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to a holistic understanding of health which is central to the definition of health promotion (Winkelman, 2009).

4.1.1.5 Critical medical anthropology's concept of health: In the earliest efforts to understand the health culture of the people, anthropologists have been sensitive to document their practices related to health, be it use of herbs or magical therapy. Murdock, Wilson and Frederick attempted to analyse data from Human Area Files to find people’s theories of illness. They categorised the theories into natural causation theory and supernatural causation theory that are found commonly in all the human societies (Channa, 1998). Critical medical anthropology adopts perspectives on health that emphasise the importance of access to resources (material and non material) necessary for sustaining life at a high level of satisfaction. Health is analysed from the perspectives of the societal factors that affect the distribution of health resources and threats to health. Medical anthropology emphasises social constructivist approaches (view that socio-cultural conditions as affecting the disease through mediation of risks such as exposures to diseases or other conditions that cause health problems) to the understanding of health problems, illustrating the roles of social and cultural processes in defining, interpreting and responding to diseases. The concepts like illness and sickness are used which shows the importance of understanding personal experiences of diseases and consequences of social responses for one's sense of well-being. Illness, the personal experience of a problem, involves much more than the disease. Experience of disease are manifested through culturally based concepts because the perceptions of the significance of a condition that affect an individual's treatment-seeking and responses to diagnosis and treatment. The consequences of culture for disease are also seen in the social responses to health problems that are represented in the
concept of social role: social expectations about how a person with a specific illness should be treated (Winkelman, 2009).

4.1.1.6 Public health's concept of health: Public health models and the Assessment Protocol for Excellence in Public Health (Durch et al., 1997) emphasise community involvement as key to a conceptualisation of health. Healthy communities have health institutions that are accountable, incorporating community involvement from planning stages through implementation and evaluation activities. Community involvement facilitates incorporation of diverse cultural perspectives on health and the services required. Community health includes services provided (treatment, immunisations) and standard performance measures. Because availability of care is a major aspect of community health, health includes the capacity of the community’s health institutions to respond to potential health problems. Responsiveness requires that health institutions understand cultural and social effects on health, incorporate community perspectives on needs and desired services, and assess perceptions of the quality of services.

4.1.1.7 Cultural and organisational concepts of health: The revolution in health care promoted by health maintenance organisations (HMOs) in the United States since the 1980s has emphasised assessment and monitoring of health and perceptions of quality of care. This has required an expansion of the concept of health from the “absence of disease” to views reflecting culturally valued functional abilities and conceptions of well-being. Quality of care is an experience based in patients’ personal, social, and cultural expectations and has become a legitimate criterion in the health industry for assessing patient satisfaction and determining how to improve health care (Press, 1997). The organisation, values, and roles of providers are cultural phenomena central to the overall quality of care that a patient experience. The focus on quality and patient experiences provides roles for anthropologists in improving health care by the following measures:

- Determining the culturally based conceptions of what constitutes quality care.
- Creating organisational change in health institutions to enhance their ability to provide culturally responsive care.
• Instituting community assessment and organisation to guide the development of institutional and personal resources to ensure health.

• Providing staff training in cultural dynamics of interpersonal relations.

Improving the quality of care requires the development of cultural measures that reflect community priorities for health and perceptions of well-being. Culture is central to health assessments because culture affects the interpretations of experiences, criteria for normalcy, social expectations, and expectations regarding quality of life. Cultural health concepts include

• Concepts of desirable physical abilities

• Views of ideal, normal, and problematic bodily conditions

• Preferred psychological dynamics, emotional states, and social relations

• Illness concepts and perceptions of symptoms

• Spiritual or metaphysical conditions and relations.

4.1.1.8 Cultural systems concept of health: Culture, the patterns of shared group behaviour transmitted between generations through learning, provides the core conceptual framework for understanding of all human behaviour including health behaviour. The effects of culture are found throughout human life, beginning with basic survival functions and structuring of interactions with the physical environment. Culture effects health through what we eat, how we protect and expose ourselves, patterns of sex and procreation, our hygienic practices, how we bond together, and lifestyle behaviours. Culture guides the experience and management of health through the classification of the condition and treatment available. Culture systems perspective of health views that the health is a product of relationships among many subsystems or fields, emphasising the following:

• The physical environment, including sanitation, housing, environmental toxicity and the physical infrastructure.

• The social environment, including family, work, education and social network.
• Individual behaviour, especially aspects of lifestyle that link people to environment.

• Medical care, part of the social environment with a special role in health.

• The genetic and biological levels.

These interdependent subsystems affect each other, operating through natural resources, the population and its ecological balance, and cultural systems mediating human interaction with all of the force fields: resources, social networks and medical services. The multiple determinants of health and their dynamic relationships illustrate that health is not strictly a function of disease, biology or genetics; rather health is derived from the complex interaction of physical determinants with social, economic, political and other cultural conditions that produce an individual's behaviour and biological conditions (Winkelman, 2009).

4.1.1.9 Ayurvedic concept of health: Health has been defined in Ayurveda as a state in which a man has balanced doshas (the physiological units of the body vata, pitta and kapha), balanced agni (digestive functions), harmonious functioning of all the organs and tissues of the body and also the acquisition of enlightened state of consciousness, sense organs, and the mind. Such a comprehensive definition of health which included all the components of physical, mental and spiritual health was known about 2500 years ago. The World Health Organisation's definition was thus laid down by the ayurvedists, so many centuries ago. Among several systems of medicine known all over the world, Ayurveda stands out distinctly as not only a system of great antiquity but also a well organised 'scientific' system of medicine with well defined aims and objectives. Ayurveda represents a total 'way of life' and not just a 'system of medicine' that offers to cure diseases through drugs and rituals. The rich Materia Medica (of herbal, mineral as well as animal origin) offered by Ayurveda has been a continuing source of interest and research for modern scientists in India and abroad. Interesting fundamental basic principles and concepts of Ayurveda have, unfortunately, not received the attention they deserve from scientists and physicians alike. To understand this paradox, we will have to first acquaint ourselves with some of the fundamental concepts of Ayurveda and its definition of life and health.
The preventive aspect of health, as propounded by Ayurveda is of great contemporary relevance. To our ancients, life was not a purposeless, accidental phenomenon to be just "lived", but had a definite, four-fold purpose (chaturvidha purushartha) viz., to achieve, dharma (virtue), artha (wealth), kāma (enjoyment) and moksha (salvation). An order to attain success in this four-fold purpose of life, it was considered essential to maintain life not only in a disease free condition but also in perfect positive health of the body, mind and spirit. Ayurveda thus gives primary importance to the maintenance of positive health and secondary consideration to the curative measures that are needed, from time to time, to alleviate temporary setbacks to health. While prescribing general rules for the maintenance of normal health and for treatment of disease conditions, great stress was laid on the individual and his constitution or prakriti. In other words, the general rules were to be applied with suitable modifications and alterations to suit an individual constitution. In order to maintain health, the healthy individual was prescribed a specific daily routine (dinacharya) and also a seasonal regimen (ritucharya). In dinacharya great importance was given to diet which had to be taken in a proper way with regard to quality, quantity as well as frequency. Several chapters have been devoted in the Ayurvedic classics to food and associated dietary factors. In the daily routine, importance is given to the use of medicated gargles, oil massages and regulated physical exercise. Further, the 'daily regimen' advocates that certain natural physical urges like micturition, defecation, sneezing, yawning as also hunger, thirst, sleep, tear, etc. should not be suppressed. On the other hand, suppression is advocated of harmful psychic urges like greed, fear, anger, vanity, jealousy, malice and excessive attachment to a particular object. Great emphasis has been laid on personal hygiene including cleaning of various parts of the body individually, apart from, bathing the whole body. Equal importance is given to psychic health or what Charaka calls sadvritta, implying mental discipline as well as a strict adherence to moral values and principles.

4.1.1.10 Holistic concept of health: The holistic concept is a synthesis of all the above concepts. Some authors argue that health is holistic concept and includes different dimensions each of which needs to be considered. Holistic health means taking account of the separate influences and interaction of these dimensions (Figure 4.2).
Figure 4.2: Dimensions of health

The inner circle represents individual dimensions of health which includes physical, emotional, spiritual, sexual, social and mental dimensions. Physical health concerns the body. Mental health concerns a positive sense of purpose and an underlying belief in one's own worth. Emotional health concerns the ability to express feelings and to develop and sustain relationships. Social health concerns the sense of having support. Spiritual health is the recognition and ability to put into practice moral or religious principles or beliefs. Sexual health is the acceptance and ability to achieve a satisfactory expression of one's sexuality. The outer two circles are broader dimensions of health which affect the individual.

Societal health refers to the link between health and the way a society is structured. This includes the basic infrastructure necessary for health (for example, shelter, peace, food, income), and the degree of integration or division within society.

Environmental health refers to the physical environment in which people live, and includes things such as housing, transport, sanitation and pure water facilities and pollution.
Seedhouse (1986) explained the unified concept of health which includes the following dimensions:

(a) **Health as an ideal state:** Health as an ideal state provides a holistic and positive definition of health. It is important in showing the interrelationship of different dimensions of health. A medical diagnosis of ill-health does not necessarily coincide with a sense of personal illness or feeling unwell. Equally a person free from disease may be isolated and lonely. However, it has been argued that this definition is too idealistic and vague to provide practical guidance to health promoters. Health in this sense is probably unattainable.

(b) **Health as mental and physical fitness:** Health as mental and physical fitness is a perspective developed by Parsons (1951), a functional sociologist. It suggests that health is when people can fulfill the everyday tasks and roles expected of them. The functional view of health imposes social norms without regard to individual variation. It excludes people who, owing to a chronic illness or disability, are unable to fulfill normal social roles. Using a functional definition of health, a contented and coping person who has a disability is not counted as healthy.

(c) **Health as a commodity:** Health as a commodity leads to unrealistic expectations of health as something which can be purchased. Health can not be guaranteed by paying a higher price for health care. This view tends to compartmentalise the total experience of health and ill-health into different economic categories. This is at odds with how people experience health and illness.

(d) **Health as a personal strength:** Health as a personal strength is a view which derives from humanistic psychology and suggests that an individual can become healthy through self-actualisation and discovery (Maslow, 1987).

This approach encourages individuals to define their own health but it does not address the social environment which creates health and ill-health. Seedhouse (1986) suggested that these four views can be combined in a unified theory of health as a foundation for human achievement (Figure 4.3).
The theory that health is an ideal state:
- A "Socratic" goal of perfect well-being in every respect.
- An end in itself.
- Disease, illness, handicap and social problems must be absent.

A group of theories which hold that health is a personal strength or ability—either physical, metaphysical or intellectual.
- These strengths and abilities are not commodities which can be given or purchased. Not are they ideal states. They are developed as personal tasks. They can be lost. They can be encouraged.

"A person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of highest importance for all people. Others are variable dependent upon individual abilities and circumstances.

The theory that health is a commodity which can be bought or given:
- The rationale which lies behind medical theory and practice.
- Usually an end for the provider a means for the receiver.
- Health is lost in the presence of disease, illness, pain, malady. It might be restored piecemeal.

The theory that health is the physical and mental fitness to do socialized daily tasks (i.e., to function normally in a person's own society):
- A means towards the end of normal social functioning.
- All disabling disease, illness and handicap must be absent.

Source: Seedhouse, 1986
Health is thus, a means to an end rather than a fixed state that a person should aspire to. Provided certain central conditions are met, people can be enabled to achieve their potential and working for health is to create the basic needs of food, drink, shelter and warmth, access to information about factors influencing health and skills and confidence to use that information. This definition acknowledges that people have different starting points which set limits for their potential for health. It encompasses a positive notion of health which is applicable to everyone, whatever their circumstances. However, it could be argued that this definition does not acknowledge the social construction of health sufficiently.

Kar (2000) pointed out that every culture, irrespective of its simplicity and complexity has its own notion regarding health and health seeking behaviour, and this is often referred to as health culture. It is an integral component of the overall culture of the community. The health of any community, by and large, is a function of the interaction between socio-cultural and socio-biological practices, the genetic attributes and the environmental conditions (cf. Winkelman, 2009).

Rao (2005) explained that the health care in a society may be located where society is articulated by three structures: cultural values, environment and social structure. In this perspective, the three elements include cultural values, social structure and environment. The health system can be seen as an intersection of these structures that may be represented in Figure 4.4.

