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Healthcare in the Context of Cultural Diversity: Representations and Experiences of the Body in Different Cultures

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Abstract

The global movement of people has created social changes that have in turn resulted in an unprecedented cultural diversity of religions, ethnic groups and modes of living. This diversity requires us to redefine priorities in healthcare. In Portugal, a multicultural country, there is an evident need to support people from other countries and of different races, beliefs and cultures in matters of health and illness. We chose to study patients and their families who identify with Muslim and Hindu cultures because this population, which is part of Portuguese society, is undergoing intense suffering and prioritizes religious and cultural principles in the care of sick bodies. This ethnographic study is part of a doctoral dissertation. The results showed differences in how each of these cultures perceives everyday life; however, under conditions of illness, these individuals tend to agree on the physical feelings they experience and the strategies to overcome them. In general, the experience of the Sick Body is expressed by both cultures in terms like “the Public Body” and “the Disobedient Body” and in issues associated with “Privacy”.

Keywords: Health Care; Multiculturalism; Islamism; Hinduism; Sick Body

Introduction

The phenomenon of multicultural countries and cities is largely due to the unprecedented flows of migration over the course of the last century. Today, we live in a multicultural society, and although migratory flows have been in existence for many centuries, it is only in recent decades that an awareness of this historical reality has developed due to increasing migration worldwide and the impact of cultural minorities on their host countries.

Many people leave their home countries in search of improved living conditions for their families and new economic, cultural and social horizons. However, their integration into other societies and cultures can often be traumatic (MAYOL, 2003).

Some authors have suggested that the awareness of living in a multicultural world where “different” people share the same or neighboring space is an integral part of contemporary life, in which the notion of culture is under question because time and space themselves have been dislocated (GIDDENS, 2000) and compressed to their limits (HARVEY, 2003). The traditional notion of culture has substantially changed because all societies and countries are composed of multiple cultures cohabiting in one space.

Societies today include cultural systems based on different ethnic and religious groups and subcultures. This diversity leads to profoundly new forms of expression and lifestyle that nevertheless share some systems of meanings and rituals.

It is tempting to define our identity in the terms of what belongs to us. However, the current challenge involves a change in perspective: what we are does not depend on what belongs to us but on that to which we belong (AUGÉ, 1994).

The International Organization for Migration (IOM) reported that in 2009, approximately 214 million people lived outside of their native countries. This group represents 3.1% of the world population; women represent 49% of migrants, and 20-30 million are illegal migrants or refugees.

Portugal has traditionally been associated with emigration, which has been conditioned by the structural and cultural characteristics of its society and economy, model of development, and the presence of Portuguese communities across the world (RAMOS, 2004). Currently, Portugal is home to people from many countries, mostly Brazil, Eastern European nations and Portuguese-speaking African Countries (PALOP). The Muslim population of Portugal is estimated at 30-35,000 people from several countries, and the Indian population comprises approximately 70,000 people (mostly Hindu, but also Catholics, Muslims and Ishmaelites). Together, these groups represent 0.5% of the Portuguese population.

Leaving one's homeland to live in an unknown country, often without one's family, is a traumatic process both because of what is left behind and particularly because the chances of returning to one's native country in the near future are low.

RAMOS (1993:561) observed that the migratory process "*is not a mere synonym for cultural encounters because it involves social and psychological adjustments to the receiving culture, a new, unknown or hostile environment. This adjustment depends on multiple factors related to the specific features of acculturation*".

Some of these changes might be positive, such as improved socioeconomic conditions, education and healthcare. However, others are not as positive, such as adjustment difficulties, psychological problems, and acculturation stress. Migrants often experience a two-fold vulnerability (psychological and social) and a two-fold exclusion (from the native and host countries) (RAMOS, 2004).

In contemporary societies, differentiation is necessary for individuals to identify themselves as human beings and as members of a given social context. Due to the possibilities associated with globalization in particular, confrontations between cultures are unavoidable and necessary. Thus, cultural diversity represents a major challenge for everyday coexistence. To achieve this goal, each individual's differences must be acknowledged and respected.

Each society seeks what it needs in a given moment. Thus, when a given culture is no longer useful, it must adapt or disappear (GIDDENS, 2000).

In Portugal, coexistence in cultural diversity should not be a challenge because historically this country has hosted a wide range of cultures, each with its own traditions, values, lifestyles and ways of adaptation. However, challenges are arising today, especially when migrants with different cultural norms attend healthcare facilities.

The institutional locus of healthcare in Portugal is the hospital, where diagnoses and treatments are codified. In hospitals, the etiological hypotheses suggested by a patient's family and their perceptions of the nature and severity of an illness are rarely, if ever, taken into account, even when we know that cultures and families organize around the severity of symptoms and the reasons they imagine to have caused them (KLEINMAN, 1980).

Healthcare professionals must have solid training to develop the intercultural skills to understand and manage other views of life, health and illness in their daily caregiving tasks. This training should cover ethical modalities of coexistence, the cultures of the sick and their families and their modes of interpreting illness (RAMOS, 2004, 2009).

Our results are the product of a doctoral ethnographic research project performed in 2011 at Lisbon Open University under the supervision of Prof. Natália Ramos. The patients represented several cultures in the Lisbon area and were mostly Muslims and Indians.

The Principales of Islam and Hinduism

Successful reception and intervention in healthcare for users/patients from other cultures requires professionals to have a basic knowledge of these cultures. Here, we summarize some fundamentals of Hinduism and Islam.

ISLAM is based on the principle of obedience, as a religious representative explained in an interview:

"Islam is a code for life, in which obedience and respect for others are foremost. It is not just a religion; it is a highly personal religion. Because Islamism is an open religion, it is always ready to find solutions...it is a part of the solution and not the problem. This

is my view on Islam. Here, in Portugal, there are 40 thousands Muslims, and essentially it is Sunni Islam" (Sheikh Munir, 2008).

Islam is growing significantly worldwide. After Christianity, it is the religion with the largest number of followers globally.

