Sociology and psychology – the scope of cooperation in studying the problems of health and disease

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ABSTRACT

The aim of this dissertation is to identify the scope of convergence of sociology and psychology with special attention to the areas which are especially essential in the analysis of phenomena connected with human health and disease. World Health Organization has defined health as bio-psycho-sociological wellbeing and thus has pointed out three areas which are indispensable in maintaining homeostasis of health (biological, mental and social area), and indicated three disciplines whose mutual cooperation is essential for building up complete knowledge of health and its determinants. Medicine, psychology and sociology are the fields of knowledge whose cooperation is essential to support individual and social health.

Regardless of the distinct fields of research that sociology and psychology cover, it is relatively easy to find within them some common scope of interest relating to health. The most important area of expected cooperation is the problem of psychosocial stress. Another identified areas of cooperation for sociology and psychology are social support and its influence on health, the issue of doctor-patient interaction and its psychotherapeutic effect as well as psychosocial determinants of health and disease.

Research cooperation between sociology and psychology in the above mentioned areas can contribute to its in-depth exploration which may result in practical implementation of acquired knowledge in the areas of health and disease.

Key words: sociology, psychology, human, health

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Motto**:"**Associations between social and psychological factors /…/ and health are now well established."

[Chloe E. Bird, Peter Conrad, Allen Freemont, Handbook of Medical Sociology, 324]

INTRODUCTION

Problems defined as the "sociology of sociology of medicine" have accompanied our subdiscipline since its original inception. Medical sociology (later the sociology of health, disease and medicine) has sought its identity, trying inter alia to define similarities and differences between what it investigates (or would like to investigate) and other disciplines concerned with phenomena related to health and illness, in particular medicine understood as an organization system and a system of knowledge [1,2]. As early as the 1960s social researchers describing and interpreting the area defined by the terms: health - disease - medicine had to determine their attitude to other disciplines exploring analogous phenomena and processes from different perspectives and in different ways. It was then that sociologists first debated and wrote about their relationships with the anthropology of medicine, bioethics, pedagogy of health, and psychology [3].

The present paper will particularly focus on the last discipline, i.e. the psychology of health, disease and medicine, which appears to be a natural, useful and inspiring partner in the currently dominant multidisciplinary approach in science, based on the cooperation of various disciplines as part of the "team approach" [4]. During the first two decades of its evolution, the sociology of medicine developing in Poland "copied", adapted and interpreted the main research ideas and theoretical concepts arisen earlier in the West, referring them most often to the ideas developed in the USA, UK, Germany, and in the Scandinavian countries [5]. That is why we will adopt this "Western perspective" to look at the relationships with and attitude of medical sociologists towards the "nearest neighbor" – the psychology of health and disease.

A co-founder of Polish medical sociology, Antonina Ostrowska, wrote '(…) membership of the European Union was accompanied by reflections on Polish interests, loyalties and hopes connected with the United States. This often provoked the question whether Europe is "closer to us" or the United States. These issues appear remote from the problems of medical sociology, but from a somewhat more general perspective they show that Poland's endeavors to be "westernized" have always had their distinct American and West European context (…). Western Europe on the one side and the United States on the other have for years functioned as standard-setters in Poland (…) including science.' [6]. To what models and "standard setting patterns", therefore, did the Western concepts concerning relations between psychology and the sociology of health and disease refer? For example, Weiss and Lonnquist (already cited) emphasize that one of the main areas of sociological inquiries into health and disease is to explain the mechanisms of social stress, health behaviors, and "experience of health and disability". In this interpretation the authors are concerned with individual experiences, emotions and mental conditions of patients by referring to the knowledge, concepts and paradigms specific to psychology (from W. Cannon and H. Selye to H. Lieberman, T. Holmes, and R. Rahe).

This is also the case is with the description of the mechanism of coping with stress (Specific Coping Techniques). While discussing social roles associated with risks of exposure to stressors which are the consequence of conflicts, e.g. related to gender definitions or resulting from one's job, they again emphasize the importance of psychological conceptions concerning this term (Psychological Distress) [2]. One of sociology's theoretical foundations is the concept of health behavior. Weiss and Lonnquist discuss at length this problem as presented by John Ware, describing six fundamental models explaining the mechanisms of "behavior in health", including two relating to the terms "psychological well-being" and "mental health", the description being entirely based on the findings of health psychologists [2].

