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Conceptualizations of Health and Illness Perspective

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Abstract: ***Health and illness issues have become major concerns for the last two centuries as more people wish to lead a healthy and long life. Major struggles in the industrial and post-industrial world have been to improve the health standards of its larger human population. The salience on health and illness has resulted in the emergence of the biomedical paradigm in modern times, based upon Western scientific philosophy. The biomedical (also termed biomedicine) paradigm has been successful in surpassing all other traditional health paradigms of health and illness. Its rising success and sheer scale of expansion have evoked counter reactions in many parts of the world, especially in healthcare. The present paper attempts to explore conceptualizations of health and illness through different ages of human history until today. It will examine the underpinnings of dominant health and illness paradigms and their limitations and, finally, explore some alternative paradigms from the health and illness perspective. The emerging health and illness perspective approaches endorse the idea that the complexities of human health and illness need comprehensive understanding. It cannot be arrived at by relying on any single formulation and conception of health and illness or adopting any single epistemological and methodological position. In contemporary times, health and illness conceptualizations embrace pluralism, which considers a given context's biological, psychosocial, cultural, political, and economic realities shaping health and illness representations.***

Keywords: Health, illness, biomedical, sociocultural, plural

1. Introduction

Health and illness are universal elements of human life that constitute the core of human social values. Health and illness issues have become major concerns for the last two centuries as more people wish to lead a long and healthy life. Major struggles in the industrial and post-industrial world have improved the health standards of its larger human population (Turner, 2000: 9-23). The present paper examines the conceptualizations of health and illness through different ages of human history until today. It will explore the underpinnings of dominant health and illness paradigms, their limitations, and some alternative paradigms. My submission is that human health and illness perspectives cannot be constructed using any singular conceptual or methodological construct. They can be understood by adopting plural approaches–ontological, epistemological, and methodological.

1) The Meanings of Health and Illness

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. " This definition contradicts the meanings of medical and existential illness and is disputed for being too vague. The conceptions of health and illness provide expression to basic human assumptions about life and death. They seem to emerge from individuals' subjective understandings. The sociology of health offers multiple meanings of health put forward by different stakeholders (Bambra et al., 2003). Many competing meanings of health coexist, such as health as an ideal state; health as a commodity; heath as the foundation for achieving potential; health as a personal strength or ability; and health as physical and mental fitness to do socialized tasks (Seedhouse, 1986). It has also been defined as the ability to adapt to challenges (Antonovsky, 1979); as a narrative, and as a metaphor (Lakoff, G. and M. Johnson, 1980; Burr, 1995) which is derived from our everyday conversations and mental map, we construct to lead lives (Bandura, 1997) and as spiritual strength (Zohar and Marshall, 1999). Health has been associated with a narrative of the good life based on the conception of morality and being normal.

These subjective value judgments on health are contradicted by the biomedical (also used as biomedicine in the text) paradigm. The medical community defines health objectively and biologically as a normal functional ability, the readiness of each part to perform all its regular activity on typical occasions with at least typical efficiency (Boorse, 1977: 542-575). The bio medics adopt this mechanistic and biological meaning of health.

The term "illness" has vague meanings too. McWhinney (1987: 873-878) interprets illness based on the patient's pathological frame of reference. He observes illness as a subjectively experienced state that may or may not have a definable organic disease as its cause. The physicians find the disease a more straightforward concept than illness. The term 'dis-ease' as discomfort is derived from the old French word 'aise' meaning 'comfort, ' which indicates that disease indicates a lack of comfort or ease. Jennings (1987: 865-870) avers that disease can be mechanistically defined as "pathophysiology or pathochemistry" and is diagnosed by demonstrating pathologic features. Disease, for him, is a matter of physics and chemistry, whereas illnesses are subjectively experienced phenomena that are opposite of "health. " He finds the "confusion between disease and illness" and argues that "illness is experience" and that disease can be investigated "by the methods of biomedicine" because the study of illness depends "directly on phenomenologic analysis of experienced suffering. He cites examples such as "one can be seriously diseased without being ill, as in the case of hypertension: one can be seriously ill without being diseased as in the case with severe depression.