Figure 4.4: Health in holistic perspective

![Diagram of Health in Holistic Perspective]

Source: Rao, 2005
The ideas about good health, ill-health and maintenance of good health are rooted in cultural values. These are developed and nurtured on the basis of people's conception and relationship with the divine beings, humans and natural physical environment. This system of man-god-nature relationship or the worldview provides a cultural repertoire that guides the individual and directs the family to adopt a particular strategy for dealing with the ill-health or orders for health management. Various social factors such as family type, family size, gender relations, gender inequality, economic equality, etc., determine the conceptions of ill-health, sick roles and responsibilities. The environment also influences the social systems as well as the human biology. The influence of environment includes altitude, temperature, biosphere and the like strongly bears upon not only the livelihood or economic activities but also on health. The cultural factors like type and shape of shelter, dress, transport and so on, are also affected by the environment. Thus, the three dimensions of human interactional framework form the basis for understanding of health behaviour in the holistic perspective (Rao, 2005).

To gain micro-level understanding of health, Rao (2005) mentioned that one must focus on health practices from individual point of view taking internal and external perceptions and interpretations at micro-level. Social norms and obligations immensely act upon the individual to acquire, consciously and unconsciously, the norms, values, attitudes and skills including acceptable health practices. Therefore, an analysis of socialisation process itself provides the basic structure on which health culture rests. The society where individual grows and interacts is not completely independent by itself. It is part of a larger system; the state having its own ideology, goals and philosophy that provides education, legal system and health care directly influences the society and the individual. Therefore, to some extent the behavioural pattern of an individual is shaped and moulded by the state's mandate. Therefore, when attempts are made to understand health behaviour focussing on individual, the family, state and society interaction may be represented as shown in Figure 4.5.
The micro-level study of health takes into account the people’s perception of natural elements and relationship of body with them. It concerns primarily with the body and the psyche. The psychological health behaviour concerns with the upkeep of mind and body. Anthropological knowledge becomes necessary for the understanding the mental health, as it closely related to social structure of the society. Anthropologists have identified two components; cultural construction of the body and physiology that affect the health of an individual. So, at the micro-level, it is necessary to understand the food habits and relate them to health. The natural conditions in which one lives also affect the health (Figure 4.6).
4.1.2 Definitions of health

Health has been defined in a variety of ways; some definitions derive from philosophy, some from practice, and some from the experience of ill-health or disability. Procter (2000) reviews the prominent definitions of health found in the literature and classifies each definition into one of two frameworks or approaches to health care provision. The definitions of health could be classified as either selective definitions of health or universal definitions of health.

4.1.2.1 Selective definitions of health: Selective definitions of health apply only to individuals who exhibit manifestations of ill-health that lead them or their family/care givers to seek health care interventions. The selective definitions of health tend to be derived from biomedical framework and split the population into two camps:

- Those who are not currently exhibiting manifestations of illness or disease processes; therefore, by definition, healthy; and
- Those who are exhibiting symptoms of illness and disease processes, come forward or brought forward for health care intervention so as to restore health or ameliorate symptoms.

The three definitions of health classified as selective are:

(A) Health as the absence of disease: Here health and illness are viewed as opposite states: a person is either healthy or ill. Blaxter (1995) has shown how this definition is used extensively by the general population (people with a better education and those with high income) when they asked how to define health. This definition is less likely to be used by those who were actually experiencing poor health or who were suffering from long-term disability. This dichotomous view of health is one that is extensively used by health professionals and social scientists (Seedhouse, 1986). This definition is closely associated with biomedical interpretation of health that, according to Seedhouse (1986), portrays health as a commodity that can be purchased. In other words, technology can be used to compensate for the breakdown of physiological functioning.
(B) **Health as a functional capacity:** In this approach, health is viewed as the capacity to fulfill essential life functions. These can include physiological functions associated with activities of daily life, such as mobility, digestion, hydration, sleep, elimination and circulation. Physiological functions include behaviour, communication and emotional stability. Social functions relate to nurturing and sustaining family members, and developing and maintaining social networks and employment (Arnold and Breen, 1998). Health as a functional capacity closely resembles Parsons' (1979) definition of health as a capacity of an individual to fulfill his or her social roles. According to Parsons, the onset of a disease or disability reduces people’s functional capacity and consequently gives rise to the need for them to adopt ‘sick role’.

Arnold and Breen (1998) link concepts of adaptation to the definition of health as functional capacity, suggesting that if physical and psychological capacity are limited or diminish, the individual, family and community may have to adapt to accommodate diminished functioning. This definition of health as functional ability is also integral to concepts of rehabilitation. Here the emphasis is on recovering the remaining capacity and maintaining maximum functioning even if that function is modified. The definition of health as functional capacity is widely used by physiotherapists, occupational therapists, speech and language therapists and nurses in relation to individuals whose ability to undertake physical activities of daily living is temporarily or permanently impaired.

(C) **Health as socio-psychological adaptation or adjustment to circumstances:** Psychosocial adaptation or adjustment to circumstances defines health as the ability to live a functional, happy and self-determined life within the context of one’s life circumstances. It is usually used as an indicator of health rather than being a definition of health. Psychosocial adjustment to circumstances differs from the other two selective definitions of health described above in that selectivity is not based on a disease classification, but it is selective in terms of identifying those who are having difficulty adapting and for whom interventions are necessary. Using indicators of psychosocial adaptation as an outcome measure, both of the above definitions might consider those who have successfully adapted to their circumstances, no
matter how deprived, as being healthy and not in need of any further interventions, providing their basic psychological needs are being met.

4.1.2.2 Universal definitions of health: These apply to the whole population regardless of individual differences; tend to focus on global concepts, tend to recognise health as relative rather than absolute state, in which individuals strive constantly to maintain their health rather than merely being healthy. Health is, therefore, a lifelong pursuit and one that people with serious diagnostic conditions or those who are terminally ill can still strive to achieve. The following aspects/dimensions are worth considering under universal definitions of health.

(A) Health as growth: The concept of health as growth has its origin in developmental philosophies such as those described by Maslow (1987). Health is defined in the context of individual human endeavour. Arnold and Breen (1998) described how, within the health as growth perspective, individuals are seen as having a capacity for growth that can be nurtured and supported throughout the person's lifespan. Growth is viewed as a progressive lifelong activity, a 'striving towards' rather than a realisation of an endpoint. This definition of health thus integrates both populations: those who suffer from disease processes and those who do not. To this extent, therefore, it overcomes some of the problems arising from the definition of health as the absence of disease. The definition of health as growth is also found to underpin some approaches to complementary therapy, health promotion and self-help groups. Interestingly, health as a growth was not a category recognised by Blaxter (1995) in her analysis of a qualitative survey of definitions of health undertaken with the general population. This may be an important observation, particularly in the context of contemporary concerns with the consumer views. For people who would define themselves as healthy, using the absence of disease as the criterion for health, the definition of health as growth may seem intrusive and interfering in what is essentially a private and independent progression through life.

(B) Health as independence, the exercise of autonomy and self-determination: Closely allied to the definitions of health as growth are the
concepts of health as independence, the exercise of autonomy (Doyal and Gough, 1991) and self determination (Seedhouse, 1986). This collection of theories of health derives from humanistic traditions, which recognise that humanity is distinguished by a respect for individual self-determination and exercise of free will. Like the definition of health as growth, definitions of health as the exercise of autonomy and self-determination are universal models that apply to everyone regardless of their physical or psychological state (Doyal and Gough, 1991). As Farsides (1994) points out, in the original Greek, *autos* means self and *nomos* means the rule of law. This recognises that for people to be described as autonomous, they need to exercise free will within a prescribed set of boundaries. At the philosophical level, theories of autonomy, based on the principle of the exercise of free will within an agreed set of rules, do not necessarily imply growth or health. Instead, at an individual level, autonomy of the exercise of the free will can be dogmatic, coercive, manipulative and aggressive. Because the rules and regulations governing the exercise of autonomy are frequently normative (that is, arising from social convention), autonomy can sometimes be used to justify unhealthy behaviours. At a collective level, the concept of individual autonomy can be used to protect civil liberties against dictatorial governments and bureaucracies.

(C) Health as well-being: Well-being is, however, an elusive term, a state that individual's experience in very different ways, making it difficult to develop a precise or objective definition. The concept of well-being as a definition of health became prominent following its incorporation into 1946 definition of health by WHO, which stated health as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity. This definition locates well-being as a universal construct that applies to all individuals regardless of their underlying physiological or psychosocial state. The concept of health as well-being gained further credibility through attempts to derive positive measures of health rather than negative measures of disease processes. A range of quality of life measures (Farquhar, 1995) has been developed in an attempt to measure well-being, and health economists have been keen to link health service costs to quality of life indicators rather
Blaxter defined well-being in psychosocial terms rather than the physical terms and explained that it tends to indicate a spiritual appreciation of life. It was recognised by respondents to Blaxter’s study, being defined in psychosocial terms rather than physical terms and tending to indicate a spiritual appreciation of life (Blaxter, 1995). The link between well-being and other definitions of health that imply growth or empowerment, or even the absence of disease, is however, difficult to establish. Any attempt to develop well-being as a definition of health needs to relate personal experience of well-being to healthy forms of individual and collective behaviour. Another problem with measures of well-being is that they assume that happiness is the individual and collective goal for a given community. Philosophically, this position is difficult to justify. Human beings seek a rich tapestry of experiences during their lives and recognise that danger, grief, conflict, anger at injustice and loss form part of that experience. Some would argue that these experiences may be instrumental in promoting health as growth, as defined by Maslow (1987) or self-determination, as described by Seedhouse (1986). To discuss health exclusively as well-being denies the human need to experience loss, sorrow, grief and anger that so often accompanies people’s experience of health, illness and living. Health economists have been the main professional group to utilise definitions of health as well-being in their work, although it is increasingly being used by a range of health care researchers to augment other outcome indicators in research.

(D) Health as the realisation of potential: Health as realisation of potential is the definition of health put forward by Seedhouse (1986). This definition, in many ways, integrates both selective and universal definitions. He recognised that the full realisation of individual potential encompasses the sense of agency associated with the exercise of autonomy within a moral framework. This definition is a direction rather than an endpoint that all healthy individuals strive to achieve; hence, it includes the definition of health as growth. This definition of health as realisation of potential develops an integrated, inclusive approach to health care provision that combines selective professional
expertise with more universal, collective approaches. While the importance of the community dimension to health is acknowledged, health as the realisation of potential tends to advocate primarily an educational approach rather than a democratic, participatory approach designed to unleash the power of the community to determine its own destiny.

(E) Health as empowerment: It is rooted in recognition of the strong link between individual's and communities' sense of power and the level of health they experience (Arnold and Breen, 1998). At one level, health as empowerment builds on developmental theories of health as growth and humanistic theories of health as self-determination and the exercise of autonomy. It recognises that work for health needs actively to transfer power to individuals and communities in order to promote a sense of control over destiny and, therefore, promote health. Health as empowerment, however, invariably encompasses a community or collective perspective and often focuses on facilitating participation in political processes by individuals and communities normally denied access to these processes (Oakley, 1989). The origin of health as empowerment can be traced to two sources: one is the community development models emerging from developing countries which recognises community participation and engagement in health policies as effective and rapid vehicle for improving health across large sectors of the world's poorest people (Oakley, 1989) and the other is derived from feminist perspectives on collective action (MacDonald, 1998) which has also recognised the important role of the community in sustaining and maintaining health. Feminist analysis has also recognised the important role of the community in sustaining and maintaining health. Women are now generally recognised as the gatekeepers of their own health and that of their families (Graham, 1984). Family health is linked to environmental community living conditions, poor housing, a lack of safe play areas for the children, heavy inner city traffic and other daily living hazards, all of which have been recognised as contributing to health problems and requiring collective political action for change to occur (Rice et al., 1992). While the principle of the empowerment of local communities by participation may have been accepted in health, the interpretation and meaning attached to this vary widely. There
are many versions of community participation in health that maintain the dominance of health professionals over health care agenda (Oakley, 1989).

**(F) Health as wholeness:** The holistic approaches to health draw on many of the ideas associated with health as growth, but they do not always promote a continual striving towards self-actualisation using developmental and lifespan frameworks. Instead, holistic definitions of health tend to focus on achieving a balance between all the component parts of the system, however that system is defined. Using definitions of health derived from complimentary medicine, disease or symptoms of ill-health are attributed to a lack of balance in the system, and the therapist seeks to restore that balance.

The holistic nature of health is fundamental to concepts of healing and tends to focus on achieving a balance between all the component parts of the system. Ayurveda is considered to be holistic in that embraces all human existence both in 'vertical' plane, from concrete forms of expression though to the most abstract area of consciousness and in the 'horizontal' plane, where it includes mind, body, behaviour and environment in its ideas and practices. A similar claim to restore balance underpins a variety of complementary therapies include acupuncture, homeopathy, osteopathy, reflexology, yoga, the Alexander technique and herbalism (Sharma, 1994). Durch et al. (1997) explained that health involves not only physical, mental, and social well-being but also the ability to participate in everyday activities in family, community, and work, commanding the personal and social resources necessary to adapt to changing circumstances.

