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THE SOCIAL AND THE EMOTIONAL IN THE QUALITATIVE METHODOLOGY

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"We are a conversation"

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The qualitative view offers unique works, halfway between art and social research; each fieldwork creates its own categories, its own narrative configurations, its own metaphors; It offers us the voice of the expert on the topic, the interviewee, and gives us the deep keys to the topic studied. It shows us complete life stories, or in the present work, going through a specific biographical moment in life.

Qualitatively contains the details that quantitative methodology can not collect. No matter the clothes, the attitude, the gestures, the voice, everything must be noted for the complete portrait of each story.

FROM THE PART TO THE WHOLE

In this research I collect the context of the anxious-depressive syndrome; patients diagnosed with SAD; The sample is significant, and is closed by the principle of saturation, that is, when continuing to add interviews with more patients does not provide new data.

Unlike the quantitative methodology that is representative.

Qualitative finds rich data, without a priori, it does not state a hypothesis, but rather asks questions. In this work I asked myself:

Can the dizzying social changes of recent decades cause temporary disadaptation to a new situation, or cause a chronic loss of homeostasis in the person?

I placed a microphone in front of the interviewee and asked him only the three Hippocratic questions:

What's happening to you, since when has it happened and what do you attribute it to?

This way the framework is an open interview, not conditioned by closed questions and answers.

It involves artisanal methodological work since through the analysis of the interview text, categories are established according to the themes referred to by its protagonists, who will in turn name the problem areas. In this work I wanted to study the context of anxiety-depressive syndrome. I chose the qualitative methodology because it allowed me maximum freedom in obtaining data so that wide-ranging connections can be established.

THE INVESTIGATION

The population under study is healthy; go to their doctor to ask for help for symptoms of physical and mental discomfort: they were referred to me from medical consultations at a health center in the north of Spain; It was explained to them in general that this was a study on anxiety-depressive syndrome, and they were asked to sign the informed consent.

The informants were 18 women and 4 men, aged between 20 and 80 years. In terms of training, they are mostly above their job occupation, the profiles range from no studies, 10%, school graduate 30%, vocational training 40% to 20% university studies. The majority perform precarious and low-specialization jobs.

The duration of the interview was an average of 30', it ended when the patient considered the information provided sufficient. I have to say that in many cases, something fundamental is left out of the recording, a last phrase, free, spontaneous, loaded with meaning, floating in the interview room while they say goodbye, and that methodologically must also be collected.

During the interview, the person narrates a specific episode, a triggering milestone in their daily life, defined as a Stressful Life Event. Once the interviews were transcribed, I established the categories, according to the text that yielded four areas of the problem, in this order: work, relationship, family, and immigration violence.

Another fundamental part of data collection is to extract the narrative configurations with which anxiety and anguish are expressed, the body metaphors with which they describe the symptoms, inadvertently showing the related context.

THE ANXIOUS DEPRESSIVE SYNDROME

It has not stopped increasing since 2008, it is defined as non-disabling discomfort associated with a process of adaptation of the person to a situation, generally brief and presenting associated physical and psychological symptoms.

Spain is at the forefront in the consumption of benzodiazepines due to the so-called Z codes, which the World Health Organization states as 'problems that are not diseases, but that present digestive symptoms, irritability, tiredness, crying. . . '

Mental Health Units are saturated with this type of anxious-depressive demand. Nowadays this phenomenon has become a public health problem,

The research includes a Macro context outside the individual and a micro context within the individual.

It is carried out in the midst of an economic crisis, and before the pandemic.

And it is through the patient's story where rich data is discovered: WHAT IS MEANINGFUL.

THE QUALITATIVE

It allows you to understand the problem in depth. The population studied presents an exposure to risk. They are subject to chance and stigmas, in a labor market where there is a flow of inclusion, exclusion, arbitrary, derived from opportunistic economic movements, anyone can be removed or rescued in a surprising way and forced to accept conditions below the previously respected rights, already legislated in the Welfare States; The surplus population without opportunities also increases. The economic regulates everything else like the moon regulates the tides; and the chain effect also causes new family models and new forms of socialization, affecting production, consumption and, in general, ways of life.

In both Health Sciences and Social Sciences, a good diagnosis is half the treatment. The methodology chosen here allows a space of respect and empathy to tell the story of the private stressful life event, which will open that diagnosis, reveal a social phenomenon and prepare the Macro strategy for minor mental health problems.