Turner (2000: 9-23) argues that disease always arrives under the subjective understanding of alienation, discomfort, and loss of power, whereas normal provides a lay benchmark for things that are healthy and moral. For Engel (1977: 129-135), disease in its generic sense is a linguistic term used to refer to a certain class of phenomena that members of all social groups have been always exposed to in the history of man. It is assumed as an undesirable deviation or discontinuity from the normal. It is derived from a particular cultural belief system of disease that is not scientific but some folk models.

There has been a struggle between the socio-centric and biological meanings of health and illness and has come to the forefront due to the dominance of the biomedical model of health and illness in the present times.

2) Health And Illness: The Socio-Historic Context

One finds health and illness to be highly contested concepts with minimal consensus about these terms having some fixed understanding across the historical, social, political, and cultural context. In different phases of human history, these concepts never had any unified parameter for their understanding. There have always been struggles between the social, cultural, religious, and natural realms for illness attribution and its management; and between secular and collective notions of human illness and well-being (Turner, 2000: 9-23). These concepts have always been understood under the contested framework-nature vs. social-in different phases of human history. Turner (2000: 9-23) has traced the history of conceptualization of health and illness beliefs from pre-modern times to contemporary times. He finds a constant struggle between the socio-cultural and the natural scientific paradigms in human illness and health perspective.

The beliefs of health and illness in traditional or pre-modern societies were strongly tagged with the notions of religious purity and danger. There was no concept of scientific health and hygiene. The medical concepts dealt with the health of the soul rather than the body. In these societies, disease symbolized the relationship between the sacred and the profane. The diagnosis and treatment of disease were undertaken within a sacred domain.

During medieval times, illness and health perspectives contained a mixture of rational, scientific, and religious attitudes and practices (Turner, 2000: 9-23). It represented a secular orientation toward health where illness was seen as the consequence of natural causes. The Greek tradition of medicine also exposed the tensions between the individualistic and the collectivist notions of health and illness. The Greek legacy of medicine laid the foundations for the conceptualization of modern Western secular medicine. It was transported via medium of religions – Judeo-Christian and Islamic. Christianity adopted a model in which religions were made responsible for both the health of the body and the salvation of the soul. The doctrines of Christianity proposed that the body is a medium through which humans learn to suffer when they fall from spiritual grace. The disease was a kind of corruption that indicated the sinfulness of humankind, where suffering and pain led one to understand the relevance of God for his existence. Both sinfulness and illness were treated within the network of monetary exchanges whereby sinful laypeople bought salvation in the next world and health in this world.

Turner (2000: 9-23) argued that the emergence of rational capitalism in the seventeenth century had brought the notion of scientific, individualistic, and rational conceptualization of health and illness. The emergence of anatomy encouraged the observer to 'know thyself' and embrace the feeling 'there, for the grace of God go I. ' In modern times, the domination of the scientific biomedicine paradigm has been an undeniable reality in the realm of human illness and health. It is viewed as a secular model of health and sickness based on Western, scientific ontological, epistemological, and methodological foundations. The enormous success and dominance of the biomedical model in human health and illness brought forth the tensions between the individualistic scientific and the socio-cultural understanding of health and illness.

3) Dominant Paradigms of Health and Illness

The salience on health and illness has resulted in the emergence of a biomedical paradigm based on Western scientific philosophy. The biomedical paradigm has been highly successful in surpassing all other traditional health paradigms of health and illness in the present times. Its rising success and sheer scale of expansion have evoked counter reactions in many parts of the world, especially in healthcare. Albrecht et al. (2000: 1-8) comment that the financial and social costs associated with highly technological medicine, managed care, and heroic efforts to fight disease in the last years of life do not result in improved patient satisfaction or quality of life. There has been overwhelming skepticism about the effectiveness and care giving values of biomedicine. Various researchers have challenged the biomedicine paradigm, and compensations for its deficits are sought in alternative paradigms of health and illness.

Throughout human development history, one has witnessed a constant struggle between the natural and the social paradigms of health and illness. Since the 1970s, the dominance of the biomedical paradigm has been challenged by the psychosocial paradigm. Before moving to the issues of crises, the conceptual underpinnings of the existing paradigms of health and illness and their relationship in the modern context need some elucidation.