Similar issues of "the experience of chronic disease" and disability are based on the concepts of psychological effects of stigmatization, labeling, and "socially imposed marginalization", and on the findings of M. DiMatteo, M. Robin, and H.S. Friedman [2]. Other examples of "socio-psychological interpretations" can be found in the studies by Michel Senior and Bruce Viveash, who, when characterizing "the anatomy of responses to illness" in their monograph ("Responses to Illness") use explanations relating to the psychological concept of self-identity as interpreted by William James and Susan Sontag, presented mainly in her monograph "Illness as metaphors" (1991) [7]. Senior and Viveash again refer to literature on clinical psychology and psychothanatology when discussing the process of dying and the mental effects of mourning and "feeling of loss" [7].

Discussions on the "sociology of mental illness" are in turn based on the sociological and psychological findings of Rosenhan and Seligman, which show inter alia seven criteria for defining an individual's behavior as "abnormal". In this context, the two authors interpret the mechanisms of social control of schizophrenics exclusively in terms of the concepts used by social psychiatrists: Schneider, Slater, and Roth. [7]. After presenting

this selective description of psychological themes in the classical Western sociology of medicine, we will sum up this line of discussion by referring to scholars who devote most room to these problems [3]. They are presented in the chapters "Social and psychological factors, physiological processes and physical health" [8] and "Medical sociology and health psychology" [9], which are a systematic exposition of arguments for equal partnership cooperation in the area of health and disease "practiced" by medical sociology and psychology. Fremont and Bird start from the assumption that the future of studies on health and disease will be the gradually expanding cooperation between sciences and disciplines that can make up a common research model providing genuine chances of obtaining valuable results. The authors explicitly say, 'As an inherently interdisciplinary field, sociology is in excellent position to embark on such collaboration' [9].

Bird, Conrad and Freemont emphasize that after Hans Selye's discoveries (GAS – General Adaptation Syndrome) medical sociology started systematic studies on relationships between social, psychological and biological-physiological factors whose joint influence accounts for the etiology of a number of civilizational diseases. In this model, individual groups of complex causative elements with different force may directly or indirectly produce or accelerate pathological changes [10]. Another good example of possible exemplifications is the model of social stress with its complex consequences. Fremont and Bird point out numerous, well-documented clinical studies showing cause-and-effect relationships between psychological factors (feeling of loss, loneliness, lack of the meaning of life, etc.), social factors (breakdown of the family, consequences of unemployment, economic deprivation, etc.) and the impairment of the immunological system [8].

Similar parallels can be seen in the cause and effect chain, relating to the etiology of cardiovascular diseases (coronary heart disease, ischemic heart disease, myocardial infarction). These types of relationships have been well known to health sociology and health psychology since the early 1990s. The cited authors present e.g. examples of the interrelationship between acute social stress and its consequences i.e. occurrences of heart attack episodes [8].

The conclusion of discussion on the affinity between the sociology and psychology of health, disease, and medicine is the position represented by D. Umberson, K. Williams and S. Sharp. Writing about mutual relationships between the two disciplines, the authors say, 'Health psychology is sister to the field of medical sociology' [9]. Both disciplines investigate the same problems and use similar or approximate methodologies, taxonomies, and theoretical constructs. Generally, the difference in research approaches lies in preference for explanations referring to structural, cultural and stratification differences (sociologists) or individual, personal ones (psychologists). Facts and relationships investigated by the two disciplines can form complementary etiological conceptions such as Saxon Graham's "etiological chain of diseases" [11].

Umberson, Williams and Sharp emphasize that categories important for health sciences such as social support, behaviors related to health and illness, and determinants of social stress can be explained only by jointly analyzing complex sociopsychological elements. The traditional divisions that artificially separate the two disciplines: psychology and sociology in the age of currently dominant holistic models should be gradually blurred and lose their importance because shared complementary elements are becoming more important than particularistic specificities. The comprehensiveness, complexity and multifactoriality of relationships between health/illness and the social world imposes desirable cooperation upon both disciplines: it has a chance of increasing their efficiency and the status of the obtained results [9].