**4.2 HEALTH CARE**

Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through services offered by the medical, dental, pharmaceutical, clinical laboratory sciences (*in vitro* diagnostics), nursing, and allied health professions. Health care embraces all the goods and services designed to promote health, including preventive, curative and palliative interventions, whether directed to individuals or to populations.
The agents of the health services or professions for the purpose of promoting, maintaining, monitoring or restoring health define health care as multitude of services rendered to individuals, families or communities. Health care includes medical care. The term medical care (which ranges from domiciliary care to residential hospital care) refers chiefly to those personal services that are provided directly by physicians or rendered as a result of physician’s instructions. Health care is public right, and it is the responsibility of Government to provide this care to all people in equal measure. The aim and objective of health care is to ensure proper physical and mental growth; freedom from disease and deformity, complete and quick recovery; and if not possible, keeping the disease under control.

4.3 CANCER

Cancer is a group of diseases characterised by uncontrolled growth and spread of abnormal cells. Over 100 different diseases are covered by the term cancer, and each of these diseases has a unique profile in terms in terms of the population at risk, symptoms and prognosis. Cancer can be caused external factors (tobacco, chemicals, radiation and infectious organism) and internal factors (inherited mutations, hormones, immune conditions and mutations that occur from metabolism). Bose (2009a) explained that the cells in a particular part of the body starts multiplying in a disorderly, uncontrolled manner and these not only grow in number but penetrate the adjoining tissues. This indiscriminate and uninterrupted growth is known as malignant tumour or cancer.

4.3.1 Key cancer concepts

(a) **Cancer burden**: Burden refers to size of a health problem in a specified area, measured by several statistics, such as incidence, mortality rates and prevalence, as well as other indicators such as cost, morbidity and risk factors (Holtz, 2008).

(b) **Cancer incidence**: Cancer incidence refers to the number of newly diagnosed cases of cancer that occur in a defined population during a specified period of time, such as a year (Mackay et al., 2006).
(c) **Cancer prevalence:** Cancer prevalence refers to how many cases of a particular cancer there in a defined population at a given point of time (Hutchison et al., 2004).

(d) **Cancer mortality:** Cancer mortality refers to the numbers of deaths from cancer that occurs in a population during a specified period of time (Mackay et al., 2006).

(e) **Cancer costs:** Cancer costs which pose an economic burden on both the individual and society are of three types. Direct costs includes both medical costs and associated non-medical costs; indirect costs such as time spent seeking medical care or economic productivity lost due to premature death; and intangible/psychosocial costs, such as pain, suffering or grief (Holtz, 2008).

(f) **Cancer risk:** Cancer risk is commonly either as lifestyle risks (the probability that one will develop or die from cancer the course of one’s lifetime) or relative risk (a measure of the strength of the relationship between risk factors and a particular cancer) (American Cancer Society, 2007).

### 4.4 COPING

The term coping has been used to denote the way of dealing with stress or the effort to master the conditions of harm threat or challenge, when a routine or automatic response is not readily available (Lazarus, 1974). Coping can thus have an effect on the three kinds of outcomes: social, psychological and physiological. The coping is more of psychological aspect but it depends on a large number of social aspects such as social support, religion, belief system, etc. Coping mechanisms employed by the patients and their relatives may either enhance the therapeutic process positively or adversely affect the outcome (Spinetta, 1984). Kupst and Schulman (1988) defined coping as a psychosocial adaptation of an individual to the illness. The diagnosis and treatment of cancer calls for the coping among the patients suffering from the disease. Because the medicine has increased the effectiveness of its treatments, cancer patients are living longer, but need to cope with the problems of chronic illness from which they will not recover.
Coping is regarded as the means that are used to combat or prevent stress. It can be defined as a process of managing the discrepancy between the demands of the situation and available resources – a process that can alter the stressful problem or regulate the emotional response. As Lazarus and Folkman (1984) emphasised that coping is constantly cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. These cognitive and behavioural efforts, as they write in their later work, are constantly changing as a function of continuous appraisals and reappraisals of the person-environment relationship, which is always changing (Folkman and Lazarus, 1991). Lazarus and Launier (1978) defined coping as efforts, both action-oriented and intrapsychic, to manage environmental and internal demands and the conflicts between them, which tax or exceed a person's resources. Coping may also be defined as the process through which individuals try to understand and deal with significant demands in their lives or as a search for significance in times of stress (Pargament, 1997). By significance, Pargament (1997) refers to, “what is important to the individual, institution, or culture-those things we care about” and includes “life’s ultimate concerns- death, tragedy, inequity”. It encompasses also other possibilities, “possibilities that are far from universal, possibilities that may be good or bad”. The concept of significance is important in Pargament's theory of coping, especially religious coping.

Folkman and Lazarus (1991) suggested three reasons as to why coping is important: (1) coping behaviour may assist in finding connections between psychological and physical systems, (2) coping behaviour influence one's negative or positive emotions and (3) although personality responses to illness may be viewed as unchanging, coping behaviour represent an area where the medical community can intervene. In conjunction with allopathic care, some practitioners are advocating the use of holistic coping and healing strategies, some of which employ the mind-body connection. They gave the influential theory of coping which states that there are two cognitive appraisals in the process of coping. The first is the “primary appraisal,” in which an
individual evaluates whether he or she has anything personally at stake in an encounter. The second is the “secondary appraisal,” in which an individual evaluates existing coping resources and options to determine what can be done to overcome or prevent harm, or to improve the prospects for benefit. They stated that the coping process can influence one’s emotions and can be used to link one’s psychological “mind” to one’s physical “body”. As one’s coping behaviours are thought to influence psychological and physical well-being, it is important to explore the coping techniques involved in one’s experience with an illness such as cancer. Recent studies describe several positive coping strategies that are thought to increase the overall well-being. These strategies include social support, progressive muscle relaxation, mental imagery and the possession of a fighting spirit.

Several components like coping strategies, coping style and coping resources are important in the concept of coping

4.4.1 Coping strategies

Coping strategies generally refers to those efforts, both behavioural and psychological, that people facing a difficult situation employ to master, reduce or minimise stressful events. Coping strategies mediate evaluation of the significance of a stressor or threatening event as well as evaluation of the controllability of the stressor and the person’s coping resources. The two general goals of coping strategies are recognised: to alter the relationship between the self and the environment and to reduce emotional pain and distress.

Coping strategies can be broadly classified into two categories: Problem Oriented Coping (POC) and Emotion Focussed Coping (EOC). POC aims to make direct changes in the environment so that the situation can be dealt with more effectively. EOC seeks to make the person feel better by reducing the emotional distress felt (Lazarus and Folkman, 1984). The other category of coping is the avoidance coping. It includes escapist fantasy, turning to alcohol and overeating etc. Another response that seems to intensify distress is the self-blame.
4.4.2 Coping styles

Coping styles may be defined as generalised ways of behaving that can affect a person's emotional or functional reaction to a stressor and that are relatively stable across time and situations. Different styles have been identified that represent those pattern or thought. Greer and Watson (1987) have distinguished five coping styles among cancer patients which include fighting spirit, avoidance or denial, fatalism, helplessness and hopelessness and anxious preoccupation.

4.4.3 Coping resources

As Pargament (1997) stressed, the resources individuals bring to coping may be material, physical, psychological, social or spiritual are referred to as coping resources. Schneider et al. (2008) described a model using three kinds of resources used by the women suffering from the cancer. The three coping resources included intrapersonal, interpersonal and extrapersonal coping resources.

4.5 RELIGIOSITY

Religiosity involves organised worship and practice, as well as theology (Jenkins and Pargament, 1995). Religiosity may be broadly defined as a search for the sacred that may include public (e.g., church attendance) as well as private and intrinsic dimensions (Miller and Thoresen, 2003). It is of two types, intrinsic religiosity and extrinsic religiosity. Intrinsic religiosity refers to an orientation where one’s faith is internalised and was originally defined as religious behaviour that was motivated by personal conviction, whereas extrinsic religiousness was conceptualised as deriving from external rewards (Allport and Ross, 1967). Gorsuch and McPherson (1989) clarified that extrinsic religiousness may include personal or external sources of motivation. The aspects of religiosity covered by them are locus of control, affect, adaptation, sense of meaning, faith/belief, go as a healer and god as a help.

There are three major components of religiosity including knowing (cognition), feeling (affect) and doing (behaviour). The cognitive component is the religious belief and Glock (1962) called this dimension as “ideology”. The
affect component is the feeling dimension and encompasses feelings toward religious beings, objects or institutions. The behavioural component is "acted out". Church attendance, financial contribution, frequency of personal prayer and scripture study, and religious and ethical behaviour are all included in behavioural component of religion (Cornwall and Albrecht, 1986).

Religiosity consists of two modes of religious involvement: the personal and the institutional mode. The personal mode is comprised of religious beliefs, feelings, and behaviour that find their source in personal and individualised religion. The institutional mode is comprised of the religious beliefs, feelings or behaviour related to formalised and institutionalised religion. A distinction between public, social, institutionalised and formalised modes of religiosity can also be made (Cornwall and Albrecht, 1986). Glock (1962) distinguished five different dimensions of religiosity:

(a) Experimental religiosity refers to a person's inward emotional tie to a religion.

(b) Ritualistic religiosity refers to frequency of ritual activity such as prayers, church attendance and listening to or watching religious services.

(c) Ideological religiosity concerns belief in religious doctrine.

(d) Consequential religiosity concern how religious beliefs are reflected in person's behaviour.

(e) Intellectual religiosity refers to knowledge of the history and beliefs to a particular religion.

The three components of religiosity are cognition, affect and behaviour. The cognitive component is the religious belief or orthodoxy component. Glock (1962) called this dimension "ideology". Stark and Glock (1968) later labelled it "orthodoxy", and King and Hunt (1975) called it "creedal assent". The affective component is the feeling dimension and encompasses feelings toward religious beings, objects, or institutions. The behavioural component is "acted out". Religious attendance, financial contributions, frequency of personal prayer, and religious and ethical behaviours. The religiosity consists
of two modes of religious involvement: the personal mode and the institutional mode. Dittes (1971) made a distinction between religion in a relatively mode-public, social, institutionalised and formalised- and religion in the more subjective mode-deeply held personal attitudes, values, loyalties and commitments. Sociologists have frequently made a distinction between these two modes of religiosity with concepts like “meaning and belonging” (Greeley, 1972; Roof, 1979), "private and public” (Davidson, 1975), or “moral and calculative” (Etzioni, 1961), and “religious group involvement” vs. “religious orientations” (Lenski, 1961).

The personal mode is comprised of religious beliefs, feelings and behaviours that find their source in personal and individualised religion. This includes the acceptance of doctrinal orthodoxy drawn from broader cultural milieu. The institutional mode is comprised of religious beliefs, feelings, or behaviours related to formalised and institutionalised religion. The institutional mode includes acceptance of religious beliefs which are unique to a sect or denomination, personal feelings and attachments to a particular religious place, and participation in religious ritual and worship services.

4.5.1 Religious coping

Pargament (1997) explained that in religious coping, control may be centred differently and four approaches are identified by him. These are:

- Control may be centered in God. Believing that life rests in divine, the individual may passively defer to God in troubled times.
- Control may also be centered in efforts to work with God. The individual may attempt to influence God and the course of events through pleasing divine.
- Control may be centered in relationship between individual and God. The individual may feel a sense of partnership with God, one in which the responsibility for coping is neither the individual's alone nor God's alone, but rather shared.
- Control may be centered in the self, growing out of the belief that God gives people the tools and resources to solve problems for themselves.
On the basis of these four approaches, the three types of religious coping were developed. Pargament et al. (1988) proposed three styles of religious coping. These include:

(a) **Collaborative coping style:** It refers to a style of religious coping which means a partnership between God and an individual in finding a solution to problems.

(b) **Deferring coping style:** It is used by those individuals who rely on divine intervention by God for relief from their problem.

(c) **Self-directing coping style:** It is used by those individuals who assume that God has given each person the agency to arrive at his/her own solution. Pargament (1997) argues that self-directing coping style is not religious as individual acts to solve problems without seeking the God’s help.

There are a number of terms which are used in context of religious coping. These include:

(a) **Seeking religious support:** Searching for comfort and reassurance through God’s love and care.

(b) **Religious focus:** Engaging in religious activities to shift focus from the stressor.

(c) **Religious purification:** Searching for religious cleansing through religious actions including confession of sins and asking God for forgiveness.