4) The Biomedical Model,

The bio-medical model of health and illness emerged in the seventeenth century and has been the most influential formal model of health and illness for the last two centuries. The biomedical model perceives that illness can be reduced to a localized pathological lesion such as cancer or infections within the confines of the body. This lesion affects the neighboring tissues, causing disruption to biological systems that result in negative experiences for patients and sometimes leading to death (Armstrong, 2000: 24-35). The primary goal of the medical physician is to locate the lesion after identifying the symptoms and clinically investigating the disease type and treating it. The biomedical model has been a scientific construct of health and illness that claims to provide clinical categories of disease that arise from close scientific observations of physical symptoms and are not

culturally or socially derived phenomena. Hence, they are timeless, scientific, and universalistic understandings of health and illness. People's belief systems about disease categories may change over time, but clinical conditions remain the same. It has no scope within its framework for the social, psychological, or behavioral dimensions of illness. Engel (1977: 129-135) argues that the biomedical model has become a cultural imperative and essentially a dogma in contemporary times. In science, a model is revised when it fails to deliver the expected results, but in the case of dogma, the discrepant data is forced to fit into it or be excluded. The biomedical model as a dogma requires that all diseases, including mental, be conceptualized in terms of some physical deficiency. It leaves just two alternatives to reconcile disease and behavior – reductionist, whereby all psychosocial phenomena of disease be conceptualized in terms of physiochemical principles or exclusionist, where they are excluded from the categories of illness.

5) The Psychosocial, Cultural Model

This model of health and illness believes that everyday understandings of reality shape health and illnesses experiences and therefore change with time and context. It is based on social constructionist perspectives of illness and health. The social constructionist perspective is based on three dimensions. Firstly, it assumes that social reality is not fixed or intrinsic but is a product of human interaction, so social reality emerges out of the constant flux of social exchange. Secondly, these meanings cannot be taken lightly as they are constantly contested in everyday interactions. Thirdly, human beings are self-reflective beings who continuously negotiate and change the meanings of interactions. The social constructionist perspective is relevant in health and illness as it helps find the negotiated meanings of interaction between doctors and patients. It also helps understand the determinants of illness at the micro-social level that reflect the more general macro beliefs.

Biomedical and socio-cultural paradigms of health and illness have existed as separate epistemological and conceptual understandings of health and illness. However, Armstrong (2000: 24-35) traces the development of the psychosocial model and argues that at every stage of its development, there has been a regular trade-off between the two health and illness constructs – biomedical and psychosocial.

In the first stage, the psychosocial paradigm accepted the monopoly of biomedicine and provided conceptual support to it. Psychosocial constructs helped understand the processes of identifying illness, assessing the consequence of disease, and discovering the causes of the disease. The identification of illness depended on the perceptions of both-the patients and the doctors. The problem of patients not seeing the professional physicians resulted in psychosocial explanatory exercises in the form of Health Belief Models to explain health-related behavior. Various psychosocial health constructs helped in identifying the intrapsychic determinants of individual behavior. The most durable form of association between biomedicine and the social sciences has been to explore the role of social factors in the etiology of disease. The sick role status, the doctor-patient relationship, and the psychoanalytical health theory have contributed significantly to biomedical intervention effectiveness.

In its second stage, the psychosocial model was less passive in accepting the dominance of biomedicine and made efforts to create an independent role for itself. It contributed by theorizing in areas like life events, labeling theory, and patient experience, which lay outside the framework of the biomedical model. During this period, Engel (1977: 129-135) advanced the notion of a biopsychosocial model of illness, which was seen as a significant effort to consolidate the psychosocial model but could not gain prominence.

In its third stage of development, the psychosocial perspective challenged the outward trappings of biomedicine, such as the profession's power, its increasing medicalization of population, and underlying social values encoded in scientific or value-neutral scientific knowledge. The psychosocial paradigm tried to move beyond the cognitive constraints of biomedicine by adding an alternative understanding of the nature of the illness. Hence, it challenged the monopoly of biomedicine perspectives in a big way. It no longer remained an addendum to biomedicine and focused on studying patients' perspectives of health and illness.

