cunoasterii si a cercetarii si, mai mult decat atat, isi pregatesc propriul viitor, dincolo de anul 2010, intr-o lume a competitiei acerbe, a internationalizarii şi globalizarii, in care, mai mult decat oricand, cunoasterea inseamna putere.

CONCLUZII

Factorii determinanţi care vor influenţa evoluţia şi accesul la sistemul educativ universitar din România sunt factorii de natură demografică, economică, socială.

În lucrarea de faţă am menţionat importanţa dezvoltării capitalului uman şi creşterea competitivităţii prin formare iniţială şi continuă, pentru o piaţă a muncii flexibilă şi globalizată, reprezintă obiective majore de dezvoltare contemporană.

În perioada care urmează învăţământul universitar se va orienta mai mult, după parerea noastră, spre factorii educaţionali calitativi şi spre ceşterea competenţelor atât a noilor specialişti formaţi, dar şi a cadrelor didactice. Acest lucru este posibil prin aplicarea fondurilor de investiţii nu numai pentru în achiziţii de material didactic, modernizarea spaţiilor de învăţământ, mobilier sau instrumentar de specialitate, ci şi pentru creşterea competenţelor cadrelor didactice, studenţilor, masteranzilor şi a tinerilor cercetători. Numai aşa vom putea ajunge la un învăţământ universitar competitiv, la performanţele calitative de nivel european sau de ce nu – mondial. Doar şcoala românească a dat lumii dea lungul timpului mulţi specialişti de calitate, rezerve există trebuie la timp depistate şi educate.

Nu trebuie să punem pe umerii crizei tot ce se întâmpla în societate, trebuie doar sfidată criza cu forţe, soluţii şi surse existente.

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CULTURAL AND ANTHROPOLOGICAL DIMENSIONS OF HEALTHY STATUS

Defining health and disease by taking into account only the functional criteria is very relative and it implies various inaccuracies because people's functional capabilities are appreciated following a normative standard consisting of a specific set of social norms (1). However, these norms are different in what concerns the reference criteria so there can be different definitions of health and disease for different societies, cultures or social groups.

Taking into account the diversity of the factors that contribute to maintaining health, Health Psychology uses the following patterns of study and intervention (2):

- *Behavioral* (the role of behavioral factors in maintaining health or in causing health problems; the application of the principles of behavioral therapy)
- *Cognitive (*the role of cognitive factors in maintaining health or causing health problems; the application of the principles of cognitive therapy*)*
- *Psycho- physiological* (the interaction between somatic and psychic in maintaining health or causing health problems; the application of the principles of psycho- physiology)
- *Constructivist (*the role of social and cultural factors in creating opinions about health, disease, treatment*)*
- *Ecological (*the relationship between the individual and the universe*)*
- *Communitarian (*the role of the community*)*
- *Cultural (*the role of cultural differences in maintaining health*)*
- *Developmental (*the role of growing stages during life*)*
- *Feminist* (the role of social gender)

It is very important, when approaching and treating patients, to take into account the cultural aspects, the traditions, the etiological and philosophical conceptions about the world and the disease; these can be different not only from a continent to another or from a country to another, but also within the same country, there are differences between regions, social environments, professions and ages. These differences are being reflected into the various explaining models of disease and in the cognitive representations of disease: the identity of disease, the consequences, the causes and duration (Leventhal), to which we can add the fifth dimension: the curability and the controllability of disease (Lau and Hartman). The scientific literature proves the fact that the cognitive representation of disease determines the attitude towards the disease and, consequently, the recovery and the social re-integration. The more the mental representation is close to the prototype (image and accurate information about the disease, delivered by the specialist), the better the adaptation to the disease.