"The Arabic language is the liturgical language...which is no hindrance to being a Muslim. The majority of the Muslim population worldwide is Sunni – approximately 85%. There are Shiite minorities and other groups such as the Sufi. However, in Portugal, the Sunni influence prevails" (Sheikh Munir, 2008).

Islamic religious law, is a complex system that developed from Mohammed's time to the present day and is taken seriously by believers. Muslims organize their lives according to the rules, values and principles in the *Sharia*. The Quran sets out clear rules for the deeds a good Muslim must accomplish, including ritual practices, allowed and forbidden food, forbidden clothes, and the division of property among heirs. For instance, contrary to popular belief, the norms and restrictions on behavior and dress do not apply only to women; a Muslim man may never appear shirtless in front of women. When a *Sheikh* or an *Imam* is not wearing their typical robes during religious ceremonies, they must wear long-sleeved shirts. Men may not wear silk shirts or gold objects. For both genders, clothing must be modest and cover the full body. Concealing the body is a part of the Islamic cultural and religious universe, and one of the most explicit reasons for this norm is that human bodies attract attention. Furthermore, contact between males and females is forbidden before marriage, and it is assumed that attraction will result from behavior rather than from physical appearance.

A Muslim cannot live in peace and joy if he does not observe the principles prescribed by the so-called "*Pillars of Faith*": the unity of God, prophecy, revelation, intercession of angels, and the existence of an afterlife. Furthermore, the "*Pillars of Practice*" must be observed in parallel to the Pillars of Faith. They comprise the *Shahadah*, prayer, fasting, charity and peregrination or *Hajj*. Despite the paramount importance of these principles, not all Muslims fully observe them.

Islamic prayer grants a Muslim several benefits: peace and the uplifting of the spirit and, at the physical level, daily exercise that benefits the body. Consequently, a Muslim who performs all five daily prayers strengthens the foundation of his faith because prayer is one of the major signs of faith and the most obvious proof of his gratitude to God for His countless graces. Prayer is mandatory for both men and women.

The Muslim holy day is Friday, when the collective prayer (*Salát' al-Jumuah*) is performed. An Imam, a man acquainted with the Quran and the Prophet's hadiths, leads this prayer. Friday sermons are lessons through which the Imam deals with the problems that might have arisen in the previous week in the community. Friday prayer is only valid when it is performed in a mosque, and it is scheduled for the noon prayer. Collective prayer is one of the most important rituals of Islam. There is perfect synchronicity in voice and motion and a disciplined, cadent rhythm of bodies turns to Mecca. Men and women pray in different areas of a mosque.

Prayer Practices are a further important feature of Islam, according to Sheikh David Munir, and they must be preceded by ablutions. These purification procedures are essential, and if there is no water available, the worshipper must perform them in some other way. No prayer is valid unless the worshipper has carried out his ablutions, and healthcare professionals must know about, or least allow, the performance of this ritual, which is known as *Wudu*.

HINDUISM, in turn, is based on the continuous renewal of life. Dating back more than 4,000 years, Hinduism is one of the oldest religions in the world. Its scope is not merely religious, as a representative told us:

"the term Hinduism essentially alludes to a culture and a way of living and thinking that is intimately linked to a religion" (Priest Nitesh, 2008).

As we know it today, the Hindu religion has a strong ritualistic content and attributes little importance to its doctrinal aspects. It is supported by a caste system, and the essential rituals, such as those associated with birth, adulthood, marriage and death, may only be performed by a Brahmin priest.

It is possible that India is the only country in the world where a large number of Hindus live in harmony with a large number of Muslims with no need for significant adjustments. Nevertheless, the two groups' religious beliefs and practices – some of them quite intransigent – are hard to ignore. This situation is the result of centuries of interaction and mutual adjustment (Jayaram, 2008).

The Muslim influence is noticeably manifested in the abolishment of offerings, rituals, and polytheistic worship. Most Indians in Portugal are Hindu. Indians who chose to convert to Islam behave as any other Muslim does, and the coexistence of these two religions is peaceful and grounded on mutual respect.

The most important figure in modern Hinduism is Mahatma Gandhi (1869-1948), who is known in the West as a political figure but revered in India as a spiritual leader.

"Gandhi, an adept of Ahimsa (the principle of non-violence) proclaimed the importance of perfect self-control for Man. According to him, the caste system would start losing meaning because only the principles of equality and solidarity were truly important. However, due to issues related to social stratification, inheritance, and other purely material matters, the castes remain today. More than a religion, Hinduism is a cultural tradition encompassing very particular ways of living and being in society and ethical and philosophical principles". (Priest Nitesh, 2008)

Hinduism is a universal religion that emphasizes fraternity. It teaches that the nature of man is divine and that the ultimate goal of human activity is to seek the supreme truth. For this reason, some intellectuals, including Gandhi, have rejected the caste system. In this regard, Jayaram, an Indian student living in Portugal, told us, *"it is hard to understand how a culture that privileges man in his full plenitude categorizes him according to the family he belongs to. It would be easier to understand if all people were integrated in a single caste, even if it were the lowest one. However, this is not the case! Many people do not even belong to a caste and thus are condemned to a life of poverty and forsakenness, without the right to minimum healthcare. Today it is hard to understand, but this system is like the dogma of any other religion: one must obey without question".*

A caste is a social category that is determined by a family's occupation and lineage. There are four different castes:

Brahmins are the caste of priests, who are entitled to study the Vedas and perform rituals for themselves and others and who are required to perform the sacraments. They are intermediaries between the gods and men. They must exhibit exemplary behavior and devote their lives to the search for knowledge and the preservation of tradition.

Kshatriyas are the caste of warriors. They are trained to protect the people and perform sacrifices to the gods. They study the Vedas and are in charge of justice. They must abstain from sexual pleasures.

Vaishyas are the caste of tradesmen and peasants. They oversee all commercial and agricultural activities, lend money and raise herds. Their role is extremely important in India because they create wealth. They are entitled to study the Vedas but cannot marry women from the higher castes.