(d) **Religious connection:** Experiencing a sense of connectedness with forces that transcend the individual.

(e) **Religious discontent:** Expressing confusion and dissatisfaction with God in the stressful situation.

4.5.2 Religion and spirituality

Pargament (1997) defined religion as a search for significance in ways related to the sacred. The term significance means a wide range of things that
may be important for the individual, institution and culture. It may involve the sense of satisfaction, value and importance that accompanies the pursuit and attainment of goals or may refer to the goals that people strive for in living. The sacred refers to the holy, and the core of the sacred consists of concepts of God, the divine and the transcendence. He defined spirituality as the search for sacred and differentiated between religiosity and spirituality by maintaining that religiosity encompasses the search for many sacred and non-sacred objects of significance, spirituality focuses specially and directly on the search for the sacred. He focussed that the religion is broader and more general construct than spirituality as spirituality involves only the search for sacred ends but the religion encompasses the search for secular ends through sacred means.

Spirituality is harder to operationalise, may involve transcendent experiences, and can include religion. In this paradigm, religiosity may be seen as a component of spirituality, as spirituality refers to a broader construct than religiosity (Holt et al., 2009).

4.6 SOCIAL SUPPORT

The concept of social support was introduced in social sciences in the 1970s that the social relations may have a health-enhancing function is longstanding. The literature before that also laid the emphasis on importance of social attachments. The sociological influences into the importance of positive social attachments can be traced to the seminal work of Durkheim (1897), who found suicide to be related to social alienation from others. Moving to more recent empirical investigations, researchers in the 1970s examined the relationship between social attachments and well-being.

Social support is a concept that is generally understood in an intuitive sense, as the help from other people in a difficult life situation. One of the first definitions was put forward by Caplan in 1974 who defined social support as an enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical integrity of the individual over time. Cobb (1976) defined social support as ‘the individual belief that one is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations’. The definition of social support varies
widely among those who have studied it. Lin et al. (1979) defined social support as "support accessible to an individual through social ties to other individuals, groups, and the larger community". The three main sources of support which have been identified are family support, support from the physicians and other medical personnel and support from other patients (Meyerowitz, 1980). It has been referred to in a general manner as support which is "provided by other people and arises within the context of interpersonal relationships" (Hirsh, 1981).

4.6.1 Types of social support

More explicit definition of social support has been offered by House (1981) who described four main categories of social support: emotional, appraisal, informational and instrumental.

- Emotional support generally comes from family and close friends and is the most commonly recognised form of social support. It includes empathy, concern, caring, love, and trust.

- Appraisal support involves transmission of information in the form of affirmation, feedback and social comparison. This information is often evaluative and can come from family, friends, co-workers, or community sources.

- Informational support includes advice, suggestions, or directives that assist the person to respond to personal or situational demands.

- Instrumental support is the most concrete direct form of social support, encompassing help in the form of money, time, in-kind assistance, and other explicit interventions on the person’s behalf.

Cobb (1976) provides another more specific definition of social support by listing four statements which together would be the essence of what he calls the subjective sense of social support. The four statements are represented by the key words, love, esteem, security, and appraisal, which could be viewed as four different kinds of support potentially available from others. In comparing Cobb (1976) and House (1981), one category, appraisal,
is similar in both definitions. Cobb's categories of love and esteem might be subsumed under House's definition of emotional support. Cobb's security category does not directly parallel any of House's categories and refers to support an individual receive from being part of a network of friends. The instrumental support included in House's definition is not included in Cobb's definition and is a dimension that is questioned by some as an appropriate category to be included within a definition of social support. A comparison of these two widely used categorical definitions indicates the variability in the definitions of social support (Cooke et al., 1988). The social support is affected by number of factors such as marital status, family size, age, gender, socio-economic status, etc. It is one of the important factors which not only affect other social factors but the psychological factors such as coping as well. Coping depends on the social support and it improves with the increased social support.

Bloom and Spiegel (1984) defined the term social support as the patient's perceived quality of the emotional aid provided by the family. This definition reduced the social support only to the emotional support and not any other form of support. Further, only family is considered as a source of social support and not friends and other professionals. This definition is improved by the definition which considers social support as a function performed for an individual under the stress by significant others such as family members, friends or professionals.

One of the general definitions of social support agreed upon by Cohen and Syme (1985) is that the social support is the resource provided by other persons and the social support has both positive and negative effects on health and well-being. Rook (1985) presented a different opinion that social support may not be necessarily positive. He pointed out the positive and negative interactions often emanate from same people. He also showed when positive and negative social interactions co-occur, that the negative ones are more disruptive of well-beings than the positive ones which are health enhancing.
Thoits (1986) defined social support as the form of coping assistance or as the active participation of the significant others in an individual’s stress management efforts. Social support is one of the most essential needs that a patient and his family look to tide over the impact of the illness. Social support may be viewed as part of the coping process in living with chronic illness like cancer.

Social support refers to the actual exchange of support. Social support has been described as an interpersonal transaction involving the exchange of one of three key elements: Aid, Affect and Affirmation. Aid refers to instrumental or tangible support such as lending money, helping with chores, or providing sick care. Affect refers to emotional support such as love, affection and caring. Affirmation refers to agreement or acknowledged of similarities or appropriateness of one’s values or point of view (Antonucci, 1990). Social support as function performed for an individual under the stress by significant others such as family members, friends or professionals. Rook (2001) defined social support as the diverse forms of aid and affirmation that are provided by informal members of social networks. Rook (2001) argued that since no single definition of social support has won universal acceptance, the researchers tend to agree that important dimensions along which social support can be conceptualised include:

- **The number and kinds of ties that exist with social network members:** This approach is often referred to as structural approach as it emphasises the structure of a person’s ties to an informal network of family members, friends, neighbours and others. It is often represented by relatively objective aspects of a person’s involvement in informal social networks, such as marital status, number of kin and non-kin ties, the frequency of contact with others and the presence and absence of a confidant in the social network.

- **The supportive functions performed by the network members:** An alternative approach to conceptualise social support, often termed the functional approach, emphasises the particular kinds of supportive behaviour performed by members of an informal social network. It focuses on how stress might reduce the adverse effects of serious life stress and emphasises the forms of assistance from social network
members that might help people respond effectively to stressful events and circumstances. A variety of different taxonomies of support functions have been proposed but most of them include social support, appraisal support, informational support and instrumental support. These support functions have often been assessed by asking people whether they have received various kinds of aid from others (enacted or received support) or whether they believe that they would receive such aid if they should need it at some future point (available support).

- The perceived adequacy of the support provided by network members: This approach suggests that the support is perceptual factor- that the benefits of social support derive, in large part, from people’s global evaluations of their social network members as supportive and caring.

The important terms related to social support are:

(a) Social network: A unit of social structure composed of the individual’s social ties and ties among them.

(b) Social integration: The extent to which an individual participates in private and public social interactions.

(c) Functional support: The varied kinds of resources that flow through the network’s social ties.

(d) Structural support: The number and patterns of direct and indirect social ties that surround the individual.

(e) Perceived support: The individual’s beliefs about the availability of varied types of support from network associates.

(f) Received support: The actual support received by the individual from network associates.

(g) Support adequacy: The evaluations about the quantity and quality of received support.

(h) Directionality of support: The determination of whether support is unidirectional or bidirectional is directionality of support.
4.6.2 Theories of social support

The effects of social support on health have most often been hypothesised as occurring in one of two forms: main (direct) effects or buffering (indirect effects). The other important theory of social support is the theory of social comparison.

4.6.2.1 The direct effects hypothesis: The direct effect hypothesis assumes that social support is generally beneficial, in times of stress and in the times without stress (Taylor, 1999). Becoming integrated into a social network that provides support in stress imparts ongoing benefits including stability, predictability, and a sense of belonging (Cobb, 1976). Belonging to a large and diverse network such as family, friends, as well as religious and community groups may also provide ongoing recognition of self-worth. The main assumption of direct effects hypothesis is that any type of social network is beneficial to individuals. This hypothesis does not assume that individual who provides support take on a specific role or provide a particular service to the distressed. It assumes that the ongoing presence of others will provide stability and predictability, which is useful in all contexts.

4.6.2.2 Buffering hypothesis: The buffering hypothesis of social support posits that the social support protects or buffers individuals from the effects of a stressful event. Support acts as a shield for the distressed individual, protecting them from the negative effects of illness (Cobb, 1976). The major difference between direct effects theory and buffering hypothesis are:

- Buffering hypothesis assumes only a shorter time span while the direct effects theory assumes a greater time span.

- Buffering hypothesis assumes the social support to be beneficial when needed only but on the other hand; the direct effects theory assumes that social support is useful even in the non-stressful times.

The buffering hypothesis supports the idea that during the times of stress, social support protects the person from the potentially devastating effects of stressful events. The size of the support network is unimportant in the buffering model because the quality of support provided is of more
importance than having large number of people who can provide mediocre support. Therefore, social support is of great importance in the stressful events in which an individual perceives he/she can not cope effectively with the situation and needs problem solving assistance (Cohen and Wills, 1985). The direct effects hypothesis positions the support provider as an individual who can decrease the stress through increasing the efficacy in the distressed individual.

4.6.2.3 The theory of social comparison: According to this theory, when individuals are distressed, they search for others to compare themselves to. Social comparison allows individuals to gauge feelings, define normative behaviour, and adjusts emotions and based on cues from the environment and others. The type of support provided by the social network is passive because the reduction of distress is attained through comparison with others, without the need for communicative exchanges between individuals. Social comparison theory postulates that the people feel a need to know whether their opinions or emotions are correct, or what their abilities allow them to do (Festinger, 1954).

4.6.3 Social support and coping

Coping is defined as non-routine measures that one implements in order to deal with stress ans social support is defined as the perception that one is cared for and esteemed by others, who could be called upon should the need arise. Thoits (1986) proposed a model of the relationship between coping and social support that represents the two as analogous. She further argued that social support and coping consist of more or less the same behaviours, only coping is initiated by the individual him or herself, whereas social support is initiated by others. An analogy is drawn between House taxonomy of types of social support and Pearlin and Schooler classification of coping strategies. Thoits elaborated the model to show how similar initiatives might be taken either independently or with the help of others in response to stressful situation. For example, problem-focused coping and instrumental support would be considered analogous, consisting of approximately the same behaviours. Problem-oriented coping would involve the individual alone and would consist of behaviours like developing a plan of action and following
it through, while instrumental support would involve the efforts of other people, and would include practical supportive behaviours like loaning the person with money or assisting with specific task (cf. McColl et al., 1995). Thoits (1986) conceptualisation of social support as coping assistance is given in Table 4.1.

**Table 4.1: Thoits (1986) conceptualisation of social support as coping assistance**

<table>
<thead>
<tr>
<th>Stress reduction</th>
<th>Personal coping</th>
<th>Social support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alter the stressor itself</td>
<td>Problem-oriented coping</td>
<td>Instrumental support</td>
</tr>
<tr>
<td>Alter the perception of the stressor</td>
<td>Perception-oriented coping</td>
<td>Informational support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appraisal support</td>
</tr>
<tr>
<td>Alter the emotional response to the stressor</td>
<td>Emotion-oriented coping</td>
<td>Emotional coping</td>
</tr>
</tbody>
</table>

Fondacaro and Moos (1987) also discuss the relationship between social support and coping. They propose model of the complementarity of coping and support: one where perceived social support influences coping through information, advice or simply psychological bolstering; and the other where coping influences the perceived availability of social support, by enhancing the potential for the development and maintenance of relationships (cf. McColl et al., 1995). Dunkel-Schetter (1985) undertook to examine coping as one of several correlates of perceived social support. They found that not only was coping the strongest correlate of social support, but also, it seemed to be related in a reciprocal, or complementary way. For example, problem-focused coping was related to perceptions of emotional and informational support (cf. McColl et al., 1995).

Social support includes real or perceived resources provided by others that enable an individual to feel cared for, valued for, and part of network of communication and mutual obligation. Research suggests that the social support have an impact on health-related quality of life. The quantity and quality of support can promote recovery of people with chronic illnesses by improving their quality of life.
4.7 QUALITY OF LIFE

Since the 1980s or so there has been an increasing realisation that traditional biologically based end points such as morbidity and mortality alone do not represent adequately the potential outcomes of medical intervention. Health status measurement has evolved to allow insight into patient's experiences in such areas of function as mobility, mood, life satisfaction, sexuality, cognition and ability to fulfill occupational, social and family roles. Quality of life emerged as a broad term to describe this domain of measurement. The quality of life construct may be viewed as a paradigm shift since it shifts the focus of attention from symptoms to functioning and establishes the primacy or at least the legitimacy, of the patient perspective. Quality of life measures have many applications in medicine and health care. They are used to describe the subjectively perceived health and social status of given populations, to compare interventions and to assess the costs and benefits of treatments and health policies (Spilker, 1996).