The factors that influence the attitude towards the disease can be grouped in 4 categories: *demographic, socio-cultural, individual (psychological) and professional* (3):

A. Demographic factors

a) Age

i. The childhood is being characterized by the dependency to the family, conformism to school rules and therefore, the attitude towards the disease depends on models (parents, teachers) and on the degree of psycho-affective development

ii. The adolescence is being characterized by the non respect of salutogenetic behaviors because of impulsivity, imprudence, need of independence and the desire to be accepted and socially acknowledged, characteristic to this stage of development.

iii. The maturity includes unhealthy behaviors (sedentary, smoking, excesses) etc

iv. The elderly are characterized by prudence, maximum therapeutic compliance.

b) Sex

i. Males, with multiple responsibilities, ignore the dangers and it rarely appeals to a physician

ii. Females, characterized by a prudent behavior (including the sexual behavior), a better hygiene (medical physiological acts such as delivery), frequent visits to the doctor, a better therapeutic conformism

A study published in Sweden in 2004 investigated the sex differences related to health behaviors and the motivation to adopt a healthy lifestyle. The study was conducted with the participation of 479 students from a university from south-west Sweden. The results showed the fact that the female students had healthier behaviors concerning alcohol consumption and nutrition, but they were also more stressed. The male students were overweight, less interested in advices about nutrition or activities for protecting health, they were sedentary and they consumed more alcohol (4).

c) Ethical affiliation

- the occidental societies are being characterized by a better health education, excessive professional implication, the promotion of internal locus of control (the children are being taught to become independent, to earn their own money and they are appreciated for this autonomy), but also by a growing frequency of abuses, sedentary, while:
- the oriental societies are being guided by philosophical and religious concepts containing salutogenetic behaviors and promoting the external locus of control (obeying the social rules, religious norms).

Intercultural studies have shown the differences concerning the locus of control between different ethnic groups within the same society, but with a different social and economic status (2). The Jewish children from Israel proved a more pronounced internality than those Arabs from the same country, the Chinese children from USA proved to be more external than the American ones, so as the black children from South Africa compared to the white ones. The forming of an internal locus of control is also associated with coherent parental capabilities, clear and non-confusing, educational, encouraging the trust, autonomy and positive strength. The internal locus of control has a positive motivational role for the action and this way people adopt salutogenetic behaviors, they give up on unhealthy ones, and, in case of disease, they are compliant to treatment (5).

d) Socio-economic status – a low one determines a poor health education, promiscuity and low access to medical services.

Siegrist (1987), quoted by Sorin Rădulescu (Sociologia sănătății şi a bolii, 2002) affirms that, groups characterized by a low socio-economic status are more stressed because of the difficult problems they have to face and there is a higher risk for health because of the poor life and work conditions. Educated people have a more accurate lifestyle and they pay often visits to the doctor in order to take care of their health. In the same time, people that belong to poorer social classes are being characterized by certain values that could explain why they go less often to the doctor: a high level of dependence upon others, fatalism and incapacity to postpone immediate gratifications- together, these values create what some authors call the *culture of misery* (1).

The relationship between the socio-economic status and the adoption of a healthy behavior made the object of many studies. For example, in 2002, a research published in UK investigated this relationship. The research was nationwide and investigated 2728 houses in UK (one adult for each house was interviewed). The authors revealed the fact that the respondents with a higher socio-economic status smoke less, made daily physical activities and they ate fruits and vegetables every day. Those with a low socio-economic status were associated with a poor awareness oh health related issues (they thought less at what they should do in order to maintain their health), they thought less of the future and they left their health on the hands of destiny (6).

B) Socio-cultural factors:

Religion has both:

i. Positive effects because it recommends fundamental specific health behaviors (eg. fast, meditation, physical activity) and by offering a psychological balance to the individual
ii. Negative effects by the promotion of a fatalist and catastrophic thinking. Some religions impose unhealthy behaviors (eg. they interdict surgical treatments, blood transfusions or contraception)

The cultural factors are important because, without the understanding of the cultural context, many of the attempts of approaching the health problems of an individual cannot be successful. The reason for which we have to take into account the individual aspect is that not all the individuals from a community share the same beliefs, norms, values or attitudes towards health, they do not have the same salutogenetic behaviors or the same support group.