To sum up and generalize our earlier remarks, it can be said that in the history of science it is possible to observe different phases and stages of the relationship between psychology and "the external world", and different ways of referring to the term "homo socius". Of unquestionable significance to the students of "the individual" and those analyzing "facts concerning the community" was behaviorist psychology established by John B. Watson, who maintained that because behaviorism created inter alia a model of controlling society and the pattern of communal life organization, it was an attractive offer to sociologists [12]. The gradual emergence of social psychology from the area of psychological sciences again brought the disciplines in question together. The above kind of psychology sought explanatory variables mainly in the elements of social life. Well-known are the discussions provoked by the question of Gordon W. Allport, Morris Rosenberg and Ralph Turner whether social psychology is closer to sociology or to general psychology. Without going deeper into the dispute over the existence of two versions of social psychology: psychological and sociological, which differ in their theoretical background and methodological foundations, it can be said that situating of the scientific systems established by George Mead, George Homans or Erving Goffman in sociology is not challengeable; such concepts as Gustave LeBon's "psychology of the crowd", theory of socialization processes, or Herbert Blumer's "theory of social actions" have entered the canon of world sociology [13].

An indisputably important common task of sociology and social psychology is to investigate, describe and interpret sociocultural factors that impact behaviors, attitudes, and consciousness of the individual. The ways of interpreting this class of phenomena were borrowed by social psychologists at the same time and parallel both from sociology and psychology. As Mirosława Marody stresses, social psychology, building mutual relationships between social structures and individual behaviors, refers inter alia to such concepts common to both disciplines as anomie, habitus, habits etc. It could be observed that these terms have been used in Polish medical sociology [14,15].

In the Polish sociology of health and illness the psychological themes and subjects were included to the canon of the subdiscipline already by Magdalena Sokołowska. Contemporary discussions of this type comprised inter alia the description of the sociopsychological environment of the hospital, investigation of doctor-patient interactions with a simultaneous reference to the perspective of sociology and psychology, adaptation of psychological anxiety indicators and ill-feeling, etc. [16, 17].

In the next monograph /1976/ which is now part of the canon of present-day Polish medical sociology (Sociology and Health [*Socjologia a zdrowie*]) the psychological-social approach already constituted a distinct set of issues, comprising, among others, discussion on the role of social and cultural factors impacting the evolution of the subject of psychotherapy, presentation of the model of research on mild mental retardation, adaptation of the concept of the "social role of the patient" for the needs of psychiatry, or the project seeking causal relationships between epidemiology and the dynamics of mental disorders in Poland in structural and stratification factors [18,19].

Summing up the historical evolution of the Polish version of medical sociology during the first twenty five years of its existence M. Sokołowska (1976) emphasized the importance of "sociopsychological aspects" as part of exploration of the subdiscipline's research field. M. Sokołowska made "the feeling of discomfort", which has psychological, sociological and physiological components at the same time, one of the key terms. She also devoted separate room to discussing sociological and psychological aspects of pain, and the mechanisms of occurrence and consequences of social stress (the character of stressors, "stress response scenario", strategies for coping with stress).

Another theme introduced by the founder of Polish medical sociology was "the concept of psychosomatic illness" with reference to classical research patterns created by S. Croog, J. Groen, S. Levine and N. A. Scotch, concerning the role of social stressors and importance of structural and emotional factors in the etiology of stress [20]. We should add that a new, autonomous theme found in this volume is the thanatological subject matter. Sokołowska broadly discussed the concepts of "consciousness of dying", "psychology of death", and communication with the dying person, using the concept of "death trajectory" after Glaser and Strauss etc. [20].

The introductory part of this paper outlines the mode of interpretation of problems in a broad sense, combining the sociology and psychology of health and disease, seen mainly from the perspective of sociologists. It appears interesting, nevertheless, to signal the same issues from the perspective of their partners: health psychologists. Therefore this point of view will be also briefly presented.

The introduction to the first Polish handbook of psychology reads inter alia: 'Transformations of health care and social care require use of new forms of collaboration of psychologists with other specialists – sociologists /…/' [21]. As is the case with Western handbooks, H. Sęk and I. Heszen, while discussing the origin and subsequent evolution of health psychology, refer to the concept of behavioral medicine - for example the model of "the matrix of problems in behavioral medicine" lists three main partners in health science research: psychology, medicine, and sociology. Defining the identity of this orientation as a multidisciplinary discipline, Heszen and Sęk stress the need "to go beyond the psychological paradigm" and take account of references to the achievements of sociology and medicine [21]. The areas that naturally bring together the two disciplines are e.g. the concepts of "health interpreted as wellbeing or potential", quality of life, socioecological paradigm /H. Noack's concept/, health behaviors and lifestyle, etc.