Quality of life has been defined as a concept that embraces a wide range of physical and psychological characteristics and limitations that describe an individual's ability to function and derive satisfaction from doing so. It is also described as a multidimensional construct that refers to a patient's appraisal of and satisfaction with their current level of functioning as compared to what they perceive to be possible or ideal; and as a personal statement of the positivity or negativity of attributes that characterise one's life.

WHO (1993) defined quality of life as the individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by a person's physical, health, psychological state, level of independence and their relationships to salient features of their environment.

Earlier studies used the term quality of life to include all manner of definitions. Current practice shows a tendency to qualify the term by speaking of health-related quality of life when referring to the quality of life of persons responding to the effects of disease and treatment. Health-related quality of
life incorporates the dimensions of socio-psychosocial well-being, physical well-being and disease and treatment-related distress. Donovan et al. (1989) suggested that adequate quality of life measures should include assessment of spiritual domain as evidences suggest that as the physical condition deteriorates; spiritual issues commonly gain importance as determinants of quality of life.

4.7.1 Health related quality of life

Because of amorphous and multidimensional nature of quality of life, most researchers in medicine and health care concern themselves with a subcomponent of quality of life called health related quality of life. This is distinguished from quality of life as a whole, which could also include adequacy of education, housing, income and perceptions of the immediate environment.

Patrick and Erickson (1993) defined health related quality of life as the value assigned to the duration of life as modified by the social opportunities, perceptions, functional states and impairments that are influenced by disease, injuries, treatments and policy such that is assessment usually focuses on physical function, psychological state, social functions, somatic symptoms, sexual functions, occupational function and occasionally, on financial state.

Chaturvedi (2003) identified the four key dimensions of health related quality of life namely:

(a) **Marital functioning** which includes the performance of marital roles and duties, relationship with the spouse, looking after the family, bringing up children.

(b) **Marital life satisfaction** which includes degree of satisfaction with the above marital role.

(c) **Occupational functioning** includes ability to go for a job, level of performance at job.

(d) **Occupational satisfaction** includes degree of satisfaction with the above occupational functioning.
Social functioning includes attending social functions, fulfilling social roles, interacting with others and gaining social support.

Social satisfaction includes the degree of satisfaction with performance of social roles.

Self care functioning includes looking after self, personal care and hygiene, clothing, grooming, feeding, toilet care, etc.

Satisfaction with self includes the satisfaction with the ability to look after self and self care abilities.

4.8 SICK ROLE

Social roles are conceptualised as the expected behaviours (including rights and obligations) of someone with a given position (status) in society. Generally, people hold a status (position) and perform a role (behaviours). Parsons (1951) utilised these concepts to construct a theoretical view of individuals who are sick, hence the “sick role.” It is based upon the assumption that being sick is not a deliberate and knowing choice of the sick person, though illness may occur because of motivated exposure to infection or injury. He argues that being sick is not just experiencing the physical condition of a sick state rather it constitutes a social role because it involves behaviour based on institutional expectation and reinforced by the norms of the society corresponding to these expectations. The sick are unable to take care of themselves, therefore, it becomes important for the sick to seek medical advice and cooperate with medical experts. This behaviour is predicted upon the assumptions made by Parsons that being sick is an undesirable state and the sick person wants to get well. Hence, medical practice becomes a mechanism by which a social system seeks to control the illnesses of its deviant sick by returning them to as normal as state of functioning as possible. As a sovereign concept in anthropology, social role is central to social psychological interpretation of behaviours and attitudes as well as being a major instrument for mapping social structure. Role as used here stands for a series of behaviours and attitudes expressing fixed, regular, or patterned cultural norms and values in the relation of one person to another which are appropriate to the person’s tasks or functions vis-à-vis the other.
This theory outlines two rights and two obligations of individuals who become sick in our society.

4.8.1 Rights

The rights of the patients according to sick role theory are as follows:

- The sick person is exempted from “normal” social roles – An individual’s illness is ground for his or her exemption from normal role performance and social responsibilities. This exemption, however, is relative to the nature and severity of the illness. The more severe the illness, the greater the exemption. Exemption requires legitimisation by the physician as the authority on what constitutes sickness. Legitimisation serves the social function of protecting society against malingering attempting to remain in the sick role longer than social expectations allow – usually done to acquire secondary gains, or additional privileges afforded to ill persons.)

- The sick person is not responsible for his or her condition – An individual’s illness is usually thought to be beyond his or her own control. A morbid condition of the body needs to be changed and some curative process apart from a person’s will power or motivation is needed to get well.

4.8.2 Obligations

Expected obligations from the patients are as follows:

- The sick person should try to get well. The first two aspects of the sick role are conditional upon the third aspect, which is recognition by the sick person that being sick is undesirable. Exemption from normal responsibilities is temporary and conditional upon the desire to regain normal health. Thus, the sick person has an obligation to get well.

- The sick person should seek technically competent help and cooperate with the physician. The obligation to get well involves a further obligation on the part of the sick person to seek technically competent help, usually from a physician. The sick person is also expected to cooperate with the physician in the process of trying to get well.
Parsons (1951) view on sick role is that if the patient seeks help from the doctor, he places himself in an inferior position and accepts the superior wisdom of the doctor. Parson’s analysis of the structure of the sick role is perhaps the most incisive exploration of the social meaning of the patient’s situation. He notes that the sick role is contagion of the ill. The ill person is defined as “needing help”, as obligated to accept this help to cooperate with the therapeutic agent. The ill person recognising his illness or having it enunciated by others, prepares to define himself as a more or less compliant partner in a therapeutic relationship. At this point in his career as patient, he typically confronts some helping agent—often, but not always, a physician. The role will change and proliferate as the individual moves from the being ill being towards recovery or towards dissolution.

Possessions of the initiative and of recognised competence imply power. They also imply a correctively heavy burden of responsibility. Although the patient too has, important obligations – especially the central one expressed by Parsons as “to try to get well”—it is the practitioner who must act.

Illness is a universal phenomenon occurring in all societies; it forces temporary disruption of regular patterns of social relationships. Fulfilment of normal role responsibilities by the sick person is often impossible and often the role responsibilities of the patient’s family can not be carried out. Considering the ubiquitous nature if illness in human societies, it is not surprising that a special role should develop for the sick person, including rather clearly defined expectations for behaviour on the part of the patient and reciprocal responsibilities between the one who is sick and those who interact with him. Behaviour of the sick person, therefore, is constrained or limited by the role expectation of the society in which he lives.

A delicate balance of roles must be maintained in the world of those institutions offering care for the sick—the patient vis-à-vis those who care for him. The concept of a hospital as a refugee too often means that patients are robbed of their status as human beings. Too often they are called ‘good’ or ‘bad’ only according to the degree of their passivity in the fact of the hospital
demand for their obedience, dependence and gratitude. The fine traditional mixture of charity and discipline they receive is a practised technique for removing their initiative as adult beings and making them ‘patients’. They are then less trouble for the staff.

The sick role is legitimate only in a conditional sense, meaning that the deviancy of the role must be recognised by the patient and his family, and that step to be taken to get well, to move back into the healthy role. Conflict between social expectations and personality dynamic centres on the “secondary gain” which can accrue from the rights of the sick role. The enforced state of dependency is illness can gratify strong needs to be taken care of, as the individual was cared for as a child (cf. French, 1968).

The dependency of the sick role can also provide a basis for the gratification of aggressive needs in terms of control over other people. The sick person may use his position to force other people to accede to his wishes, not only in terms of immediate gratification like special foods, but also in long term plans like job changes or living arrangements. In a functional sense, the person occupying the sick role abuses his rights to be taken care of by extending them into areas that are not immediate to the illness, and in a sense abrogates his responsibilities to try to get well. Principally, this is due to the fact that the relationship between the sick person and family members is largely on an emotional basis, while that between the sick person and medical personnel is much more on an objective, emotionally neutral basis (cf. French, 1968).

The ‘sick role’ concept is a useful approach to illness since it takes into account the doctor-patient relationship within the framework of social roles. Attitudes and activities of both actors in a situation are considered (Mehta, 1992).

4.8.3 Weaknesses

- The model does not examine how the interests of doctor and patient might conflict nor explore how this creates imbalances of power.
- Being sick does not automatically lead to being a patient. The people
often rely on lay opinions and advice as to whether or not a professional consultation is appropriate. For example “That looks bad, shouldn’t you see a doctor?” or “Don’t be soft! The doctor would think you’re daft asking about that!”

- Being a patient does not always involve being sick (i.e. pregnancy, contraception, vaccinations, etc)
- Chronic diseases do not fill the model’s criteria of being a temporary condition. In an age when it is becoming normal for people to suffer a chronic illness for some part of their life can it still be seen as deviant?
- The model has no place for ‘abnormal’ illness behaviours (i.e. Munchausen’s syndrome, ‘flight to health’ or the denial of illness).
- The patrician model of medicine is simply out of date. Patients are more likely to view themselves as critical consumers of health care and be less willing to comply with medical advice uncritically. Doctors are also more likely to be part of a health care team rather than a sole authority.

4.8.4 Strengths

Inspite of its shortcomings the idea of the sick role has generated a lot of useful far-reaching research. Arguably, it still has a role in the cross-cultural comparison of ways in which ‘time-out’ from normal duties can be achieved or in which deviant behaviour may be explained and excuse (i.e. comparing ideas of mental illness with demonic possession or religious inspiration).

4.9 DOCTOR-PATIENT RELATIONSHIP

The quality of the interaction between doctor-patients in the consultation is central to effective health care delivery. Many patients reported that they had not been given sufficient information nor had difficulty in understanding information, which was presented in the consultation. Very often, this was also found to be associated with a subsequent reluctance or inability to follow the doctor’s recommended treatment of advice. Many studies, which have analysed the process and outcome of the medical
consultation, have revealed that there is considerable variation in the pattern of doctor patient interaction and that this is influenced by factors that the doctor and patient bring to the encounter.

(a) Input factor in doctor-patient communication: The main input factors in doctor-patient communication reflect variations between and within both doctors and patients (e.g. age, personality, coping style, expectations, etc.), which can influence the process and outcome of a medical consultation-

- Patient input factors: Patients differ for information that they would like to receive about their health problem. Patients come into the health care setting with different levels of biomedical knowledge based on their experience.

- Difference between doctors: Although doctors undergo a common process of training and share, a common body of knowledge and skills, wide variation in their consulting behaviour has been noted. Part of this variation is a by-product of personality differences and can be seen in differences in interpersonal aspects of clinical practice but part is a reflection of differences in the approach to clinical problem.

(b) The consultation process: There is a range of methods and frameworks for analysing the process of consultation. One of the broadest distinctions made has been between consultations described as patient-centered and those that are doctor-centered, reflecting the extent to which the doctor or patient determines what is discussed. Doctor-centered consultations are ones in which closed-questions are used more often and the doctor determines the direction, typically with a primary focus on medical problems. While, patient-centered encounters involve more open-ended questions with greater scope for patients to raise their own concerns.

(c) Outcomes of doctor-patient communication: Three broad groups of outcome have been studied, namely understanding and recall, satisfaction, and adherence. Generally, information that is presented in the consultations is recalled well as are statements, which are perceived as being relevant. Recall is better for the information that has been provided in an organised way based around specific themes, e.g. the nature of problem, the details of treatment,
etc. Patient satisfaction is concerned with how patients evaluate the quality of their health care experience and the outcome from consultations is reflected in the extent to which the patient adheres to the advice or treatment offered by the doctor.

4.9.1 Approaches to doctor-patient relationship

Talcott Parsons was the first one to theorise the doctor-patient relationship, and his functionalist, role-based approach defined analysis of the doctor-patient relationship. Parsons (1951) began with the assumption that illness was a form of dysfunctional deviance that required reintegration with the social organism. Illness, or feigned illness, exempted people from work and other responsibilities, and thus was potentially detrimental to the social order if uncontrolled. Maintaining the social order required the development of a legitimised “sick role” to control this deviance, and make illness a transitional state back to normal role performance. As discussed earlier, Parsons saw four norms governing the functional sick role.

For Parsons, the physician’s role is to represent and communicate these norms to the patient to control their deviance. Physicians exemplify for Parsons Shift to “affect-neutral” relationships in modern society, with physician and patient being protected by emotional distance. Medical education and social role expectations impart normative socialisation to physicians to act in the interests of the patient rather than their own material interests, and to be guided by an egalitarian universalism rather than a personalised particularism. Because physicians have mastered a body of technical knowledge, it is functional for the social order to allow physicians' professional autonomy and authority, controlled by their socialisation and role expectations.