At a cultural level, the way in which a group defines what is or isn't healthy can substantially vary from a group to another. At an individual level, the beliefs about health, although influenced by cultural conceptions, can vary from a person to another.

The value associated to health can vary from a culture to another, but also within the same culture. For instance, the Judaic law says that health is given by God and that people have the responsibility to maintain it. Nevertheless, among the 3 Judaic subgroups, there are different degrees of accepting this idea: Orthodox Jews accept it, Reformed Jews accept it less and Secular Jews do not give it a big importance (7).

Health behaviors vary as well. For instance, the classification of an aliment as "comestible" can be the object of a cultural differentiation. There are many aliments which are not accepted by occidental cultures, but that are a part of a daily diet among other cultures. Then, there are individual differences- people have various dietary habits, depending on age, status and factors related to the belonging to a certain clan.

The cultural differences are also found at the level of the social organization of health activities and role assignation (curer, patient). Sexual or religious matters can influence the curer position (only some people with certain spiritual qualities or only men can become curers), while, in other cultures, high costs of medical training limit this role to those with high income. In some cultures, health services are available and integrated into the community life, while in others, doctors, hospitals are rare and many individuals don't have access. In the first case, the relationship patient-doctor can be collegial, a partnership is being established between the two parts in order to obtain healing and in the second one, the relationship is hierarchical, involving the authority/ subordination rapport (7).

There are numerous examples proving that, far from having an absolute and invariable character, the notions of *pathology-normality, disease- health* are being invested with variable cultural meanings, different from a community to another. The microbiologist and medical historian René Dubos gave the suggestive example of a South America tribe, for which the *dyschromic spirochetosis* (skin disease characterized by the apparition of colorful flecks, caused by tattoos) was so common (*normal*) that those who did nor have it were considered *abnormal* and they were refused the right to marriage (Dubos R., 1959). In order to give more examples, the anthropologic research has shown that, within some Indian populations, the presence of intestinal warms is not considered a disease, on the contrary, it is appreciated as an essential element of the digestive process. On the other hand, in Latin America, there are manifested symptoms of diseases that are virtually unknown in other regions of the world (Herzlich C., 1984) (1).

In many geographical areas (especially in poor regions from Africa, South America etc.) even today there are beliefs that psychological problems are being caused by incantations, angry Gods, the lost of soul, and, taking into account the specifics of the disease, the treatment applied by the so called "curers" is the same: rituals, oils or plant extracts, irrigations in order to induce shock, confessions, catharsis, the transfer of the suffering to an animal who is afterwards sacrificed. The

mechanism of action of such therapeutic procedures is the following: the blaming of certain unpleasant experiences (depression, anxiety, obsessions etc) on vicious gods, the transfer of these states to a sacrificed animal, which is being killed instead of the person. So, the disease is considered as having a spiritual nature, this is why the treatment is addressed to the soul. Afterwards, the medical model appeared, which concentrated only on the organic part of a human, and nowadays a powerful interaction between somatic and psychological is being promoted. This model is able to accurately and usefully explain the complex character of somatic diseases, generated by the pathogenic action of environmental factors (physical, chemical and biological) together with psychological ones, modeled by the socio-cultural model (8).

B. Individual factors (personality traits)

Individual factors are related to temperamental particularities and especially character particularities of individuals (3).

The individual level is being characterized by the personal knowledge about health issues and diseases, healthy attitudes and behaviors and interpersonal relationships (7).

In order to better understand the attitudes towards health behaviors, we have to take into consideration cultural factors (related to the community) and psychological factors (individual). Beliefs on what causes a disease or a disability or about the control one has upon their health vary. For instance, within a community, the general belief may be that if a pregnant woman eats too much there may be too little space for the baby to develop; as a consequence, malnutrition is a widely spread phenomenon which leads to the risk of baby developing disabilities. However, there are variations among the individuals towards this belief and an important role is played by psychological factors, as well as education, status, taking part in public health programs. (7).