Sudras are the lowest caste of workers. Their only duty is to serve the three higher castes. They are not allowed to study the Vedas and cannot even listen to sacred chants. They cannot sit to eat with members of the higher castes and can only marry within their caste.

According to many people, the caste system may have served its purpose in ancient times. However, it is hard to reconcile this system with modern values and principles, including democracy, human rights, individual freedom, equality and nondiscrimination, which are the basis of peaceful existence today.

Hinduism's *Sacred Writings*, the "Vedas", are the oldest in the world. These hymns are considered the divine word and the foundation of Hinduism.

The god Brahma revealed the "Vedas", which is a Sanskrit word that means "the science". They are the oldest works in Indo-European literature; their background is noticeably religious, and they cover a period of 2,000 years (2500-500 BC).

The books of the Vedas are considered authoritative sources of knowledge. As a whole, the books are also known as *Shastras*, which means that they are revealed books that explain physical and spiritual matters. They include a collection of sacred, poetic hymns that were subsequently complemented by interpretations of the revealed word and the practice of the cult. Sacerdotal families transmitted these texts from generation to generation using complex mnemonic systems that were designed for accuracy (SHATTUCK, 2009).

According to Priest Nitesh, the principles of Hinduism include general features and symbolic aspects that are extremely important in the life of a Hindu.

In Hinduism, human beings are endowed with spirit (*Atman*), an indestructible power. The spirit's trajectory depends on our actions, and every action implies a reaction (i.e., the Law of *Karma*).

Until we reach final liberation – *Moksha* – we are condemned to a continuous cycle of death and rebirth. We can only leave this cycle, the Wheel of *Samsara*, after attaining Illumination or Perfection.

Hindu rituals consist of two main elements: *Darshan*, meditation/contemplation of divinity, and *Puja*, offerings.

A vegetarian diet is an essential aspect of Hindu philosophy because it is free from impurity (death/blood). And food must be first offered to the gods, and a Hindu cannot offer them anything "dirty".

Prayers are sung as chants in Sanskrit, a "dead" language that gave rise to Hindi. These prayers are known as *Mantras*, which are addressed to different divinities or foster personal qualities.

The most important Mantra is *OM*, the "sacred syllable" that represents God's name. *OM* is the root of all *Mantras* and the principle of creation; it originally gave rise to all matter.

The Hindu perspective on life after death is centered on the idea of reincarnation. Hinduism exhibits a range of different beliefs; however, all of them share the notion that life on earth is part of an eternal cycle of birth, death and rebirth.

Corpses are cremated after being properly cleansed and adorned. In Portugal, Hindus are able to perform this ritual at the crematorium of Alto de São João cemetery.

In Indian society, the members of a family usually live together, including the grandparents, parents, children and the paternal uncles and their families. However, with increasing urbanization, this structure is slowly shifting to a nuclear family model (i.e., parents and children). Several types of cohabitation exist in Portugal. There are nuclear families, but the extended family still prevails. Furthermore, grandparents play a crucial role in the education of their children and grandchildren.

Some fundamental values in Hinduism prioritize privacy, and in the case of illness or health-related problems, a family will make decisions before seeking external help. Thus, when a family member is hospitalized, a crowd of relatives will typically accompany him. Additionally, when the sick remain at home, visits are a regular habit.

The Body – Representation and Cultural Identity

Today, the diversity of people from other cultures compels us to reconsider healthcare practices in a more coherent and efficient manner that considers different individual, social and cultural contexts.

Culture and knowledge of cultural diversity are the keys that will allow caregiving practices to adjust to the needs of contemporary society. We must face these new challenges while keeping in mind that terms such as transculturalism, interculturalism, and multiculturalism refer not only to cultural diversity but also to difference and coexistence with difference.

We know little about the Other, particularly the sick Other. Ethnocentrism, which occurs when we belong to the (cultural) majority, might prevent us from attributing proper value to the identities and behaviors that our culture does not value. Thus, we risk increasing patients' pain and harming those who seek healthcare. According to GARCIA (1995:84), "(...) *Culture defines and typifies illness, attributes social meaning to it, and creates its therapeutic context.*"

Thus, we cannot provide quality healthcare if we do not pay attention to the cultural characteristics of both members of a therapeutic relationship: the healthcare professional and the patient. Therefore, cultural skills pose new challenges for everyday practices of caregiving to provide services that are optimally adapted to promote health and wellbeing and to prevent illness and suffering. Treating the body as a privileged instrument of care constitutes a personal trajectory that involves more than reporting the feelings we have when we assist someone or use the hands to manipulate, transport, lift, puncture, caress and massage.

The body is the main object of caregiving by default. It is also the most private cultural object we possess and our tool to socially relate to others. It works as a locus of social categorization, and, according to GOFFMAN (1988:22), "*one may see the marks caused by clothes, or by the ways of presentation of a half-naked athletic or sexual body, or the stigmatization of a disabled, deformed or sick body*".

Beyond its biological nature, the human body is influenced by religion, family, culture, social class and ideology. When appearance acts as the guarantee of a person's integrity, the body exerts a strong impact on the way it is articulated within a field of social representation that, according to MOSCOVICI (1989:63) (...) *"is neither a copy nor a reflection, or a photographic image of reality, but it is in transformation together with the object it tries to elaborate. It is dynamic and flexible, and it gives the subject of knowledge the possibility of being active and creative"*.

Cultural socialization shapes not only reason, intellect and emotion but also the body. However, the body always has dark and silent areas where it is not the body and where it draws confusing and unstable boundaries (NAVARRO, 2002).

The body has inspired countless sayings and stories throughout history, from myth to religion to science. Corporality has always been a major concern of man, possibly because a person's sense of self almost always emerges through the body first. According to COSTA (2004:20), *"(...) the ethical measure of interest in the body is not the amount of care devoted to it, but the signification care assumes. If the interest with the body begins and ends in it, we fall prey to the cult of the body, a humanely poor and socially futile variety of asceticism. If, conversely, interest follows a centrifugal direction, it turns to creative personal action and widens the horizon of interaction with the others (...)"*. This reflection supports the ideas of MARCEL MAUSS (1974) on the social dimension of corporality; the ways we walk, run and weep and use and treat our bodies express the origins and beliefs of a given society and lends meaning to it.