Holistic concepts of health – the role of psychosocial factors in the process of health

Holistic concepts of health underlying the analyses both in psychology and sociology of health and disease emphasize the multi-dimensionality of health and diversity of its determinants. The World Health Organization's definition of health formulated in 1946 can be regarded as the first concept of this type. Rejecting the negative definition, which treated the absence of disease as the only criterion for health, WHO indicated three areas where the optimal level is necessary for the experience and maintenance of health: biological, mental, and social wellbeing [22]. The definition thus formulated shows that health is a state of dynamic balance between three spheres of an individual's functioning: the physiological state and the feeling of mental and social comfort. Apart from unquestionable advantages of this concept, i.e. the holistic

interpretation of determinants of individual health, its essential characteristic should be pointed out: the definition shows that health is not an objective value but a subjective one, determined by individual, cultural and structural features characterizing a specific person.

If health is a state of subjectively perceived balance in the functioning of an individual, the feeling of it changes with the social situation, environmental conditions, and norms and customs of particular social communities. It depends on goals and values which guide human aspirations. It becomes important insofar as it is located in the context of space and time, and in reference to the features of a specific individual [23]. Consequently, objective medical criteria are no longer sufficient in order to define the state of health or disease: it is necessary for specialists in psychology and sociology to collaborate to jointly define the criteria for mental and social wellbeing – different ones depending on an individual's psychosocial resources, his social position and the culture he lives in.

The 1970s was the period of fast spread of the new holistic health paradigm. At that time many pioneering ways of viewing health and its determinants appeared. The first to be named should be the concept of the etiological chain of diseases by Saxon Graham, co-founder of American classical sociology of medicine, who investigated health from the broad environmental perspective taking into account special features of the human social habitat and the character of natural environment. Graham distinguished many groups of factors originating from different levels of human functioning which, by co-occurring, increase the risk of occurrence of specific diseases [24,25]. Among significant variables positioned in the polyetiological chain there were both personality factors, social roles, ways of coping with stress, an individual's social position, and the genetic resources of the organism and its wear and tear consequent upon of the lifestyles and past diseases [24]. The co-presence of biological, psychological, and social factors in this concept that come from different levels of an individual's functioning stresses the need for collaboration between medicine, psychology, and sociology.

Another holistic approach to health is the classic health-science concept of M. Lalonde's Health Fields [26]. Formulated in the early 1970s, it is still a relevant, comprehensive interpretation of factors that determine the health of individuals and society. The Polish National Health Program [27] based on this model points out four groups of factors which, in the context of present-day incidence and mortality rates, exert the greatest impact on health. These are: life style, genetic factors, environment, as well as the character and traits of the health care system. Two of the foregoing factors have a distinct social component. Lifestyle, socially and culturally determined, accounts for 50-60% of all effects in the process of shaping human health, while 20% is attributed to the environments – both physical and social. Lifestyle, so important for health, is a function of multidimensional relationships and sociopsychological factors that are involved in life choices made by individuals. Of significance here are both the elements of social background: the position of an individual in the stratification system, culture or the system of values and norms, and an individual's mental dispositions (personality, social consciousness, motivations, feeling of coherence, etc.). The knowledge of social environment-related risks analyzed now in the context of psychosocial stress requires an in-depth analysis, both psychological and sociological, which is of special significance with the prevalence of psychosomatic disorders without distinct organic causes, which occur increasingly often among the Polish population.

The fact of multidimensional determinants of health is also emphasized by the Mandala of Health, the so-called model of the human ecosystem. It emphasizes a number of complicated interactions between human health and many systems of which man is a part. The Health Mandala is made up of a series of circles surrounding a person who is their center. The main areas determining human health are "culture" and "biosphere" – the opposing scopes, as it were: biosphere existing independently of human actions, and culture entirely created by man. Between them there are a number of bio-psycho-social factors (e.g. work, family, psycho-socio-economic environment, lifestyle, physical environment, human biology) which, while determining health, interact with one another at the same time [28]. The Health Mandala, therefore, presupposes a close mutual interaction between the sociocultural and ecological environments [29].

The Mandala of Health has become part of the socio-ecological health paradigm, which emphasizes the role of socio-economic and cultural factors in the process of shaping individual and social health. However, as Noack observes, health or illness are not a simple consequence of specific social and environmental factors but the effect of multiple and complicated relations between the conditions of social life and an individual's physical and mental resources [30].