C. Professional factors:

Ever since antiquity, physicians noticed that they have to take into consideration the level of professional training of the patients when dealing with them. Thus, Soranus of Efes stated: „to the farmer you talk about agriculture, to the sailor about the sea...".

For many people, profession may be an important cause of psychological distress because of its characteristics (difficult tasks and responsibility), the work environment, the relationships, general working conditions (3).

Epidemiological studies show an increased frequency of the professional diseases, of work-related accidents and illnesses, no matter if the physical effort is prevalent or if the job rather requires mental effort (individuals are exposed to stress factors that can induce a variety of problems, such as cardiovascular or psychological conditions) (1).

From an anthropological perspective, one can notice a variation in time of the interpretations the patient gives on the situation: while, in some totemic societies, the epileptics (from amongst which most of the shamans or tribe healers were recruited) were appreciated as a „privileged" social group and were believed to possess magical, supernatural powers, in present societies they are considered ill, in need of special medical treatment.

Thus the **Medical Anthropology** developed as a branch of social and cultural Anthropology; its roots run deep within the field of medicine and other natural sciences, because it deals, among others, with a large spectrum of biological phenomena, especially those related to health and disease, but its subject lies at the meeting point of social sciences and natural sciences and it borrows from the theoretical perspectives of both sciences.

Medical Anthropology can be divided in 3 major areas(12):

1. biomedical studies on human adaptation that include: paleontology, demographics, disease development, population genetics and pathology, social epidemiology, nutrition

2. ethno-medical studies on health and healing that include: *culture-bound syndromes* as disease is seen as a socially learnt behavior, traditional therapies, healer roles, medical pluralism, ethno-psychiatry, ethno-pharmacology etc

3. applied medical anthropology interested in : public health, international health, clinical anthropology, addictive behavior, family violence etc (13)

Medical anthropology studies indigene conceptions on health and disease in different cultures; studies ideas and behaviors of health practitioners in different cultural areas, including hospitals and clinics from developed or less developed countries; studies scientific knowledge development in western medicine and it compares it with beliefs, practices and complex ideologies that represent the baseline on western and non-western medical systems such as those from Japan, China and Muslim world (K Oths, 1995).

The psychotherapeutical effects of healing rituals were studies thoroughly in many countries, and the symptoms, symbols, customs, and means used must be comprehended in the limits and within the boundaries set by the culture of those territories. (11). La Barre (1945) and Spitzer (1947) with respect to Japanese described a predilection for politeness, discretion, obedience, persistance and ceremony, to which Doi (1962) added their will to be loved, protected and their prevalence for resignation and a strong need to obey to authorities, features that cand be foundin their worship ceremonies (8). Probably these features may be attributed to the tradition of Buddhism, that preaches mind tranquility, serenity and accepting adversity. (8) In fact, these ideas form the base of the Morita psychotherapy, practiced in Japan. Through this psychotherapeutical method, the patient is prepared to accept suffering by confronting theirselves, by isolation and partial deprivation. In this respect, Kimura (1972) stated that „if you stroll through the rain you feel sad and cold. This is because you feel rain as something apart from you. If you became one with the rain and didn't feel any separation, no duality between you and water, like the swimmer emerged under water, the you would instantly feel no more sad and cold... ". Thus, the basic principle of Morita psychotherapy is „give up your whole being to suffering and pain". So, the psychotherapeutical differences related to culture can be found even in the techo-industrial and cultural developed countries. For instance in USA, as long as narcisistic individualism, the non-conformism tolerance and freedom of speech were emphasised, psychoanalysis found the best ground for spreading; however, when the focus of attention moved from the narcisistic ego to community, the downhill of psychoanalysis came and the importance of group and family psychotherapy increased. (8)

People have always built explanatory models in order to understand diseases and to set a therapeutic plan. The means of explaining the etiopathogeny of the illness to the patient is always directly related to the level of culture. When there are big differences in culture, beliefs and way of understanding of local traditions and realities between the therapist and the patient, conflicts occur and lead to non-compliance and the failure of the therapeutic act. (8)