4.9.1.1 Szasz and Hollender model: Szasz and Hollender’s (1956) work refined Parsons by elaborating different doctor-patient models arising around different types of illness. They proposed that patient passivity is characterised by the physician’s assertiveness and is the most common reaction to acute illness; less acute illness is characterised by physician’s guidance and patient co-operation; and chronic illness is characterised by physician’s participation in a treatment plan where patients had the bulk of the responsibility to help
themselves. Szasz and Hollender (1956) distinguished between three types of doctor-patient interaction: activity-passivity; guidance-co-operation; mutual participation (Table 4.2).

Table 4.2: Basic model of doctor-patient relationship

<table>
<thead>
<tr>
<th>Model</th>
<th>Physician’s role</th>
<th>Patient’s role</th>
<th>Clinical application</th>
<th>Prototype of model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity passivity</td>
<td>Does something to patient</td>
<td>Recipient (unable to respond or inert)</td>
<td>Anesthesia, traumas, coma, delirium, etc.</td>
<td>Patient infant</td>
</tr>
<tr>
<td>Guidance participation</td>
<td>Tells what to do</td>
<td>Cooperator (obeys)</td>
<td>Acute infectious processes, etc.</td>
<td>Patient child (adolescent)</td>
</tr>
<tr>
<td>Mutual participation</td>
<td>Helps patient to help himself/ herself</td>
<td>Participant in partnership uses expert help</td>
<td>Chronic illness, psychoanalysis etc.</td>
<td>Adult-adult</td>
</tr>
</tbody>
</table>

Source: Szasz and Hollender, 1956

In the activity-passivity type the doctor is active and the patient passive. This type of situation originates in, and is appropriate for, emergencies (severe injuries, marked blood loss, delirium, or coma). The patient is more or less completely helpless as the doctor completes procedures and treatments on him.

The guidance-co-operation model usually underlies the doctor-patient relationship when the circumstances are less desperate. Then it applies to most acute disorders and especially to those of an infectious type. Although the patient is sick, he is keenly aware of what is going on, is capable of taking instructions and of exercising judgment, and has to be taken into account as a person.

197
Finally, there is the relationship of mutual participation. This approach is regarded as essential for the management of chronic illness in which the treatment programme is carried out by the patient with only occasional instruction from the doctor (as, for example, in most cases of diabetes mellitus or psoriasis). Psychotherapy falls into this category of relationship. According to the model, the doctor helps the patient to help himself. For the purpose of completing the treatment the doctor needs the patient and the patient needs the doctor.

The three types of doctor-patient relationship analysed by Szasz and Hollender should be considered not as types of relationship that actually obtain (although they sometimes will) but as types of relationship that doctors wish to create with patients suffering from different conditions. Analysis may then focus on the conflict, bargaining, and negotiation that take place as doctors try to create these types of relationship. If we add in the patient's point of view we can consider the mutual bargaining over roles and goals that occurs.

4.9.1.2 Marxist and feminist approaches: Drawing on, and extending the professional power analysts, the growing school of Marxist sociologists interpreted the doctor-patient relationship within the context of capitalism. In Marxist analysis, the “medical-industrial complex” conditions the doctor-patient relationship; profit-maximisation drives the innovation of technologies and drugs and constrains physician decision-making. Freidson and Starr who see professional power as having some autonomy from, and sometimes being direct conflict with, capitalism and corporate prerogatives. For Navarro, physicians are both agents and victims of capitalist exploration, engineers required to fix up the workers and send them back into community and work environments made dangerous and toxic by capitalism.

4.9.1.3 Economic approaches: The growth of studies on cost-containment, and the economist trend of 1980’s social science, led to the rise of methodologically individualistic “rational choice” studies of the doctor-patient relationship. These studies usually ignored the functionalists’ interest in norms
and roles, as well as the critical theorists’ interest in power and exploitation. Instead, the economists’ model starts from the assumption of a mutual “utility-maximising” agency contract between the doctor-patient. The patient is interested in maximising consumption of health, and the physician is interested in maximising income.

4.10 STIGMA

Stigma is defined as a negative evaluation linked to characteristics of a person, which places the person outside some socially acceptable standard for human attributes and performance. The attribute, breast cancer, makes a woman different from her peers. Women with breast cancer are less desirable, as they not only have a life threatening condition but also have one which affects the breast, a symbol of sexuality in our society. The attribute is deeply discrediting, as it affects one’s femininity. It also affects the relationship between the individual and those with whom she interacts. Since the loss of breast is discrediting, it can be designed as a stigma; i.e. “a special kind of relationship between attribute and stereotype” (Goffman, 1963).

Stigma is described as a sign or a mark that designates the bearer as “spoiled” and therefore as valued less than “normal” people. Stigmatised individuals are regarded as flawed, compromised and somehow less than fully human. As Goffman puts it, “society establishes the means of categorising persons and the complement of attributes felt to be ordinary and natural for members of each these categories”. For a characteristic to be a stigma, it must be shared among the members of a given group (Goffman, 1963).

Goffman (1963) distinguished three different varieties of stigma or stigmatising conditions: “abominations of the body” (e.g., physical deformities), “blemishes of individual character” (e.g., mental illness, addictions, unemployment), and “tribal identities” (e.g., race, sex, religion, or nation). Using a different approach, Jones et al. (1984) identified six dimensions of stigmatising conditions:

(a) “Concealability,” which involves the extent to which the stigmatising characteristic is clearly visible.
(b) "Course of mark," relating to whether the mark may become salient or progressively debilitating over time.

(c) "Disruptiveness," which refers to the degree to which the stigmatising characteristic interferes with the flow of interpersonal interactions.

(d) "Aesthetics," which relates to subjective reactions to the unattractiveness of the stigma.

(e) "Origin," of the stigmatising mark which can also involves the person's responsibility for creating the mark.

(f) "Peril," which involves the perceived danger of the stigmatising conditions to others.

Research since Goffman's seminal essays has been incredibly productive, leading to elaborations, conceptual refinement, and repeated demonstrations of the negative impact of stigma on the lives of the stigmatised. The stigma concept is applied to literally scores of circumstances ranging from urinary incontinence (Sheldon and Caldwell, 1994) to exotic dancing (Lewis, 1998) to leprosy (Opala and Boillot, 1996), cancer (Fife and Wright, 2000), and mental illness (Angermeyer and Matschinger, 1994).

Stafford and Scott (1986) proposed that stigma "is a characteristic of persons that is contrary to a norm of a social unit" where a norm is defined as a shared belief that a person ought to behave in a certain way at a certain time. A substantial portion of the productive research on stigma has been contributed by the social psychologists who have used the insights of the social cognitive approach to understand how people construct categories and link these categories to stereotyped beliefs but late on anthropologists and sociologists started taking up the concept in order to understand the social consequences of stigma, functions of stigmatising others and effects of stigma on the stigmatised and their social life and interaction (c.f. Link and Phelan, 2001).
4.10.1 Link and Phelan stigmatising model

Link and Phelan (2001) proposed that the stigma exists when four specific components are covered. These are:

- Individuals differentiate and label human variations.
- Prevailing cultural beliefs tie those labeled to adverse attributes.
- Labelled individuals are placed in distinguished groups that serve to establish a sense of disconnection between “us” and “them.”
- Labelled individuals experience “status loss and discrimination” that leads to unequal circumstances. In this model stigmatisation is also contingent on “access to social, economic, and political power that allows the identification of differences, construction of stereotypes, the separation of labeled persons into distinct groups, and the full execution of disapproval, rejection, exclusion, and discrimination.”

Subsequently, in this model the term stigma is applied when labeling, stereotyping, disconnection, status loss, and discrimination all exist within a power situation that facilitates stigma to occur.

A person who is stigmatised is a person whose social identity or membership in some social category calls into questions his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others. From the perspective of the stigmatiser, stigmatisation involves dehumanisation, threat, aversion and sometimes the depersonalisation of others into stereotypic caricatures. Thus, stigmatisation is personally, interpersonally and socially costly. Crocker et al. (1998) have argued that “stigmatised individuals possess (or are believed to possess) some attribute or characteristic that conveys a social identity that is devalued in some particular social context”.

The experience of stigma has both private and public faces. The private face of stigma often involves feeling of grief, loss of control and anxiety on the part of person who is stigmatised. The public face of stigma involves the general public’s negative beliefs, feeling and behaviour directed toward those with stigma (Corrigan and Penn, 1999).
Thus, the term "stigma" could be defined as a condition of existence where an individual carries an attribute that discredits her or him as a "normal" person, an attribute that bestows moral, mental, or physical impurity. There are two kinds of stigma; one that is outwardly visible to others and other that can be easily hidden. Additionally, the stigmatised differ in terms of whether they were born with their stigma (as in a person with a birth defect) or whether they acquire it later in life (as in a person who experiences a disfiguring injury as an adult). Stigma is an ascribed characteristic, which means that it is attached to individuals because of their actual or perceived membership in a stigmatised group. All members of such a group are perceived as carrying the stigma.

It is clearly understood from the studies carried out on stigma that once stigma is ascribed to an individual, it is nearly impossible to remove it. It then becomes a self-fulfilling prophecy, as the treatment that the stigmatised individual receives begins to have an effect on the individual's own behaviour, reinforcing the stigmatised identity.

Even when stigmas are not outwardly visible and reacted upon by others, their presence affects the behaviour of their bearer. For instance, stigmatised individuals may work hard to conceal their stigma for fear of the treatment that they would receive were it known or for shame of its existence. They may also come to see themselves in a negative light because of the existence of the stigma, internalising negative attitudes about themselves and their group.

Stigma stems from the human proclivity to judge themselves and others. Based on those judgements, we categorise or stereotype people, not necessarily based on factual or actual circumstances or evidence but on what we deem as inappropriate, unusual, shameful or unacceptable. Stigmatisation occurs in all aspects of human life. A person can be stigmatised because of anything from disease, birth defects and mental illnesses, to sexual preference, occupation and economic status. Stigma can be associated with a wide variety of diseases and occupations.
Each society establishes certain means of categorising its members and combinations of persons felt to be natural for them. A characterisation is imputed to each individual who may be called ‘virtual social identity’. Thus, in day-to-day life, we come across people, who are not taken special notice of. The question arises when a stranger enters on the scene. When a particular individual does not fit in the normative expectations, his ‘actual social identity’ is taken as against normal. A special type of discrepancy is created between the virtual social identity and the actual social identity. Such type of discrepancy between virtual and actual social identity is created in some other cases also, but it should be noted that the traits causing this discrepancy are not undesirable but they are equally anticipated and sometimes are also taken as superior or above normal.

Not all undesirable attributes are at issues in the cases of stigma, but only those which are incongruent with the stereotypes and with the standard to which each individual is expected to approximate. There is distinction between strong expectations of realising a norm and of merely supporting it. Certain norms are strongly demeaned while others are not. Stigma seems to have arisen when there are expectations from all the sides towards these in a given category that they should realise and not only support a particular norm. It thus, follows that “stigma is a special kind of relationship between an attribute and a stereotype”. Stigma has been identified with loss of dignity, ill-treatment, deterrence, degradation, the denial of citizenship, shame, embarrassment, disadvantage, an imputation of failure or inadequacy, the reluctance to claim benefits, labelling, and feelings of inferiority. Goffman (1963) first refers to stigma as

- A feeling, a shortcoming, a handicap
- An attribute that is deeply discrediting
- An attribute that makes person different from others and of a less desirable kind
- A shameful differentness
There is an implication, when one talk about someone who is stigmatised through homelessness and unemployment, that his condition somehow defines his characters. The idea that stigma is a personal characteristic implies a pathological view of social problems. This use is unsatisfactory. A mark cannot be inherently discrediting; the marked individual is discredited by the interpretation that is put on it. A stigma is socially defined as it is an imputation attaching to a present’s reputation; stain on one’s good name. A reputation exists in the minds of others, not in the character of the person and the attitudes of other people are clearly important to the stigmatised person. A stigmatised person loses respectability and the shame he feels is a natural consequence of that.

People suffer a loss of esteem through the receipts of social services. The stigmatised person may experience discrimination. Mentally ill people, epileptics and coloured people may experience discrimination in the job market. Goffman (1963) tries to explain the position by saying that a stigma is really a special kind of relationship between attribute and stereotypes. The important element in the ‘feeling stigma’ is not the stigma but the feeling. Something is assumed to exist to account for the feelings and reactions which people experience, and that something is called ‘a stigma’. But ‘stigma’ in this sense is inseparable from those feelings’. It is possible to have stigma, in the sense of a mark of disgrace, or to ‘feel stigma’; but it does not make sense to talk of someone as if ‘he’ had stigma or ‘felt a stigma’.