According to BAUDRILLARD (1995), the status of the body is a fact of culture. The relationship that man establishes with his body reflects how he forms social bonds and structures economic organization. The body has been conquered and transformed in individual and private property; it has been overvalued to an unprecedented extent in the history of modern civilization and has come to occupy a privileged place in the media. According to SANT'ANNA (2004:130), *"(...) several cults of the body that are currently growing might transform the body into a kind of bunker: nothing leaks out of it, nothing enters it, and nothing germinates by its side. Alternatively, they might make of the body an enduring link connecting the individual and the collective (...)"*.

The use of the body is simultaneously individual and collective, social and natural; that is, people express themselves with and through their bodies. This fact is not self-evident or universal: the body is changeable and changing (GOELLNER, 2003).

Starting from birth, our bodies adjust and transform by means of action and motion and assume a corporality that is indispensable to communication.

Through this process, barriers may appear that make healthcare difficult. Perceptions and experiences of health and illness differ not only due to individual needs and different cultural backgrounds but also because different modes of dependence and autonomy are imposed on us during healthcare. According to RAMOS (2008:4), *"(...) the encounter with cultural difference within the context of healthcare might lead to strong emotional reactions or to the rejection of caregivers, especially when the latter lack sufficient knowledge of the patient's culture and training in interculturalism"*.

Culturally competent communication involves awareness and knowledge of different approaches to health and illness and the understanding that sociocultural factors have an important impact on health-related behaviors. Therefore, this type of communication is crucial for the sick to acquire the skills they need to face their ongoing problems and cope with them in a more balanced manner.

When these factors are not considered, according to RAMOS (2004:298), there are consequences: *"suffering, anxiety, insecurity and the difficulty of adjusting to illness increase; it causes dissatisfaction with the quality of care and the behavior of caregivers; the difficulties in assessment or diagnosis increase; the compliance with preventive behaviors or health-protection measures decrease, and the odds of dropout or carelessness in seeking help increase"*.

One of the first difficulties exhibited by patients belonging to other cultures manifests upon arrival at the hospital. They tend to ignore the rules of hospital behavior, documentation requirements, the position and the rights of the family, visiting schedules, dietary habits required during hospitalization, and requirements on clothing. In general, they struggle with a range of difficulties in their new circumstances of suffering and illness. It is difficult for them to understand why they cannot have their relatives and neighbors around them, and they are deprived of the comfort that the presence of their loved ones might afford them.

Such collective visits help the sick to reduce their fear and unhappiness and to strengthen their

community bonds. It is important for healthcare teams to consider different patients' cultural and social backgrounds and have flexible attitudes and relationships with their patients on these issues (RAMOS, 2008).

The body and how it is treated in healthcare settings may constitute a disturbing issue for people from other cultures and religions. As a rule, caregivers establish guidelines and give explanations, but we rarely consider that our questions might not be acceptable in many cultures. Some patients do not answer or ask for explanations, which might prevent them from understanding their condition or properly complying with treatment. Thus, their recovery process may be compromised.

This situation is complex for both the patient and the caregiver. The former does not know how to explain himself, and the latter cannot understand the issue or act on it. For serious diseases, this lack of communication may be dangerous. It is possible that a translator could solve such problems, but under some circumstances, patients are reluctant to explain their problems, particularly intimate issues, to a third party. Although translation is not successful across the board, it is employed in some healthcare facilities.

The Life of the Sick Body

The Body as Object

The sick body is an object of investigation. It is examined, given drugs, opened and closed - as if the body were a lifeless thing. It is often forgotten that the sick body, a default object of healthcare, is a living body that belongs to someone with a life and sense of privacy that extends beyond the circumstances imposed by illness and hospitalization. A path must be found to help caregivers go beyond using their hands merely to manipulate, transport, and suture, which are among the many activities that must first cause pain for the patient to heal. Expressing respect is an ethical principle that everybody should keep in mind. The following quotations are some of the most significant expressions by patients regarding the Body as Object:

"I feel like a thing. Not a person, but a thing. I'm sad I can't wash myself. I'm here just waiting until they find out what is wrong with me. They (the doctors) come, talk, decide and that's it." (Muslim, male, 30 years old)

"My body doesn't belong to a person. It belongs to a book of illnesses and medications. It is the same as all the others with this same illness." (Hindu, 60 years old)

This feeling of powerlessness makes it difficult for patients to believe that something good will happen. The attitude of caregivers contributes significantly to this impression, which is an issue caregivers must improve. For example, caregivers should not assume that because someone cannot speak Portuguese, he is unable to communicate. Sometimes, especially in the case of younger people, this assumption may lead to catastrophic results. When panic sets in, it is not uncommon for misunderstood and confused patients to run away from the hospital and thus endanger their lives.

Dealing with the body as with an object, even unintentionally, perpetuates the depersonalization of others and ourselves. The body of the person we care for is like our own, but it has a different status in this context. If we always keep in mind how we would like to be treated and put ourselves in the place of the Other, we will improve our caregiving at its core.

"They turned me upside-down as if I were a toy." (Hindu, 25 years old)

"They touch me badly. They look at me as if I weren't a person." (Muslim, male, 30 years old)

"When they bathe me, they stop half-way and go away. They leave me as if I were a doll. Then, they come back, and everything starts again. They talk, but not to me." (Muslim, female, 25 years old)

Depersonalization, or the objectification of the body, leads to impersonal and unsatisfactory caregiving. In addition to cultivating the mental state needed to deal with sick people, healthcare professionals must establish empathetic relationships. Otherwise, we will never be able to understand the Other, particularly the sick Other.