In 2005 a research that reviewed the studies that evaluated the interventions for improving the cultural competence of health care specialists was published. 34 studies published between 1980 and 2003 were examined. It was discovered that there are a lot of proofs that certify that training for cultural competence improves knowledge of health care specialists (17 out of 19 studies proved the positive effect), proofs that certify that increased cultural competence improves their attitudes and abilities (21 out of 25 studies, and 14 out of 14). Cultural competence leads to increased patient satisfaction (3 out of 3 studies). However there is not enough information related to costs of a cultural competence training (5 studies included incomplete estimations towards costs). Conclusion was that by creating a cultural competence of health care specialists, a strategy to improve their knowledge, attitudes and abilities is set (9)

A pathology with strong cultural influences is represented by eating disorders, which prevalence increased significantly lately. Socio-cultural studies underlined the important role of cultural factors in anorexia nervosa. Some cultural factors like mass media, internet, professional requirements have established being skinny as a mandatory symbol of success.

The Internet represents an extraordinary powerful means of connection. Virtual communication between female patients suffering from eating disorders has the advantage that the risk of social rejection is minimum and the access to information is extremely fast: (fast weight loss methods, drastic diets etc) (10). Thus, online communities appeared which created a „virtual support group" for such a lifestyle. This feminine model was over encouraged in western culture but it extended also in the eastern countries and affects at a worrying extent other cultures' population. As a response to the need of imitating existent models, today's women change their behavior to fit the reference group.

Recently an exaggerated interest for healthy eating appeared, called orthorexia nervosa, that isn't yet officially recognized as an eating disorder. It also originates in the western societies, where the media pressure on healthy eating is much greater. Nowadays, all around the world, campaigns that encourage healthy eating are run. They inform about different eating relating illnesses (genetically altered organisms, E's that cause cancer, parasite and virus transmission through foods in case of mad cow disease, aviary flu, as examples). These messages can be misinterpreted and thus, exaggerated care for healthy eating appears.

Contemporary society progressive development, the rapid technological and material evolution, the fast socio-economical changes, migration, the disappearance of many socio-cultural models and different institutional forms of solving existential problems, things that led to isolation of individuals, despite the diversity of communication means, are all factors that concur at a great extent to the dissonance in adaptation of the contemporary man to the new living and working conditions and to the increased frequency of psychological disorders. These imbalances influence the somatic health of the individual and thus the role of Health Psychology in promoting and maintaining health becomes more important. In this respect the Romanian Academy, through the Anthropology Institute Francisc Rainer, has set as objective to investigate in 2009 the psychological vulnerability at urban population and the psychological frailty during the transition from adolescence to young adult on the transition background specific to our country nowadays.

In his work The cultural foundation of personality, the anthropologist Ralph Linton emphasized that, if the normative references on a certain culture are thoroughly known, the shape (nature) of the future hysterias can be almost accurately predicted. (Linton R., 1968)

A solid knowledge of rules and customs of a community as well as the individual factors is crucial in treating different kinds of diseases and also in building a good therapeutic relationship between the therapist and the patient.

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Mihaela- luminița Staicu, Mihaela Cuțov

CULTURAL AND ANTHROPOLOGICAL DIMENSIONS OF HEALTHY STATUS

Speaking about healthy status only by the functional criteria is a very relative approach and that is because people's functional capabilities are appreciated following a normative standard consisting of a specific set of social norms. This is why, it is very important, when it comes to treating patients, to take into account the other aspects as well: cultural aspects, the traditions, the etiological and philosophical conceptions about the world and the disease; these can be different not only from a continent to another or from a country to another, but also within the same country.

This paper aims to underline the various aspects that a therapist has to take into account when dealing with a patient; the attitude towards health and disease can be very different from an individual to another, as their definition is influenced by factors such as: age, religion, sex, ethnical affiliation, socio-economic status, profession, psychological and cultural factors. This is why the medical science has developed a new branch called Medical Anthropology, a science that studies the indigene conceptions about health and disease in different cultures.