What is collected is what remains outside the medical consultation, and yet it has become a public health problem.

THE LANGUAGE

The life story at a specific moment in the patient's biography offers us the intimate, the narrated identity and what others assign to us.

Language is a social agreement. What is said so that communication is not interrupted is a social action.

As the Social Psychologist Still already developed, it serves to express what is most important to one, it reinforces the person and their performance.

In communication there is a circle of reward, it is triggered with verbal and non-verbal language, by putting a hand on the shoulder or similar physical contact, with eye contact, a smile.

The silence of the Other is dangerous, it is avoided by talking for the sake of talking, in the best sense, that of conversation.

QUALITATIVE RESEARCH gives us internal conversation, intersubjectivity: the three interlocutors, a concept developed by M. Mead in Symbolic Interactionism: THE SELF, the ME, the Other.

The analysis of the SAD text speaks of the ability to narrate oneself, of one's identity being safe despite the attacks.

In the population studied, we identified two types of identity, which Bauman already defined:

LEGITIMATE: the one generated by civil society, institutions.

OF RESISTANCE: generated by actors in devalued, stigmatized positions. and we see that this is reinforced.

RESULTS

The profile of those studied is those who believe in the laws, fight with fair play, want to be recognized, are honest, have hope. They do not return anger, but rather function as a containment dam, they are more rational than emotional.

They will not appear in the news as aggressors but for being attacked

The family occupies a fundamental place in supporting the AVE (stressful life event) even when they cannot help them more, because it is beyond their control, but they are present in their influence, even when they are hostile, feel alone, isolated in the problem, without leisure time. They are resilient, they take a long time to ask for help.

They have those present in their thoughts, absent, hostile, indifferent.

Answering the initial research question, the results show how such rapid social changes affect and go from causing temporary disadaptation to chronically breaking the person's homeostasis, affecting health in different ways.

They represent the Social Being, which is currently the target of these changes, in the atomization of known socialization.

They are ``healthy" patients who do not want to hide behind the drug, the ``Role of the Patient" but end up consuming them to preserve their work, family and social functionality. They experience an attack on their identity, but they preserve it, they anchor themselves in it. They are experiencing different forms of daily violence:

1- Economic violence: Mobbing, exploitation, precariousness, unemployment, but they do not throw in the towel.

2- Intimate partner violence: abuse, mistreatment, and they put up with it thinking that they are responsible for containing it and changing the situation.

3- Family violence: caregiver syndrome, abuse within the family, between siblings, parents-children, they do not ask for help to distribute care tasks, they feel invisible, with a feeling of guilt if they ask for help; They are ashamed of their isolation at home, they report leaving social relationships, they do not want to talk because they believe they have nothing to contribute, nothing interesting to say outside of the caregiver routine.

4- Immigration violence: lack of recognition, integration, occupied in precarious jobs, with excessive hours, poorly paid, without leisure time, in ethnic ghettos, their children play alone in the park, they do not feel invited to do so with others. from the country of settlement, they experience a welcome in the best of cases with ``papers" but not social immersion.

CONCLUSIONS

We are facing a problem of emotional discomfort, not mental health, classic mental illnesses are not increasing: Schizophrenia, Psychosis, Bipolar Disorder, but rather behavioral disorders and, above all, Anxious-Depressive Syndrome that demand help in Primary Health Care consultations and Units of Mental Health.

Anxiety and anguish are related to pressure in the present and uncertainty about the future.

There is a deficit of social emotions: belonging, recognition, bonds, trust.

The problem is social: psychosocial and socio-health, the trend paints a picture of: everyone tired, everyone medicated, the drug being the cheapest regulator to maintain the social functionality of the population.

The consumption of anxiolytics and antidepressants is growing in Spain and since the pandemic we have been at the head of the world.

The Mental Health Units are saturated with patients who collapse the priority attention of other mental conditions, self-harming behavior and suicide, who cannot be distracted, causing long waiting lists.

The problem is focused on the lack of psychologists, although it is true, but it is necessary to incorporate social liaison professionals to address daily emotional discomfort, reinforce the social Prescription that contains and accompanies, with closeness, frequency, and follow-up, where the main It is listening and psychosocial support, the usefulness of community, cultural, associative resources, in a personalized way.