"We like dancing a lot. Dance is an escape...a joy...but only when our bodies obey...Our bodies are weapons...We have codes known only by that group of friends." (Hindu, 42)

years old)

Empathy is the exact perception of the feelings experienced by someone else. According to DRUCKER, (1990: 539) it is the experience "(...) of being within the skin of somebody else, however, without feeling his feelings, without thinking his thoughts. Empathy is not sympathy, i.e., the compassion caregivers feel for patients. It is a feeling of 'being with' the patient."

We can all act in a tolerant, generous and understanding manner in keeping with our experience. Like any other quality, empathy can be developed; according to ROGERS, (1972:107) "(...) whoever practices this way of understanding the other will soon find out that the acquisition of this interaction skill represents personal growth with highly positive repercussions on the lives of both participants."

Healthcare professionals' attention is usually focused on the sick organ. The hospital acts as a workshop where the body is repaired and its parts are removed or replaced. Caregivers require skills to perform these functions, and, as technicians, they do not find this task difficult. However, the crucial point is the establishment of a dialogue between the performed technique and the humane treatment necessary to make it succeed (POLAK, 1996).

The Useless Body

For much of our lives, our bodies perform their expected functions well. However, one day everything changes! Disease interrupts the normal flow of individuals' lives, deprives them of activities they found simple and feasible, and imposes new requirements on them that people do not always face as challenges. Illness is always violent and dangerous because it surprises us, imposes itself on us and does not teach us how to overcome it.

Sick people are often observed to be rebellious and can be classified as "difficult patients". Frequently, these people did not have time to prepare for or adjust to their illness, and they need someone to listen and to mediate between them and their new condition. Acceptance and adjustment are crucial elements that have favorable impacts on health. The difficulty lies in healthcare professionals developing the ability to mediate. In this context, we selected the following testimonies:

"I'm totally useless. Before I managed to do something, but now I feel so tired that I can't even comb my hair." (Hindu, female, 42 years old)

"Food for us Muslims is essential, and I, who should express my love through it, am unable to do it. My body is unable to do it! I feel useless! I'd like to vanish." (Muslim, female, 39 years old)

"I'm ashamed I can't play with my children. I can't have them sit on my lap as I used to. I don't have strength even to laugh. I've never felt so useless before and it makes me very angry." (Hindu, 45 years old)

"My husband doesn't touch me anymore. My body doesn't seduce him anymore. It must be because I can't have children. My body serves for nothing!" (Hindu, 25 years old)

"My body is a brittle shell with nothing inside." (Hindu, 60 years old)

"There is nothing I can do to erase this appearance. If I apply makeup, it becomes even worse. I look like a ghost. Makeup helps everybody, but it makes everything worse in my case. I just need threads tied to my hands to look like a marionette." (Hindu, 42 years old)

"I don't know what my body serves for. It just hinders me." (Muslim, male, 30 years old)

The body loses meaning when it is unable to perform the simplest of tasks. There are some physical weaknesses that people never learn to overcome. The body becomes an unknown to which we cannot adapt but with which we must coexist. Obviously, we might help these people find meaning in their lives, but, as a rule, these periods are discouraging and can make healthcare professionals' work difficult. Sometimes we should wait for more favorable occasions to motivate patients and use such opportunities wisely.

The Sensual Body

Physical sensuality or beauty is not only a function of appearances or relationships. Any body can always be sensual; it is just a matter of perspective. It takes two to play (or not play) this game, and healthcare professionals can and should teach patients to look differently at their bodies. It is a

difficult task, perhaps the most difficult, but some empathy and creativity are helpful. The art is in the harmony between what the caregiver does and says. Regarding the art of caregiving, WATSON (1994:XV) says, "(...) *the true essence of caregiving, as in any other art, lies (...) in creative imagination, sensitive spirit, and intelligent understanding behind all techniques and skills. Otherwise, caregiving might become highly technical but will never be rated a true art.*"

It is worth noting that the body is not a natural entity; it is a dimension produced by social and cultural imperatives. Our physical feelings are conditioned by the cultural meanings that our natural and social environments provide (MAUSS, 1968).

"Despite the amputation of my leg, I don't let myself go. I'm still young. I must fight for balance at home, and I can't let my husband feel anything is lacking. I dance a lot for my husband in our bedroom." (Muslim, female, 50 years old)

"As long as illness doesn't devour me, I must live. I take better care of my appearance now. I like compliments! At times, it even doesn't look like I'm sick! Everybody says so." (Hindu, 25 years old)

Indeed, exhibition of the body increases with self-confidence. Arousal is related to the visual side, which also implies socialization (ELIAS, 2000; HEILBORN, 2002). Culture is the major factor behind the transformation of sexualized bodies into socialized bodies, which are embedded in networks of meanings that shape sexual orientation and the choice of partners. Values are the factors that orient desire, which is why, for instance, the sick are not usually seen as potential sexual objects. Frequently, if we look carefully, we can attribute value to the remains of a damaged body or an unusual appearance. Experience teaches us that patients appreciate when we notice what they can do rather than what they cannot do.

The idea that there is a human nature, an unchanging essence across all cultures and social groups regarding how we face our bodies, is more or less unalterable (LE BRETON, 1995).

Everyone accepts his own image as he would like it to be, whether imaginary or real. This phenomenon helps people overcome the limitations imposed by illness or disability.

"Now I'm a lot more appearance-minded. This might sound odd in a man, but they still look at me with some desire. My eyes are pretty, at times I get compliments." (Muslim, male, 30 years old)

When we care for someone, we might think about options other than the technical ones. We could try to be attentive and creative because, as a rule, patients do not have the strength to do so on their own.

"I like a lot of beautiful clothes, and I don't lack imagination! The body must be covered, but it can be covered in good taste, right? People take even more notice when the body is covered. It is something beyond the vulgarity of these modern times." (Hindu, 40 years old)

Indeed, this analysis of healthcare practices calls on professionals to rebuild our praxis with sensitivity and creativity, based on our everyday experiences, and to improve our practice in the service of the community and their wellbeing.