According to the foregoing interpretations of health, it is a multidimensional phenomenon that cannot be described using only one parameter, thereby implying both the interdisciplinarity of health problems and actions taken in its field. Therefore, for a higher efficiency of these actions both in the research field and in the practice of social life, the participation of specialists in

different disciplines is necessary, while representatives of behavioral disciplines such as psychology and sociology should be equal partners supporting the doctor both in the process of diagnosing health condition and in maintaining it at a satisfying level.

The Model of psychosocial stress as an inspiration for interdisciplinary collaboration

The currently most important area of expected collaboration between sociology and psychology appears to be the problems of stress in a broad sense. The holistic approach to health stresses the role of psychosocial health-shaping factors, and puts special emphasis in this field on the role of stress in the etiology of present-day diseases.

Ample literature on the subject shows that there is a substantial connection between social living conditions, the experienced stress, and the condition of a person's life, both physical and mental [31-35]. Psychosocial stress is now viewed as one of the major health risk factors. Chronic stress of different origin, both micro- and macrosocial, produces far-reaching consequences for human health [36,37]. J. Bejnarowicz distinguishes two kinds of stress effects:

1) indirect health effect: diseases – coronary and neoplastic, but also almost any frequent disease, from heart diseases to flue,
2) direct health effects and closely associated effects:
   a) subjective effects (e.g. anxiety, aggression, apathy, depression, irritability, etc.)
   b) health effects (e.g. pain syndromes, diarrheas, fainting, indigestion, etc.)
   c) effects manifested in particular behaviors (e.g. overuse of medicines, emotional outbursts, eating too many meals or loss of appetite, etc.)
   d) organizational effects (e.g. absence from work, bad relations at work, low efficiency, lack of satisfaction from the job, etc.) [38].

After carrying out a meta-analysis of studies on the relationship between psychosocial factors and health, B. Dudek points to several systems of the human organism, particularly sensitive to the pathological impact of stress. These are: the circulatory system (hypertension, coronary heart disease, stroke, heart attack), the alimentary system (ulcers), the nervous system (depressions, neuroses), the motor system (muscular pains, spinal pains), the endocrine system, in which stress produces various disorders, and the immune system (cancers, lower immunity) [39].

It is now assumed that psychosocial factors involving stress can bear at least half of responsibility for health [38,40,41]. Although the mechanism of the effect of stress on health is difficult to explain in unambiguous terms, there is a lot of evidence of its destructive action. The final health effect is, however, a function of a number of factors related to stress intensity, duration of impact, human reactions, and the special support a person receives [42]. We can therefore venture a proposition that psychosomatic disorders suffered by more than half of the Poles nowadays "consist not so much in physical damage as in expression of their life problems and failures" [40].

It is estimated that ca. 50% of patients consult their doctors about somatic symptoms that have no underlying equivalent in organic changes [20,43], which provides grounds for suppositions that the source of these ailments and symptoms is stress and difficulties with "coping". Consequently, psychosomatic disorders diagnosed in more than half of the Poles may result from the lack of sufficient abilities to adapt to the growing social problems (unemployment, breakdown and decomposition of the family, mass migrations, etc.). Without analyzing the stress theory in detail because these problems have been thoroughly described in psychological literature, it is nevertheless necessary to refer to Lazarus's approach - the author of the concept of relative stress, who distinguished three levels of it: social – one that describes an individual's relationships with other people, psychological – one that covers an individual appraisal of a situation, and the biological level concerning changes in the functioning of human organism as consequences of the impact of stress. To put it very simply, we can say that the multidimensional treatment of stress corresponds with the biopsychosocial model of disease [44].

Sociology enriches the knowledge about stress with information on its macrosocial sources connected with the functioning of global society (risk society) and with processes and phenomena taking place within it. Functioning at the microsocial level, in social roles (role conflicts, overburdening) and in small social groups (family groups, employee groups, peer groups) is also classical sources of stress with which a person has to cope, regardless of his age and position in the social stratification. These issues have been present in the Polish sociology of health and illness since the beginnings of the discipline, which can be exemplified by M. Sokołowska's text (published already in 1984) about the concept of stress in interpreting the mechanisms of biological and social adaptation [45]. We cannot fail to also mention the pioneering monograph by A. Titkow, "Stress and Social Life. Polish Experiences" [Stres i życie społeczne. Polskie doświadczenia] [46], in which the author shows the sociological interpretation of the problems of social stress in relation to the transformation changes in Poland in the 1990s. Publications on social stress appeared in the nationwide interdisciplinary periodical "Promocja Zdrowia. Nauki Społeczne i Medycyna"

(no. 8-9 was entirely devoted to the issues of social stress) [47].