The biomedical paradigm received the bitterest criticism from Freidson's thesis (1970) that the biomedical profession was a product of political action in the wildest sense. This idea ushered in a series of recent studies that exposed the self-seeking appropriation of the biomedical domain. In addition, the concepts of the population's medicalization brought forth the medical profession's hidden agenda. Armstrong (2000: 24-35) claimed that biomedicine was seen to replace the church's role and law in policing the boundary between normal and abnormal. The thesis of over-medicalization strongly indicted the usage of medical knowledge for people's good and challenged the biomedical scientific epistemological underpinnings.

During its fourth phase of development, psychosocial theorizing questioned the cognitive basis of biomedicine underpinned by viewing biomedicine as a historically and culturally located model of illness. The radical and far-reaching implications of Freidson's thesis (1970) led to the questioning of the relevance of the biological reality of illness. Instead, illness is perceived as a socially constructed phenomenon. The concepts of normality and pathology could not be predicated in 'nature' but must be seen as socially situated. These perceptions widened the scope for critical evaluation of the biomedicine model of health. In its postmodern stage, the psychosocial perspective has engaged itself in constructing a world that itself can be explored under the reflexive and transformative framework.

The changing forms of association between the two paradigms at distinct stages of development lays the basis for examining the causality of challenges to the biomedical paradigm that have seriously eroded its exclusive monopoly in the health and illness perspective.

6) Challenges to the Biomedical Paradigm

The paradoxes of the biomedicine paradigm in health and illness have resulted in serious debates about alternative paradigms in health and illness studies. It becomes relevant to explore sources of discontent that challenge the dominance of the biomedical paradigm in the contemporary health and illness discourses. The reasons for crises in the biomedical paradigm are firstly, it rests on some flawed philosophical assumptions about health and illness, and secondly, some socio-cultural externalities that result from its overuse.

The biomedical, a highly reductionist paradigm, defines diseases in discrete and specific states of the human body. However, most of the illness representations are nothing more than the belief systems which explain the natural phenomena to make sense of what is disturbing or confusing. The more socially disruptive or individually upsetting the phenomenon is, the more pressing need humans must delineate explanatory systems (Engel, 1997: 129-135).
The biomedical paradigm culture-bound assumptions are inconsistent with the existing cultural plural realities. The biomedical culture-bound beliefs reflect the experiences of a particular white, male, formally educated group and share upper-or middle-class culture orientations. Understanding this specific culture group has been highly problematic in other cultural contexts. The Western egocentric proposition that locates individuals at the center of morality and culture is articulated in biomedical discourse. It does not reflect the beliefs of other cultures, which are significantly socio centric.

The other problematic culture-bound notion of biomedicine is the mind-body dualism that locates illness in either brain or mind, with the former being its major determinant. It separates mental from physical, whereas human illness is viewed as a psychosomatic phenomenon in other cultures. The crisis in the biomedical paradigm results because of its constant endorsement of a particular cultural value system and claiming it to be the universal discourse of health and illness. Bracken et al. (1995: 1073-1082) have rightly asserted that the cosmological and ontological focus on the individual, the underlying philosophy of biomedicine, is not universally endorsed. The universality assumption of biomedical categorization of illness has also been challenged by Kleinman (1987: 447-454) as a 'category fallacy, ' which he clarifies as:

(This is) the reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not been established (qtd. in Bracken et al., 1995: 1073-1082).

In addition, the biomedical modalities of treatment and therapeutic provisions are changed and adjusted according to the local cultural contexts. Bracken et al. (1985: 1073-1082) questions the universality of therapies developed for trauma patients in the West with 'egocentric' societal values for societies with socio-centric value orientations. Especially the non-western countries, where the western professional sector of biomedicine is undeveloped, the Western treatment modalities remain a dubious phenomenon. The major problem in biomedical models lies in its neglect of socio-economic, political, and cultural context in the dissemination of its knowledge, which has far more significant consequences as Bracken et al. (1995: 1073-1082) quote from Higginbotham and Marsella's review of implications of Western biomedical prescriptions for the third world countries, where they point:

…. investing authority in biomedical reasoning about human problems eliminates explanations of disorder at levels of psychologic, political and economic functioning. Consequently, problems with origins in poverty, discrimination, role conflict and so forth are treated medically (Bracken et al., 1995: 1073-1082).