In everyday practice, this approach can make a significant difference because, as a rule, families tend to remember their sick loved one as he used to be, which makes them even more dependent. Caregivers should be able to listen without judging and to develop creative resources to help the sick and their families cope. Caregivers' showing of sincere interest in listening and helping is a key factor in their patients' recovery, and multidisciplinary healthcare teams have better odds of achieving success.

"Disease doesn't mess too much with my body ... I do everything at home, absolutely everything! For the time being, I have no limitations ... whatsoever..." (Muslim, male, 40 years old)

Sick people may be dependent, depressed or disfigured, and thus they rarely feel attractive. As a result, we rarely find perceptible beauty in their everyday routines.

Patients understand and are pleased when we adjust our practice specifically for them and when we take special care to organize their surroundings to be harmonious and comfortable. Sometimes patient care requires highly technical actions, but this requirement does not stop a healthcare

professional from performing them skillfully, sensitively and empathetically.

The Disobedient Body

The experience of illness would not be so traumatic if suffering and its physical manifestations were less visible. Besides being sick and in pain, the body becomes disobedient, which is the true measure patients have of their autonomy or lack thereof. There is little originality left for healthcare professionals to deal with this situation. It is not easy to seek unique solutions in the Other or to use our creativity to find new perspectives on old problems. The challenge is huge, but it is highly rewarding to overcome it. A patient will try anything when his body does not obey.

"My body is so rebellious that it doesn't obey the medications". (Muslim, male, 26 years old)

In their daily relationships with people, healthcare professionals can create an atmosphere of compromise and trust. According to APPLETON (1993:899), the caregiver-patient relationship becomes "(...) *an original relationship expressed by strong feelings grounded in intuition and empathy that allow both to achieve their aspirations because this exchange involves a humanistic perspective.*"

Dealing with a disobedient body is frustrating and difficult for both caregivers and patients.

"I want my body to obey as usual... but it is stubborn." (Hindu, 60 years old)

"I want to go to one place, and my body wants to go to another. The most disturbing fact is that I always lose this game." (Muslim, male, 30 years old)

Migrant populations of ethnic and cultural minorities are, as a function of their lifestyles, precarious housing, and lack of access to healthcare facilities, much more vulnerable than the rest of the population. Furthermore, language difficulties and a lack of information about the procedures to gain access to treatment exacerbate existing issues, such as ignorance about treatments and illness prevention.

Migrants and minorities tend to use fewer health preventive measures, and they only resort to doctors and hospitals in emergency cases or in the advanced stages of disease. However, many of the serious diseases to which they are frequently exposed (e.g., infectious diseases such as tuberculosis, hepatitis B and C, and HIV/AIDS) might be prevented or treated (RAMOS, 1993, 2004, 2006, 2009).

"I never imagined the body could deteriorate so quickly. I notice I lose abilities everyday... at a dizzying speed." (Muslim, male, 30 years old)

A person's bodily scheme is defined as the immediate experience of perceiving one's own body. However, it is much more than perception. All people have a multidimensional image of their bodies; this image may be visual, motor, auditory or tactile and may be analyzed as a whole rather than separately (SHILDER, 1999).

"I'd like to be remembered as I was, not as I am ... but this is difficult ... How I am ... this is the present time ... everything else is in the past and very easy to forget ... the body does not allow it." (Hindu, 45 years old)

Any change may elicit memories of the body as it was in the past and of what it used to do. For patients and their families, the imminence of the body's death causes apprehension, which triggers the development of mechanisms to control the pain caused by the illness and strategies to end life as harmoniously as possible.

In both Muslim and Hindu cultures, the main concerns are suffering and the future of those who outlive the sick person.

In both cultures, religion helps to orient the body in its transformation into something more important than our material being: namely, the life of the soul.

"I feel that my body is stubbornly ending. I'd like it to happen quickly! At least I know I'll become something else." (Hindu, 60 years old)

"My body doesn't feel pleasure from smells or flavors. I feel this fragile shell around me will soon be broken, and I have absolutely no way to stop it." (Hindu, 42 years old)

The body is an object that is constructed into an identity. We are born with a body and the image of the world that was built by our parents under strong cultural influences. However, this constructed body does not correspond to our concrete body. There is a deep relationship between the images we have of our bodies, our cultural identity, and the looks and stimuli we receive from the others (ALBUQUERQUE, 2009).

Death is an inherent part of a life experienced in a given context. The problem is that sometimes death does not occur in the same context and experience as the ones into which we were born.

"I never imagined I'd feel death so strongly. It is visible in the body. Its smell is not the same. It's bad. I put on perfume, but it doesn't work." (Muslim, female, 50 years old)

"My face and my hands are not the same. I'm drying up and withering away. I'm not myself anymore! Some people can only recognize my voice. I feel I'm ending." (Hindu, 60 years old)

"My body not only doesn't obey me, but it is giving the orders. It's like Nature. When it doesn't want something, nothing can be done." (Muslim, male, 26 years old)

"I can't pray, my body doesn't allow it. I only hope God will understand." (Muslim, female, 19 years old)

Expressions of faith, either through prayer or rituals, help people to make this transition more or less peacefully. However, quite often these expressions are not possible because of hospital routines or because the body is a hindrance. As caregivers, we must understand that not all prayers are spoken aloud or recited in the mind; sometimes, the body itself is the prayer.

The Public Body

A patient-caregiver relationship is only possible when the participants have reached a consensus after overcoming the barriers of the first encounter. Then, feelings of solidarity and empathy can emerge. DANIEL (1991:33) emphasizes "(...) manifestations of politeness, understanding and interest. Such attitudes result in a better ability to adjust to the situation."

The ability to please a sick individual, according to MICHALIS (2002:3), "(...) allows caregivers to create an atmosphere of comfort, which will allow the patient to gain some control of his recovery process."

Every person reacts in his own way to the news of a disease. When an illness has a serious impact on a patient's bodily image that is intense, he will become more dependent on caregivers, particularly on nurses and doctors. Consequently, sick people almost always establish close relationships with these caregivers. Nevertheless, these relationships do not always arise, and healthcare professionals do not always behave in the best of manners.