It is particularly in this area that sociology and psychology can help each other. The former offers an extensive knowledge about the social sources of stress linked to the functioning of an individual in large and small social groups, identifies social stressors that might be ignored or underestimated by specialists in other disciplines, and it also points out the sociocultural determinants of reactions to difficult situations. Psychology, in turn, generates knowledge about the mechanisms of how stress arises and functions, about individual responses to stress, and the ways of coping with it. However, the area shared by the two disciplines is the knowledge about health consequences of stress, i.e. diseases and health disorders consequent upon the simultaneous (and parallel) action of social and psychological factors.

Social support in health and in illness – common areas and demarcation lines

Social support and its effect on health is another area of necessary collaboration between sociology and psychology. Social support systems, which are part of the structure of present-day society, are some of the more essential elements of strategy for coping in crisis, but they also have a preventive action protecting against all types of risks, including health hazards. Although the buffering hypothesis of support, claiming that support protects against the appearance of adverse health effects as a reaction to a high stress level, has not been definitely confirmed in clinical psychology studies [48], yet it will not be an exaggeration to contend that support is a factor protecting against the harmful effects of stressful life events, at the same time increasing individual resources for coping with them [49]. Research suggests that a high level of social resources, strong social ties, and support are linked to a better health condition [50-53].

The indisputable fact of the positive effect of social support in different dimensions of human functioning makes the issues of support a significant area of exploration by many health sciences, including health sociology and health psychology. A thorough and multifaceted (interdisciplinary) analysis of support permits getting to know social expectations associated with it, and first of all the social and health effects arising from the support one experienced, which at the same time increases chances of effectively stimulating supportive measures both in health and in illness [54].

As H. Sęk and R. Cieślak observe, knowledge about support initially came from clinical observations and from the activities of mutual-help and self-help groups, which researchers associate with the trend of community psychology [48]. However, the studies on local support resources, the number and quality of self-help groups functioning in a particular area, and forms and manifestations of their activity might well be classified as the problems of sociology of local communities. In the broad interpretation, support is related to the phenomenon of social integration, whose dimension is the specificity and character of social ties, this being one of the problems that are the subject of sociological interest almost from the beginnings of sociology.

Already in 1897, in his work *Suicide*, E. Durkeim demonstrated links between the level of social integration and the number of suicides, thereby laying foundations for the first sociological suicide theory [55].

Support analyzed as the feeling of belonging to a larger social group, the availability of relations owing to which human interpersonal needs are satisfied, gratifications gained through contact with persons of importance in the social environment, is an indisputable factor that improves the functioning of a person in the environment and increases the level of his adjustment, thereby it has a positive effect on his health [48]. An extremely important variable is the fact of availability of that support. Support seen as available is regarded as one of the most significant psychosocial factors, confirmed by research, that impact an individual's physical health [56].

Literature most often analyzes the effect of support under conditions of crisis situations accompanied by psychosocial stress. Stressful life events such as death, illness, problems at work, at school or in the family increase the need for support whose resources, and the mode of receiving and perceiving it modify the ways and level of coping with crisis [57].

In the structural interpretation, support is the objectively existing and available social networks which, through the existing ties, perform an assistance function to those in difficult situations. Although in this approach support is not identical with social integration and a social group, because it depends on the qualitative and quantitative characteristics of these structures [48], yet a *sine qua non* condition for its activation is the objective existence of social support systems. They are both institutions (networks of institutions) that provide different forms of support to persons and families, and the non-institutional system consisting of all kinds of help groups, self-help groups, foundations and associations. An extremely important support system is the people in a person's closest environment. Usually, they are the family, but the system can also include friends or close acquaintances. These natural sources of support have the most beneficial effect on health because they are easily accessible, do not cause

stigmatization and usually involve the relation of interpersonal trust [58].