The biomedical paradigm has also been challenged because of the externalities that resulted from its predominance. Some socio-economic changes also complemented it. In the 1970s, the growing dissatisfaction with biomedicine resulted in debates that challenged the centrality of professional medicine and the dominance of the medical model for its over-indulgence in the 'medicalization' of the population. Turner (2000: 9-23) comments that over professionalization and specializations in biomedicine have ended up in the era of medical-industrial collaboration where the concept of 'medicalization' of society and growth of iatrogenic illness took precedence over other things. In addition, some socio-economic developments in the West, such as the erosion of health security schemes, centralized welfare state systems, and the extreme commercialization of the medical profession, contributed to the questioning of the centrality of biomedical understandings of health and illness. During the same period, Thomas McKeown, a famous medical historian, and epidemiologist established that the great epoch of infectious disease such as TB has ended with improved housing, water supply, and food and education. The growing conflict between the individual and the social causes of the disease led to the emergence of the new discipline of social medicine.

The other point of distress with the biomedical paradigm is its alignment with power and authority structures. The over-indulgence in medicalizing problems, such as aging as disease with profound medical interventions, has been motivated by some hidden political and commercial interests. Friedman (1993) comments that the rich and the powerful have been attempting to deny aging; the mainstream grey politics has challenged the proposition that immobility, memory loss, and erosion of libidinal interest are inevitable consequences of aging.

7) Alternative Approaches of Health and Illness

The conceptualization of disease in purely individualistic terms and taking the context issues as mere factors has impinged upon the progress of now reified psychological or biological process (Bracken et al., 1995: 1073-1082). The fallacies of the biomedical paradigm led researchers to explore new paradigms of health and illness that will be more inclusive and considerate of the cultural concerns of broader humanity. The alternative framework for health and

disease in response to Post Trauma Stress Disorder (PTSD) for trauma victims proposed by Bracken et al. (1995: 1073-1082) in their study provides a comprehensive model for health and illness:

…. (proposed illness and health model) …issues of context in terms of social, political and cultural realities should be seen as central. By social reality we are referring to such things as family circumstances, available social networks, economic position and employment status. Political reality refers to the individual's engagement, or otherwise, in a political movement, their social position as determined by gender, class and ethnic factors and whether they are victims of state repression or other forms of organized violence. By the term cultural reality we are referring to such things as linguistic position, spiritual or religious involvement, basic ontological beliefs and concept of self, community and illness (Bracken et al., 1995: 1073-1082).

Some other approaches in response to the inconsistencies of the biomedical paradigm also have far-reaching consequences for understanding illness and health issues. The new models under these approaches have tried to incorporate the missing elements of the biomedical paradigm to provide a more holistic, comprehensive, and humanistic understanding of health and illness discourse. Some of them have been enumerated to give an overview of health and illness discourse direction.

8) The Biopsychosocial Model

The biopsychosocial model of health and illness is a more holistic and inclusive paradigm proposed by Engel (1997: 129-135) in his paper 'The Need for a New Medical Model: A Challenge for Biomedicine. Both –biomedical and psychosocial – paradigms adopt contradictory positions on health and illness. The former claims to be a universal and scientific understanding of illness and health, whereas others advocate for having constructed people's perspectives considering their particular context. However, both models can never be perfect in their exclusive realms. Engel (1977: 129-135) argues that contemporary medicine and psychiatry crises have occurred because they adhered to the same old practice, where the disease is defined in terms of somatic parameters, and psychosocial aspects are completely overlooked. The existing biomedical model of illness is not adequate for providing a complete understanding of the determinants of disease and arriving at the rational treatments and patterns of health care. The medical model should also consider the background of patients, the social context in which they live, and the complementary system devised by society to deal with the disruptive effects of an illness; that is the role of a physician and the health care system. Both paradigms should be fused to produce a holistic and pertinent understanding of health and illness. The biopsychosocial model for understanding the illness representations, diagnoses, and management is an inclusive scientific model that includes the ethnomedical perspectives of health and illness. It encompasses both – the patient's biological determinants of illness and his psychosocial context. In this way, by considering all the factors contributing to both illness and patienthood, the biopsychosocial model can explain why some individuals experience 'illness' conditions. In contrast, others regard them as simply the 'problems of living. '