"Sometimes I feel completely lost! At the hospital I belong to everybody but to myself." (Muslim, female, 50 years old)

"Many doctors and nurses come in. My body is the map they use for orientation." (Hindu, 50 years old)

"They ask me a lot of questions I can't answer, not because I don't know, but because of all that people around ... including the other patients." (Muslim, female, 19 years old)

The hospital environment is impersonal and rarely agreeable. This environment is a determining factor in causing patients, cut off from their familiar context, to feel maladjusted. A more "humane" and "harmonious" environment that focuses on several features – technical, instrumental, cultural and psychological – might improve the efficacy and competence of healthcare.

"I hate to lie down in the presence of people I don't know. I don't like to do things that I do alone at home. Everybody is staring." (Hindu, female, 40 years old)

"It feels like I'm being exhibited. I don't care too much because they have to treat me ... but they take too long." (Hindu, 25 years old)

The personal environments that promote wellbeing are characterized by their safety, comfort and functionality. They allow people to enjoy nature and beauty, and they make it possible for people to

give and receive affection. Many people, especially those who spend a long time in a hospital, struggle to find the personal environment that would fulfill such needs. We must make every effort to allow people to find wellbeing and satisfaction, even at the hospital, because basic wellbeing is an inalienable right.

In hospitals, the treatments some patients must undergo often give rise to embarrassing situations and extensive dependence on the healthcare team. After lying on a hospital bed (about one meter above the ground) for many days, patients may feel alienated from time and normal activity (SANT'ANNA, 2000).

Notions of the body, sexuality, sensuality, illness, health, disgust and pleasure vary in a complex society according to each individual's social insertion in a particular context. When healthcare professionals act based on specific understandings of the naturalness of bodies, sensuality, sexuality, and feelings about health and illness, they risk perpetuating preconceptions about certain social groups. Thus, they may behave in an improper and unfair manner and reproduce gender inequalities in their professional context (HEILBORN, 2002).

Whatever knowledge a healthcare professional may have, he is not immune to patient anger. However, when healthcare professionals are aware of their patients' needs and limitations, they can identify and take the appropriate measures to provide a balanced and supportive environment for themselves and the people under their care.

Hospitalization creates uncertainty, mistrust and intense fear of the unknown. For patients, every exam, every doctor asking questions, and every nurse administering a treatment can be frightening. In addition, patients encounter a sterile, white and silent environment that is only broken by the moaning or weeping of others. Nights are difficult, long and dark, and they seem longer than they do at home. For patients, hospitalization is a time when one does not live; or rather, one lives in silence and suffering.

The Privacy of the Body

In their activities, healthcare professionals come very close to patients; they touch them, expose their bodies, and invade their space. To be sure, this proximity is understandable in a therapeutic setting, but, nevertheless, some activities do not require the body to be so exposed. The anxiety, shame and discomfort patients feel as a result of these procedures do not contribute to their recovery or pain relief. On the contrary, they often make the healthcare professional's job more difficult.

"Sometimes all of them surround me, and I can't even breathe. Everything is too small here, we're all one on top of the other. There's not enough room." (Muslim, female, 50 years old)

Healthcare today favors increasingly impersonal, short and formal patterns of interaction that are a function of increasingly mechanized routines. For example, there is a fixed time to begin and end each procedure. These institutional approaches are understandable in some circumstances but completely inappropriate in others. The underlying problem is that every healthcare facility struggles to manage the cost/care/time equation.

Issues related to privacy are frequently addressed in healthcare education. Usually, the aim is to draw professionals' attention to the positions and behaviors that may infringe on patients' privacy and individuality and to encourage professionals to consider their patients' personal needs.

"Sometimes they take no care whatsoever. They leave everything open. Only yesterday I had to watch them bathing the elderly lady in the next bed. She didn't like being seen by me." (Hindu, 50 years old)

Respect for privacy is one of the main indicators of quality service in healthcare institutions. A study performed in 2007 showed that privacy is strongly related to patient satisfaction, independent from the facility itself, and that there is a strong correlation between stress reduction and patients' ability to accept their prognoses (NAYAR, 2005; ADHAJANI, 2008).

"I feel I have no privacy whatsoever, not even to read. I'm always worried that my nightlight might bother the neighbor. Everything is so cramped." (Muslim, male, 26 years old)

"A few days ago, during the doctors' visit, three of them had to sit on my bed because there was not enough room. And what could I say?" (Muslim, female, 19 years old)

Privacy is an abstract notion that is culturally defined and context dependent. The norms of privacy that are defined by the dominant culture have to be redefined in the professional/caregiving relationship between a healthcare professional and a patient (APPLEGATE; MORSE, 1994).

Therefore, understanding patients' concepts of privacy requires a healthcare professional to have thorough knowledge of their patients' physical, cultural, spiritual, social and emotional background because these individuals have unique personalities and a right to dignity. It is also worth noting that patients have the right to humane, kind and respectful assistance by healthcare professionals and that they are entitled to a decent and clean care facility. They also have the right to maintain their privacy when they address their physical needs, including nutrition and hygiene, when they are assisted in bed, and when they are in a hospital or waiting for assistance (WALDOW, 2001).

Studies by MAIRIS (1994), HADDOCK (1996) and MATITI and SHARMAN (1999) helped to identify some factors as the precursors of patient privacy, including the preservation of dignity, respect and the ability of patients to maintain some control over their circumstances. ENES, 2003 and MATITI and TROREY, 2004 reported that during hospitalization, patients adjust their sense of what is necessary until they overcome their illness. These studies emphasized that this adjustment depends on the degree of physical exposure the patient endures in technical procedures, public discussions of the patient's health, and the patient's tolerance threshold.

Upon admittance to a hospital, patients implicitly consent to some infringements on their privacy. However, this consent does not give professionals unlimited access to their bodies, and not all cultures would permit such an invasion of privacy. Professionals must develop an atmosphere of trust and behave in a way that deserves patient trust. As healthcare professionals, we know that confidentiality is one of the cornerstones of ethical practice, and we must never forget that when we invade a patient's privacy during a required task, we are not entitled to disrespect the dignity of the patient who placed himself in our care. Caregiving is much more than an act; it is a holistic attitude of concern, empathy, responsibility and emotional involvement with the Other and requires a compromise between the healthcare professional and the person who needs attention and care.