The stigma concept is revealing with regard to why so many definitions of stigma are extant in the literature. There are several components, each one of which has been described as stigma. Stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them. One reason it is helpful is that the term stigma is in very wide use and some degree of clarity will help us communicate about the concept. Second, there are words that aptly describe each of the components like label (or mark or status), stereotyping, exclusion, status loss and discrimination so that the use of the word stigma to describe any particular aspect is not necessary. Third, the definition coheres with the current usage of the term as it is applied to groups that are commonly referred to as stigmatised groups.
Stigma exists as a matter of degree. The labelling of human differences can be more or less prominent. A label can connect a person to many stereotypes, to just a few or to none at all. Moreover, the strength of the connection between labels and undesirable attributes can be relatively strong or relatively weak. The degree of separation into groups of “us” and “them” can be more or less complete, and finally the extent of status loss and discrimination can vary. This means that some groups are more stigmatised than others and that some of the components used analytically to think about why differences in the extent of stigma experienced vary from group to group.

4.11 BODY IMAGE CONCERNS

From the moment an individual is born, perceptions of oneself and one’s environment are constantly forming and developing. These perceptions continue to develop throughout an individual’s life, representing how a person views himself/herself, how he/she views his/her body, mind and environment. “The body and its evolving mental representations form the foundation of a sense of self” (Krueger, 2002). Throughout the life span, experiences not only affect one’s mind, they also affect one’s body. These experiences, whether pleasant or unpleasant, help shape a persons’ body image. When referring to the term body image, there seems to be some discrepancy among writers and no single shared common definition, due to the complexity and multidimensional facet of this construct. Body image is a component of one’s self-concept and refers to a mental picture of the physical self, including attitudes and perceptions regarding one’s physical appearance, state of health, skills, and sexuality (Pikler and Winterowd, 2003). Another researcher defines body image as an individual's physical attributes, “overall wholeness, functionality, and ability to relate to others” (Pelusi, 2006). Regardless of what specific definition one uses to describe body image, it can be viewed as “…a dynamic rather than static process”. The body appears in the narratives of dreams, metaphors, and symptoms as a symbolic vision of inner landscapes, mysterious structures and configurations, and geographical terrain (Krueger, 2002).

Body image is a complex and multidimensional psychological construct that encompasses body related self-perceptions and self attitudes including
thoughts, beliefs, feelings and behaviour (Fan and Eiser, 2009). Body image is an important component of a patient's QOL having a relevant role in their adjustment to the disease. Although there is not yet a clear definition of body image, the most recent perspectives that have emerged in the mainstream body image literature consider this to be a multidimensional construct that encompasses cognitive, affective and behavioural components (Moreira et al., 2010). Price (1990) has defined altered body image as any significant alteration to body image occurring outside the realms of expected human development. It can also be seen simply as an alteration to the way people imagine their unique body. During life, body image will change due to the process of ageing, but trauma to the body, caused by disease or treatment such as chemotherapy or radiotherapy, will create an alteration to that body image. The way that either concept is received by a person depends very much on how they are able to respond to such changes, which in turn is dependent upon many different influences, and Price (1993) has commented, it is often difficult to separate psychological and physical factors.

Body image is often thought of in terms of physical appearance, but there is also a body image pertaining to integrity, wholeness, and normal functioning. People who are greatly concerned about either aspect of their body image are vulnerable to poorer psychosocial adjustment when confronting treatment for breast cancer. The poorer adjustment takes a different form, however, depending on the nature of the patient's body-image concern (Carver et al., 1998). Body image and sexual functioning are aspects of human behaviour that depend upon one's vitality, physical functioning, role and social functioning (Mock, 1993). Body image is defined as the mental picture of one's body, an attitude about the physical self, appearance, and state of health, wholeness, normal functioning, and sexuality. Body image is a component of a larger concept of self that for women includes feeling feminine and attractive (Mock, 1993; Carver et al., 1998; Hopwood, 1993; Cohen et al., 1998; White, 2000), enjoying one's body as a symbol of social expression, and as a way of being in the world (Cohen et al., 1998). The way in which one experiences her body is highly subjective, and is a product of her perceptions,
thoughts, and feelings about body size, competence and function (Cohen et al., 1998; White, 2000). The significance of body image as a concept in the life of women was underscored in a study by Pikler and Winterowd (2003) who found that the better one's body image, the better women coped with cancer. Women with better body image perceptions had higher levels of self-confidence in coping with breast cancer. Negative perceptions of body image among breast cancer survivors include dissatisfaction with appearance, perceived loss of femininity and body integrity, reluctance to look at one's self naked, feeling less sexually attractive, self-consciousness about appearance, and dissatisfaction with surgical scars (Pikler and Winterowd, 2003).

4.12 DEATH AND DYING

The anthropology of dying and death itself considered from the early days of ethnographic practice illustrates a major shift in how those terms have been situated and employed. Late 19th and early 20th century studies of death were conducted within the frameworks of anthropology and sociology of religion, ritual practice, and structural-functionalism. Late 20th century and contemporary studies focus primarily on controversies that emerge from biomedical understanding about the physiological body, the brain and the idea of consciousness, and how the cessation of life can be measured on unequivocally known especially in the context of organ transplantation and values about life prolongation. Social and cultural studies of the body, medicalised death and biotechnologies point to a double problematic: first, that death is a negotiable terrain, rather than an absolute status; and second that the separation and opposition of life and death is a culturally produced dualism, rather than a natural fact.

World events throughout the 20th century, especially the Nazi holocaust and more recent genocides, displacements and political violence, AIDS and other epidemics have fostered anthropological studies of the normalisation of violence, ways in which the effects of war and terror are embodied, emerging considerations of risk in the face of disease and natural and human-made disasters, narratives of illness, dying, trauma and how death is lived, and
ethnographic exploration of social suffering. Within anthropology and medical anthropology, the subject of dying and death must be placed too, in the changing shape of disciplinary knowledge and practice. Early investigations of death were undertaken in an anthropological enterprise that conceived the object of study to be discrete cultural groups whose native practices were considered perduring. The framework for approaching death was the individual within a bounded cultural group, the threat of death to social stability, and the role of ritualised and re-integration of small-scale societies. The studies of war and violence were not conceptually connected with studies of death or their associated rituals. The critiques of colonialism, the deconstruction of ‘the native’ and the impacts of migration and globalisation have forever altered earlier conceptions of culture as static and territorially demarcated. The subject of longstanding anthropological interest in contemporary death studies include: personhood, identity, liminality and the relationship between sacred, and the secular. Of more recent interest to medical anthropologists are three lines of enquiry:

- Studies of death situated in social sciences analyses of technoscience are concerned with biopower, body commodification, bioethics and a rethinking of the culture/nature and human/non-human dichotomies.

- AIDS has fostered anthropological work on the social underpinnings of disease acquisition and its spread, the political economy of epidemics, and the culture of risk.

- The anthropology of violence, war, and terror explores ways in which death is lived in memory, in illness, in the body, and in everyday practices.

The critical, narrative and phenomenological analytic approaches come to the fore in these contemporary explorations. Death is now a site where investigations of technology, medicine and science, epidemics, poverty and structural inequality, state and ethnic conflict and genocide, intersections of person, community and the state and traditional and innovative approaches to ‘culture’ and ‘nature’ come together.
Death and dying are inevitable events in a human’s life. Death is the real inspiring genius or the muse of philosophy (Schopenhauer, 1969). Human beings have an odd habit of considering the inevitability of their own mortality, even when such consideration bears no immediate benefits for survival or reproduction. Yet, from an applied perspective, mortality awareness is essential to overall well-being as one confront the ageing, global health disparities, emerging biomedical technologies and shifting understanding of 'good deaths' and lives worth living. Given these issues, one might argue that death is a central domain of medical anthropology. Despite its importance, the topic of death rarely receives attention from social scientists in general and medical anthropologists in particular. A few medical anthropologists have worked on issue of death and dying (Murphy, 1990; Fox, 1991; Byock, 1997; Bosk, 1999; Kleinman 1999, Kaufman, 2005; Kaufman and Morgan, 2005 and Green, 2008).

Death and dying are profound aspects of human experience whose definitions and meanings are fabricated through cultural and historical lenses. Though death is biologically inevitable, it is also a social fact; knowledge about it is made. It is understood through frameworks of religion and social structure, science and medicine, loss and disruption that are available to individuals within societies (Kaufman, 2004). Palliative care is centred on improving the quality of life of patients and their families when faced with life-threatening illness, focussing on prevention and relief of suffering through early identification and careful assessment and treatment of pain, as well as physical, psycho-social, and spiritual needs. Watson’s (1979; 1999; 2005) theory of caring provides support for the importance of this integrative review. Dimensions of caring reflect deep transpersonal involvement and caring as part of caring science (Watson, 1979; 2005), and they capture the human dimension of nursing, including the personal experiences of the recipient and provider of care. Caring as art, a moral ideal, is the starting point that leads to commitment and judgement, resulting in concrete actions (Watson, 1999; 2005). The goals of caring are mental and spiritual growth, finding meaning in self and others, discovering inner power and control, and promoting transcendence and self-healing (Watson, 1999; 2005),
End-of-life implies the presence of a chronic disease(s), symptoms, and/or functional impairments that persist, but they also may fluctuate. In addition, symptoms or impairments resulting from the underlying irreversible disease require formal (paid, professional) or informal (unpaid) care and can result in death (Centers for Disease Control, 2004).

4.13 THEORETICAL FRAMEWORK

If we want to study human action and not just human behaviour, we must adopt a theory and a method that take into account of the interventions of the actors in their proper context. In social sciences we cannot talk about typical form of scientific law, but we can definitely make informed suggestions about what is likely to happen or why things happened as they did, but we cannot say what will happen.

Theories, whether social or scientific, are the ways in which we bring order into world. They allow us to make sense of what we see before us. They include the concepts and methods for getting to know the world better. Two categories of theoretical models including pre-diagnostic and post-diagnostic stages of cancer will be used for the present study.

4.13.1 Theoretical framework for pre-diagnosis stage

The models of pre-diagnostic stage include health belief model (Rosenstock, 1966), health care utilisation model (Andersen and Newman, 1973), model for strategies of resort (Kroeger, 1983), the “four As” (Good, 1987) and pathway model (Good, 1987).

4.13.1.1 The health belief model (Rosenstock, 1966): The health belief model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The Health Belief was a psychological model developed by Rosenstock in the 1966 to predict behavioural response to the treatment received by acutely or chronically ill patients, but in more recent years the model has been used to predict more general health behaviours (Figure 4.7).
The original Health Belief Model, constructed by Rosenstock, was based on four constructs of the core beliefs of individuals' basec perceptions:

(a) **Perceived susceptibility** (an individual's assessment of thei getting the condition)

(b) **Perceived severity** (an individual's assessment of the seriousne condition, and its potential consequences)

(c) **Perceived barriers** (an individual's assessment of the influen facilitate or discourage adoption of the promoted behaviour)

(d) **Perceived benefits** (an individual's assessment of the consequences of adopting the behaviour).
A variant of the model include the perceived costs of adhering to prescribed intervention as one of the core beliefs. Constructs of mediating factors were later added to connect the various types of perceptions with the predicted health behaviour:

- Demographic variables (such as age, gender, ethnicity, occupation)
- Socio-psychological variables (such as social economic status, personality, coping strategies)
- Perceived efficacy (an individual's self-assessment of ability to successfully adopt the desired behavior)
- Cues to action (external influences promoting the desired behavior, may include information provided or sought, reminders by powerful others, persuasive communications, and personal experiences)
- Health motivation (whether an individual is driven to stick to a given health goal)
- Perceived control (a measure of level of self-efficacy)
- Perceived threat (whether the danger imposed by not undertaking a certain health action recommended is great)

The assumption in this model is that by taking a partial action, susceptibility would be reduced, or if the disease occurred, severity would be reduced. The perception of the threat posed by disease “X”, however, is affected by modifying factors. These factors are demographic, socio psychological and structural variables, which can influence both perception and the corresponding cues necessary to instigate action. Action cues are required says Rosenstock, because while an individual may perceive that a given action will be effective in reducing the threat of disease, that action may not be taken if it is further, defined as too expensive, too unpleasant or painful, too inconvenient, or perhaps too traumatic action is necessary and the presence of energy to take that action, a person may still not be sufficiently motivated to do something. The likelihood of action also involves a weighing
of the perceived benefits to action contrasted to the perceived barriers. Therefore, Rosenstock believed that a stimulus in the form of an action cue was required to “trigger” the appropriate behaviour. Such a stimulus would be either internal (perception of bodily status) or external (interpersonal interaction, mass India communication, or personal knowledge of some one affected by the health problem.).