9) Socio-Cultural Model of Biomedicine

This model has emerged as a recent paradigm in contemporary health and illness studies. It advocates for a plurality of biomedicines – global-local exchanges-that are socio-culturally situated rather than a single unified body of knowledge and practice. This paradigm advocates 'opening up' for comparative analysis of a medical system to a cultural studies approach in interpreting medical training and expertise. This trend leads to a new epistemological paradigm, 'naturalist and relativist epistemologies of science' in health and illness studies. Good (1995: 461-473) has revealed how local and international political economies of medical research and biotechnology shape the cultural, moral, and ethical worlds of biomedicine. He calls for research to focus on the dynamics, tensions, and exchanges between local and global worlds of knowledge. Integrating interpretative analyses with investigations of the political economies of biotechnology and the biosciences will eventually lift the biomedical paradigm from its current crisis. He argues that not only in poor countries, but the practice of biomedicine also varies in the local context due to the lack of poor infrastructure and resources. Practice of biomedicine, when compared across societies of equivalent wealth and a similar commitment to biomedical research and technology, such as Japan, Italy, and the United States**,** the practice of biomedicine is considerable variation in their practice, patterns, and standards of health care. These variations lead to the understanding that local medical cultures and political economies influence how clinical science and technologies are institutionalized in medical practice. Although the biomedical and socio-cultural understandings of health and illness have existed as separate epistemological and epidemiological realms in health and illness studies, the cultural studies of the bioscience paradigm have united them for analyzing the clinic's culture, the interaction between physician and patients, and public health and social policies.

10) The Narrative-Based Approach to Coping

The narrative has empirical as well as conceptual dimensions. It offers a new perspective by highlighting the role of the sociocognitive work those subjects do to give meaning and coherence to the events and situations they encounter and, more generally, to their life stories. In medical sociology, many studies have been undertaken to examine the subjectivities of the actors and their experiences embedded in different levels of interpersonal, structural, and symbolic contexts. The distinction of this approach lies in its restoring that part of an agency that is often ignored in the field of coping research. Ville and Khlat (2007: 1001-1014), through narratives, analyze about the significant events in the life of 26 people and conclude that people are not passive when they are facing the experience of illness but try to find a line of continuity again with the past to give meaning and coherence to their life history. They try to give meaning to their disjointed lives by innovating or adopting new representations and values. This approach gives way to methodological innovation by replacing traditional tools of measuring the sense of coherence and meaning/purpose in life using psychometric methods such as checklist and SOC (sense of coherence) constructs. The alternative perspective

based on the self as the narrative will reduce certain conceptual and methodological inconsistencies in the coping research.

2. Conclusion

The emerging health and illness perspective approaches endorse the idea that the complexities of human health and illness need comprehensive understanding. It cannot be arrived at by relying on any single formulation and conception of health and illness or adopting any single epistemological and methodological position. Throughout the history of human health and illness, multiple conceptual standpoints such as natural, social, cultural, individual, collective, secular, biomedical, and psychosocial have been witnessed. Even in contemporary times, the predominance of the biomedical scientific model has been countered by the emergence of psychosocial, cross-cultural, and socio-economic models in health and illness perspectives. On the epistemological front, the constructionist paradigm has contested the positivist scientific paradigm using multiple approaches such as discourse analysis, experiential studies, grounded theory, and narrative analysis to illuminate the intricacies of health and illness. In addition, one sees that along with modern biomedical therapeutic interventions, the traditional forms of healing and treatment practices have persistently existed in modern societies. As is universally established, humans, by nature, are designed to resort to multiple strategies to restore health after illness experience and make meaning in life after any disjointed event.

The health and illness perspective adopts pluralism as its underlying principle in contemporary times. Pluralism entails different culturally constructed ontologies of health and illness and their influence on patients, clinicians, health care workers, and family members. It considers the psychosocial, cultural, political, and economic realities of a given context in shaping health and illness representation. In addition, the exchanges between the transnational and the local biomedical world are being studied for a deeper understanding of health politics. The methodological field incorporates different approaches to collecting and analyzing data that can enhance understanding of health and illness. To talk about pluralism in the health and illness perspective is to consider concerns that reflect inclusivity, reflexivity, and creativity.

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