Conclusion

A better knowledge of diverse cultures will enable us to care better for the people who identify with them and to understand their universe more holistically. We noted that in spite of the different principles and lifestyles in Islam and Hinduism, these two remarkable religious cultures conceptualize the representations and experiences of the sick body in a similar way. We may say that their overall concerns are quite similar.

Both Hinduism and Islam recognize that God has the knowledge and power to exert His will and compel us to comply with it; thus, the universe moves according to His plans. God is generous and endows human beings with free will to take responsibility for their actions and choices.

Hinduism teaches that God is the Supreme Being and that creation as a whole is his body. Islam teaches that the community of the faithful is like a body that shares one experience when Muslims show love, mercy and kindness to their fellow human beings.

Both cultures believe in the moral responsibility that each individual has towards others and in virtues such as charity, justice, forgiveness, moderation in eating and drinking, mercy or compassion, self-control, fraternity, friendship, patience and gratitude.

Hinduism believes in the Law of *Karma*. Islam believes that God rewards good actions and punishes bad ones.

Hinduism is a tolerant religion. Hindus believe that each individual is entitled to choose his own path according to his inclinations and religious beliefs. For Hinduism, the search for the Truth is more important than believing in God or a specific divinity.

Islam acknowledges the religions mentioned in the Quran. However, Muslims also respect anyone who believes in God and who is pious, no matter what his religion might be.

Islam does not acknowledge any intermediary between man and God. In Hinduism, someone may worship God directly or indirectly through the mediation of a priest or guru.

Islam believes in resurrection and the Day of Judgment, whereas Hinduism holds life in heaven and hell to be temporary.

Hindus consider the world we live in to be delusory and unreal. We have no certainty that what we

see is real because our senses are imperfect and unreliable. According to Islam, words on earth are as true as they are in heaven or hell.

Hinduism does not see much difference between man and the other living creatures, whereas Islam places an insurmountable barrier between human beings and animals. For Muslims, only man can be a true and faithful follower of God.

Islam prescribes a specific dress code for Muslims based on the principles of modesty and circumspection. Women must be covered; although they are free to wear or not wear a headscarf, they may not expose their arms and legs in public. Hinduism has no specific dress code for men or women except on particular occasions or during rituals. Widows may not wear strong colors or adornments. However, as a rule, Indian women may dress in a feminine manner and wear many adornments.

Neither Islam nor Hinduism tolerate obscenity or public nudity. Furthermore, both religions reject pre-marital and extra-marital cohabitation, sex and the mixing of genders. Kissing in public is taboo, and marriage is seen as a union effected by mutual consent, where God acts as a witness.

Both religions prescribe a code of behavior for eating and drinking. To Hindus, cows and bulls are sacred and may not be slaughtered. Thus, their meat is forbidden. As a rule, Hindus follow a vegetarian diet, but some Hindus consume chicken or lamb. To Muslims, pigs are impure animals, and their meat is forbidden. Muslims may only eat meat prepared according to Islamic rules and rituals, and animals must be slaughtered in locations that are specifically designated for this purpose. This meat is known as *Halal*. Both cultures forbid alcoholic drinks and other intoxicating substances.

Regarding representations and experiences of the sick body, both cultures approach the sick body as a disturbing and challenging issue.

The most remarkable aspects of representing the sick body in both cultures involve the alteration of one's concept and image of the body.

The most significant texts in this article related to the thematic areas and categories we defined concern the *Life of the Sick Body*.

Although we discussed other categories, most representations correspond to the *Public Body*, which involves those contexts where caregivers dismiss privacy issues for a procedure or medication. Because caregivers are allowed to intervene in the patient's body, they tend to neglect the patient's individuality, modesty and privacy. The category of the *Disobedient Body* describes a body that is sick and in pain and that stops obeying. This disobedience becomes the true measure of a patient's dependence. Healthcare professionals should use initiative and empathy to deal with this situation. It is not easy for caregivers to look for what is unique in their patients and to develop new views and solutions for their problems. One of the major challenges healthcare professionals must face is helping people to overcome the stage of dependence and to learn to cope with what remains, no matter how little. Caregivers may not always be successful, but they will feel highly rewarded when a patient overcomes this stage.

Hospitalization introduces countless changes and ruptures into patients' relationships and everyday lives. Entering and leaving a hospital on a regular basis makes patients accept routines that are very different from their habits. The scheduling of meals, changes to dietary and hygienic habits and changes that prevent patients from performing religious rituals have a strong negative impact on people from both cultures and may cause pain and anxiety.

Privacy is a right and should be safeguarded when it is not necessary to expose a patient's body. Hospital routines are problematic in this context because routine practice usually prevails and healthcare professionals rarely stop to ask whether an invasion of patient privacy is really necessary. The resulting anxiety, shame and discomfort that patients experience do not contribute to their recovery. Patients experience many contradictory feelings; on one hand, they must allow their bodies to be touched, but, on the other, they find being handled displeasing and uncomfortable. Furthermore, patients must talk about the most intimate details of their lives in this context. As healthcare professionals, we must be careful not to say or do something that might offend our patients' moral and social codes. Thus, we must learn about these codes to avoid increasing their suffering.

There should be further research on these matters to build professional skills that allow us to understand the needs of users/patients who identify with other cultures. Furthermore, schools and universities that train healthcare professionals must cover these issues in their curricula.

In our opinion, the promotion of culturally competent communication would represent a major step towards overall efficiency and competence in regional and national health plans. Communication that is grounded in multicultural knowledge and that is respectful of the individuals who seek healthcare will certainly contribute to successful care and patient satisfaction. It will also help to reduce the inequality and complaints that commonly occur in our healthcare facilities by supporting culturally competent caregiving.

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