Unfortunately, the usefulness of the Health Belief Model is limited in that it has been applied mostly to preventive situations in which the behaviour studied is voluntary. Obviously, however, many people who seek health services are motivated to take action only by the appearance of clear and definite symptoms. Therefore, it remains to be seen whether an improvement in health and the avoidance of future disease are strong enough motivating factors for healthy people to use health care delivery systems.

4.13.1.2 The health care utilisation model (Andersen and Newman, 1973):
The socio-behavioural or Andersen and Newman model groups in a logic sequence three clusters or categories of factors (predisposing, enabling and need factors) which can influence health behaviour. The model was specifically developed to investigate the use of bio-medical health services. Later versions have extended the model to include other health care sectors, i.e., traditional medicine and domestic treatments. Health care utilisation model is shown in Figure 4.8.

Figure 4.8: The health care utilisation model

The factors organised in the categories of Health care Utilisation Model are:

- **Predisposing factors**: Age, gender, religion, global health assessment, prior experiences with illness, formal education, general attitudes towards health services, knowledge about the illness, etc.
Enabling factors: Availability of services, financial resources to purchase services, health insurance, social network support, etc.

Need factors: Perception of severity, total number of sick days for a reported illness, total number of days in bed, days missed from work or school, help from outside for caring, etc.

Treatment actions: Home remedies (herbal, pharmaceuticals), pharmacy, over the counter drugs from shops, injectionists, traditional healers, private medical facilities, public health services, etc.

This model centres specifically on treatment selection. It includes both material and structural factors, which are barely taken into account. Weller et al. (1997) emphasised its particular use for working with statistical data on actual cases. The model has also been used for gaining evidence on the weight of different factors for health service use. Based on the data of demographic and health surveys, a comparative study of six African countries has been carried out using the categories proposed by Andersen and Newman (Fosu, 1994).

4.13.1.3 Kroeger’s model (1983): A further variant of Andersen and Newman model was elaborated by Kroeger (1983) and is given in figure 4.9.

Figure 4.9: Kroeger's model

Source: Kroeger, 1983
Based on an extensive and well-elaborated literature revision, he proposed the following:

- Interrelated explanatory variables, all of which are affected by perceived morbidity.
- An individual's traits or pre-disposing factors: age, sex, marital status, status in the household size, ethnic group, degree of cultural adaptation, formal education, occupation, assets (land, livestock, cash, income), social network interactions.
- Characteristics of the disorder and their perceptions: Chronic or acute, severe or trivial, etiological model, expected benefits of treatment (modern versus traditional), psychosomatic versus somatic disorders.
- Characteristics of the service (health service system factors and enabling factors), accessibility, appeal (opinions and attitudes toward traditional and modern healers), acceptability, quality, communication, costs. The interactions of these factors guide the election of health care resources.

The advantage of socio-behavioural models such as Kroeger (1983) is that the variety of factors which are organised in categories, making interventions on therapeutic actions feasible. They predict the establishment of correlations with good predictability, but not specification of how and why the different factors affect therapeutic selection (Weller et al., 1997)

4.13.1.4 The “four As” (Good, 1987): It has become popular among researchers to use different categories which group key factors for health-seeking behaviour. The best known is the grouping into the “four As”:

- Availability refers to the geographic distribution of health facilities, pharmaceutical products, etc.
- Accessibility includes transport, roads, etc.
- Affordability includes treatment costs for the individual, household or family a distinction is made between direct, indirect and opportunity costs.
• Acceptability relates to cultural and social distance. This mainly refers to the characteristics of the health providers – health workers’ behaviour, gender aspects (non acceptance of being treated by the opposite sex, in particular women who refuse to be seen by male nurses/doctors), excessive bureaucracy etc.

The model of the “four As” and has been widely used by medical geographers, anthropologists and epidemiologists who mainly emphasize distance (both social and geographical) and economic aspects as key factors for access to treatment. The advantage of the “four As” is the easy identification of key potential barriers for adequate treatment.

4.13.1.5 Pathway model (Good, 1987): Starting with the recognition of symptoms, they centre on the path that people follow until they use different health services (home treatment, traditional healer, biomedical facility). The Figure 4.10 shows an example of a pathway model (Good, 1987), which stresses the importance of ‘significant others’ and the decision-making process.

Figure 4.10: Pathway model

'Significant others' are part of the 'therapy managing group', a concept elaborated by Janzen (1978) which is key for understanding decision making in therapeutic processes. This idea challenges the strong emphasis on the individual and stresses the pivotal role of extended groups of relatives and
friends in illness negotiation and management. In the course of the illness episode, the involvement of support group in illness management can successively change. Pathway model acknowledge these dynamics of illness and decision making. Most of the studies which use pathway models investigate the path until the first contact with a health facility. More recently, there has been an increasing emphasis on successive therapy choices.

The strength of pathway models is that they depict health seeking as a dynamic process. Factors are sequentially organised, according to the different key steps (i.e. recognition of symptoms, decision making, medical encounter, evaluation of outcomes, re-interpretation of illness) which determine the course of the therapy path.

4.13.2 Theoretical framework for the post-diagnosis stage

The models for post-diagnosis includes biopsychosocial-spiritual model for the patients at the end of life (Sulmasy, 2002), model for coping resources used by cancer patients (Schneider et al. 2008), model of role of religion in cancer coping and quality of life (Holt, 2009).

4.13.2.1 Biopsychosocial-spiritual model for the patients at the end-of-life: A person is a being in relationship- biologically, psychologically, socially and transcendently. The patient is a human person, illness disrupts all of the dimensions of relationship that constitute the patient as a human person, and therefore, only a biopsychosocial-spiritual model can provide a foundation for treating patients holistically. A biopsychosocial-spiritual model given by Sulmasy (2002) divides the relationship of an individual into two components i.e. intrapersonal and extrapersonal components and also interlinks these two components.

The intrapersonal component includes the physical relationships of body parts, organs, physiological and biochemical processes. It also includes the mind-body relationships including multiple relationships between and among symptoms, moods, cognitive understandings, meanings, and the person’s physical state. The extrapersonal components consist of the
relationship with the physical environment, relationship with the interpersonal environment- family, friends, communities, etc. It also involves the relationship with the transcendent. The model describes that the illness disturbs more than relationships inside the human organism. It disrupts families and workplaces. It shatters pre-existing patterns of coping. It raises questions about one’s relationship with the transcendent. Thus, the illness disturbs relationships both inside and outside the body of the human person. Inside the body, the disturbances are twofold, namely, intrapersonal (within the human body) and extrapersonal (outside the body):

- The relationships between and among the various body parts and biochemical processes.
- The relationship between the mind and the body.

Outside the body, these disturbances are also two-fold:

- The relationship between the individual patient and his or her environment, including the ecological, physical, familial, social, and political nexus of relationships surrounding the patient.
- The relationship between the patient and the transcendent.

**Figure 4.11: Biopsychosocial-spiritual model for the patients at the end-of-life**

Source: Sulmasy, 2002

218
This model (Figure 4.11) emphasises the importance of the importance of intrapersonal and extrapersonal resources for maintaining the health of an individual in totality and maintains that the healing is not merely restoration of health but the restoration of right relationship. It emphasises on a holistic health care to take care of ill-person as a whole. Holistic healing requires attention to social, spiritual and psychological aspects as well. The appropriate care of dying persons requires attention to the restoration of all the intrapersonal and extrapersonal relationships that can still be addressed, even when the patient is dying. Considering the relationship between mind and body in its broadest sense, symptomatic treatment restores the human person by relieving him or her of the experiences of pain, nausea, dyspnoea, fatigue, anxiety, and depression. Considering the relationship between the human person at the end of life and the environment, this means, for example, that the facilitation of reconciliation with family and friends is genuine healing within the biopsychosocial-spiritual model. For the dying individual to experience love, to be understood as valuable even when no longer economically productive, and to accept the role of teacher by providing valuable lessons to those who will survive, are all experiences of healing. Finally, to come to grips with the transcendent term of each of these questions about existence, meaning, value, and relationship is also an opportunity for healing for dying individuals. The relationship with the transcendent is difficult to be measured. Thus, Sulmasy (2002) suggested four domains:

- Measures of religiosity.
- Measures of spiritual/religious coping and support.
- Measures of spiritual well-being.
- Measures of spiritual need.

All the four domains are very crucial to be studied for the present research work as religiosity and spirituality could play a very important role in coping with cancer. Secondly, religiosity could be measured with ease but not the spirituality. The relationship with the transcendent is difficult to measure and describe.
4.13.2.2 **Coping resources used by cancer patients:** Schneider et al. (2008) described a model using three kinds of resources used by the women suffering from the cancer Figure 4.12. The three coping resources included intrapersonal, interpersonal and extrapersonal coping resources (Schneider et al., 2008).

![Figure 4.12: Coping resources used by cancer patients](source: Schneider et al., 2008)

The three coping resources included intrapersonal, interpersonal and extrapersonal coping resources (Schneider et al., 2008). The term intrapersonal refers to something that "occurs within the individual mind or self." Some of the intrapersonal resources are the power of the mind to influence illness outcomes, positive thinking, being spiritual and developing feelings of empowerment through personal control. The term interpersonal refers to "being, relating to, or involving relations between persons." Hence, interpersonal coping resources are those coping resources that revolved around supportive others in the lives of these women and how they assisted in this coping process throughout their cancer journey. The extrapersonal coping resources are described as resources employed in day-to-day efforts of the cancer patients to cope, which were external to themselves, such as specific therapeutic programme or modalities that they had learned to do themselves. They are labelled as extrapersonal resources because they refer to those resources that occur outside of the individual and that employ a specific technique (e.g. yoga, relaxation exercises, etc).
4.13.2.3 Role of religion in cancer coping and quality of life (Holt et al. 2009): Holt et al. (2009) proposed a model relating three main dimensions which includes religiosity, coping and quality of life (Figure 4.13). Religiosity is linked both to coping and improving the quality of life among cancer patients.

**Figure 4.13: Role of religion in cancer coping and quality of life**

![Diagram showing the relationship between religiosity, coping, and quality of life](image)

Source: Holt et al., 2009

Cancer can be a frightening experience because there is often no known cause of cancer, and prognoses and recurrence are often uncertain, it may be seen as somewhat uncontrollable and therefore stressful. As a result the individuals may look to their religious beliefs in thinking about cancer. The two concerns are very common among cancer patients and these are cancer fatalism and death anxiety. Cancer fatalism is defined as “the belief that death is inevitable when cancer is present” (Powe, 1994). There is an anxiety related to cancer among the patients which is referred to as death anxiety. Webster's New World Dictionary defines anxiety as a state of being uneasy, apprehensive or worried about what may happen; concern about a possible future event. The dimensions of religiosity such as locus of control, affect, adaptation, sense of meaning, faith/ belief, god as a healer and god as a help forms the important part of the model.

The religiosity helps in coping with cancer and the model suggests three religious coping styles including deferring, collaborative and self-directing.
(A) Deferring: A 'deferring' religious problem-solving in which the individual passively waits for solutions from God. Deferential religious copers seek control over problematic situations through a divine other, who then becomes a psychological crutch. Because this style is associated with lower levels of competence, it is regarded as part of an externally oriented religion. Pargament et al. (1998) indicated that a deferring coping style is connected with a religious orientation in which fulfilling individual needs involves looking for external rules, convictions and authority.

(B) Collaborative: A 'collaborative' religious problem-solving style involves active personal exchange with God and collaborative religious copers perceive themselves as being actively engaged in dynamic partnership with a divine other. A collaborative religious coping style appears to be part of an internalised committed form of religion, one that has positive implications for the competence of the individual. Pargament et al. (1998) showed that this coping style is related to an individual religious orientation in which religion is the motivating force.

(C) Self-directing: In a 'self-directed' religious style, the individual does not lean on God. “Self-directed religious copers employ religious cognition and activities only sparingly in response to stressors”. It is individual's responsibility to solve problems through the freedom God gives people to do so. In comparison to other two styles, the connection to traditional religiousness is very weak.

In this chapter, the conceptual and theoretical framework used for the present study is described in detail. The concepts of health, coping, religiosity, social support, quality of life, sick role, stigma and body image concerns have been discussed in detail. The theoretical framework is divided into two themes, namely, theoretical framework for the pre-diagnosis stage and theoretical framework for the post-diagnosis stage.