We concluded that a solid knowledge of rules and customs of a community as well as the individual factors are crucial in treating different kinds of diseases and also in building a good therapeutic relationship between the physician and the patient.

Mihaela- luminița Staicu, Mihaela Cuțov

КУЛЬТУРНЫЕ И АНТРОПОЛОГИЧЕСКИЕ ПАРАМЕТРЫ ЗДОРОВОГО СОСТОЯНИЯ

Говоря о здоровом состоянии только по функциональным критериям - это очень относительный подход, и это потому, что функциональные возможности людей ценят по существующим нормативным стандартам, состоящим из определенного набора социальных норм. Вот почему очень важно, когда речь заходит о лечении пациентов, с учетом других аспектов, а именно: культурные аспекты, традиции, этиологические и философские представления о мире и болезнях; они могут отличаться не только от континента к континенту, из страны в другую страну, а также в пределах одной страны.

Это исследование призвано подчеркнуть, что Терапевт должен принимать во внимание различные аспекты при рассмотрении пациента; отношение к своему здоровью и болезни могут иметь различное течение от человека к другому, поскольку их определение зависит от таких факторов, как возраст, религии, пол, этнической принадлежности, социально-

экономического статуса, профессии, психологических и культурных особенностей. Именно поэтому медицинская наука разработала новую ветвь под названием медицинской антропологии, науки, изучающей первостепенные представления о норме и патологии в различных культурах.

Мы пришли к выводу, что твердое знание правил и обычаев сообщества, а также индивидуальные факторы играют решающую роль в лечении различных видов заболеваний, а также в создании хороших терапевтических отношений между врачом и пациентом.

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ОСНОВНІ НАПРЯМКИ ОСВІТНІХ ПРОЦЕСІВ У РОЗВИНЕНИХ КРАЇНАХ СВІТУ

Проблеми змін і розвитку освіти у розвинених країнах світу активно підіймаються і аналізуються в контексті модернізації та пост модернізації суспільства в цих країнах. Модернізація при цьому розуміється не просто як "становлення" сучасності, і як процес міжнародної соціалізації, тобто процес набуття рис, притаманних розвиненим цивілізованим державам. Петер Штомпка визначає модернізацію як наближення суспільства через усвідомлення здійснення певних намірів, цілей і планів до ухваленої моделі сучасності, частіше за всього до зразка якогось існуючого суспільства визнаного сучасним [3, С.528].

Процеси модернізації мають університетський характер, розповсюджуються на всі аспекти і грані суспільного життя. Наприклад, соціальний тип особистості, характерний для суспільства, що модернізуються, характеризуються раціоналізмом, індивідуалізмом, прагненням до змін, мобільності, самовдосконалення.

В умовах постмодерністських впливів відомий харківський філософ Є.А. Подольска вважає наступні:

1. *Відмова від ідеології диктату* в тому, що стосується світогляду тих хто навчається. Система освіти більше не бажає формувати людину із заданими властивостями, їй більше не до души людина, що рефлектує, міняється, людина можливостей, а не реалізацій.

2. *Множинність педагогічних принципів,* що виникла на місці однієї педагогічної системи, причому вони можуть бути абсолютно протилежні, але при цьому не заперечувати один одного, мирно уживаються.

3. *Значно більше свободи вчителів, викладачів, учнів і студентів,* яке іноді уявляються руйнуванням.

4. *Трансформація авторитету викладача, вчителя,* які тепер не є втіленням Істини і Знань. Вчитель, в широкому розумінні, втрачає свій інституційний авторитет, що виникає з самого факту визнання ролі наставника. Авторитет тепер набуває *"особисістного"* характеру. В ситуації постмодернізму вчитель покликаний створити умови для *"освітнього діалогу",* де разом з вихованцями буде шукати шлях до успіху в складному світі.

5. *Реалізація мультикультурної освіти.* В ситуації, коли постмодернізм затверджує *"відмінності і особливості"* культури і релігії Заходу втрачають позицію