In building knowledge about the mechanisms of creating social support systems in this sense, their character and specificity, as well as functionality and dysfunctionality, the capabilities of sociology appear to be invaluable as it devotes a lot of room precisely to this kind of elements of social life. In contrast, psychology first of all focuses on the detailed mechanisms of how support works, on variables modifying its impact, and on consequences, both psychological and health-related. Collaboration between psychology and sociology in this area, both empirical and applicative, may contribute to increasing the efficacy of the supportive influence in diverse situations of the need for help and support. The knowledge about sociological mechanisms of the functioning of social groups that are part of both the secondary (groups, associations, foundations) and primary sources of support (family, friends, neighbors) complemented with psychological knowledge provides a genuine basis for effective stimulation of such measures.

Doctor/patient interactions – sociopsychological themes

Another identified of cooperation between psychology and sociology is the problems of doctor-patient relationships and their diverse consequences. From the sociological standpoint, a doctor-patient interaction is a classic example of a social relationship based on social roles played by both parties to the interaction. The way of playing roles is determined by the cultural and institutional context created by society and medical institutions. During interaction both parties interact with each other using a specific set of behaviors, gestures, symbols or requisites at their disposal [59] in order to achieve the highest possible effectiveness of their action.

The problems of doctor-patient interaction are a classic object of interest of medical sociology. From T. Parsons onwards, who presented the characteristic features of this relationship already in 1951 pointing out its asymmetry and complementarity [60], the next scholars, mainly sociologists, sought its most essential characteristics, socio-cultural determinants, and factors deciding its effectiveness. Szasz and Holender stressed the interrelationship between this relation and the specificity of a disease (health situation) determining the level of the patient's activity;

Freidson pointed out its conflictual dimension caused by the "clash of perspectives" of the doctor and the patient [61], whereas DiMatteo, referring to the Szasz and Holender concept, was in favor of the model of participation and joint responsibility of the two partners to this relation (doctor and patient) in the treatment process [61].

As the clinical pictures of diseases changes and transformations take place in global society and in the organization of the health care system, the expected models of this relationship change. Commercialization in health care, the progressing consumerism that makes the patient the doctor's client, or the new forms of health care management that contribute to deprofessionalization of the doctor's profession, compels the definition of a new conceptual framework for the doctor-patient relationship, in which "professional dominance" will certainly be replaced by the concept of "countervailing powers" [62].

The doctor-patient relationship, on account of its interdisciplinary dimension, is also of interest, apart from sociology, to other disciplines, including psychology [44].

As the authors of the often cited psychology handbook say; 'the meeting of doctor and patient is interpersonal. The patient takes part in it as a person, committing his hopes and fears, views and strivings; he would like the doctor to take this context into account. (…) and the doctor also has expectations concerning the patient's attitude towards doctors, and expectations concerning his (doctor's) profession' [44]. Apart from the diagnostic-informative and persuasion functions the proper doctor-patient relationship also has one significant function – the therapeutic one, whose objective is to improve the patient's psychophysical condition by eliminating his emotional tension and illness-related fears [63].

The doctor-patient interaction is a social relation in which socio-emotional behaviors of both parties appear [64].

Sociology focuses on socio-cultural determinants of this relation while psychology focuses on persons and their relationships, individual determinants of how the contact proceeds, and on the importance of personal participation by doctor and patient [44].

Building the right relationship based on mutual trust, respect, and empathy is of fundamental importance both for the understanding between the doctor and the patient, and ultimately, for the final results of treatment prescribed by the doctor. It is possible only with effective communication between the interaction partners, both at the verbal and non-verbal levels.

Collaboration between sociology, which interprets doctor-patient interactions in the broader socio-cultural and institutional context, and psychology, which, focusing on persons and their relationships, indicates the most effective forms and ways of communication, may contribute to both disciplines developing the optimal forms and ways of management in prevention, treatment, and rehabilitation.

CONCLUSIONS

The sociology and psychology of health and disease have many areas of conscious and unconscious common interests. The present study has outlined the problems of crucial importance for both sociology and psychology: these issues appear to be particularly significant from the perspective of optimizing actions in the area of health and disease. There are more and more of those areas in common, and they grow proportionately parallel with the development of present-day health sciences evolving towards the multidisciplinary holistic model based on the "team approach" concept – it is these factors of growing importance that should bring together the two "sister disciplines".

Therefore, without losing sight of particular methodological, theoretical and taxonomic differences, sociology and psychology should, while retaining their identity and autonomy, build a vision of deeper cooperation and collaboration because the future decidedly lies on the side of enlightened convergence, the more so that there are far more bridges than walls between the two disciplines.

Conflicts of interest

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