We are facing a problem of emotional well-being, not mental health, which does not depend only on health services, but on community networks and other professionals.

Social T. , Social Educators, occupational therapists.

It requires:

- direct measures: SOCIAL PROFESSIONALS, not just psychologists
- indirect, transversal measures, economic plans, community services, communicative action, methodological embrace.

EMOTIONAL WELL-BEING

It includes a sense of belonging: family, friends, community group, being recognized, feeling useful, having survival and pleasure needs covered, having one's own time.

THE SIGNIFICANT

The person is historicized within a culture

We see the role that Significant/present, absent/hostile Others play in your life, their values, codes of conduct. How you define your situation and how you orient yourself in it;

the connections of some events with others in the thread of his life.

The continuous and simultaneous recreation of social contexts with the person and their social action; More than psychological treatment, it requires communicative and community action.

The phenomenon of SAD requires many social actors working collaboratively to promote crisis care services.

This syndrome discovers and describes the fear, uncertainty and current collective exposure to the risk of the lifestyle created by the current economy.

The latest data show that SAD becomes chronic, it is no longer a temporary maladjustment, but rather it becomes chronic, because the living conditions of the context do not change.

AVE, stressful life event

SAD, anxious depressive syndrome

REFERENCES

Abramson,J. H. (1988) Survey Methods in Community Medicine. Ed. Churchill. Livingstone. Longman Group Limited, Edinburgh

Alonso, E, Nauranera, R. Varela, J. y Picas,(J,1987). Estudios observacionales de la demanda

Asistencia Primaria. Atención Primaria,4148-154.

Bauman,Z,(2007). Miedo líquido, la Sociedad contemporánea y sus temores. Paidos. Madrid.

Blanchs,M. A. (1990). Las representaciones sociales, aportes críticos a la Psicología Social en Latinoamérica. Universidad de Guadalajara,pp-183-217.

Beck. U. ,Guidens,A. ,Lash. Scott. (2008). Modernización reflexiva: política, tradición y estética en el orden social moderno. Alianza. Madrid.

Bobes,J. (2001). Trastornos de ansiedad y trastornos depresivos en Atención Primaria. Masson-Barcelona.

Castells. M. (2001). la era de la Información (I-II-III) Alianza editorial-Madrid.

Christlieb,P. (1984). La psicosociología. Un proyecto de psicología social. Laboratorio de Psicología Social. UNAM.

Clemente Diaz, M. (1992). Psicología Social. Métodos y Técnicas de Investigación. Eudema. Madrid.

Conde, F. (2008). El diseño de la Investigación Cualitativa. Criterios de elección de las técnicas de investigación. Taller de Investigación Cualitativa. Observatorio de Salud Pública. SCS Cantabria.

Damasio,A. (2019). En busca de Spinoza. Booket

Durkheim, E. (1982). El suicidio. Akal. Madrid

Foucault,M. (1999). Arqueología del saber. Siglo XXI. México.

Freud, S. (1916-1938)Ensayos, El malestar de la cultura. Obras completas,vol III. Biblioteca Nueva. Madrid.

Habermas,J. (2011). Teoría de la Acción comunicativa. complementos y estudios previos. Cátedra.

Lipovetsky,(2022). La sociedad de la decepción. Anagrama

Mead. G. (1994). La mirada reflexiva de George Herbert Mead. Centro de Investigaciones Sociológicas.

Rorty R. (1991),Philosophical Papers. Cambridge University Press.

Russel,B. (2003). La conquista de la Felicidad. Debolsillo.

Sassen,S. (2007). Una sociología de la globalización. Katz, Buenos Aires.

Simmel,T. (2002). Cuestiones fundamentales de Sociología. Gedisa,Barcelona.

Sloterdijk, P. (2003). Esferas. Siruela. Madrid.

Touraine. A. (2014). Critique de la modernité. traducida al castellano, Fondo de Cultura Económica. México.

Trujillo,M. (2002). Psicología para después de una crisis, como superar el estrés en situaciones críticas. Aguilar.

Van Dijk,T. A. (1997). Discourse Studies. A. Multidisciplinary Introduction. 2. vols. London. Sage (traducción española publicada por Gedisa, Barcelona, 2001)

Watzlawick,P. Bavelas, J. , Jackson,D. D. (1997). Teoría de la comunicación humana. Herder,Barcelona.