Illness and the sick role as context for social work practice
Biomedical definition of health — focus on disorder, inhibits the view of the patient as a total person in a total environment; WHO (1940) — a state of complete physical, mental, and social willing; Ahmed, Kolker and Coelho — a multidimensional process involving the welling-being of the whole person in the context of his environment.
Disease, illness, sickness

- **Disease** — deviations from the norm of measurable biomedical variables
- **Illness** — subjective state of being unwell, of experiencing distress or pain
- **Sickness** — a social concept, refers to a social label applied by others and accepted by the individual
- Accepting the social identity of “ill person” therefore involves a process of negotiation between the individual, his social network, and the physician.
Becoming a patient

- Suchman’s hypothesis—the symptom experience; assumption of the sick role; medical care contact; dependent-patient role; the stage of recovery or rehabilitation. The model of illness experience (p.38) is a generalization. In any episode of illness, not every stage may be involved. SW has most often made its contributions to health care during the 4th and 5th stages of the illness experience.
Conflicting Explanatory Models of Illness

The Influence of Culture: 3 domains of health care: popular or lay care; folk care and scientific health care. Kleinman and associates’ suggests that each domain has its own explanatory model of illness, including explanations of cause, onset, course of sickness, and treatment goals. When the P holds a different explanatory model from that of the professional practitioner, communication about illness and disease is apt to be distorted, clinical management adversely affected, and P satisfaction diminished.
Conflicting Explanatory Models of Illness

- In many health care organizations, workers may be the only professional who is aware of and concerned about the cultural and social factors in illness behavior. Kleinman and colleagues believe that the P’s EM must be elicited and understood, the biomedical model explained in lay terms (by the physician), and the two models openly compared for the P and practitioner to identify discrepancies, clarify value conflicts, and plan appropriate P education. Communicating it to the physician or the health care team.
Psychological and Social Factors in the Patient Role

- Two extreme from the patient population—those who use hospital emergency service inappropriately for nonmedical concerns and those who fail to respond appropriately to serious symptoms and even painful illness.
Patienthood

- It is not merely a response to illness. It is a formal social role involving reciprocal expectation, perceptions, and relations with a variety of health care professionals. It must therefore be understood also within the role network or social structure of the organization itself.
Dehumanizing processes

It involved in patienthood that make of the human being a mere object. Freidson (1970) suggests that the most hurtful depersonalizing procedures are those which stem from professional orientations. These are the practices that undermine patients’ and family members’ hard-won capacities for competence and effectiveness, human relatedness, self-regulation, and the sense of personal identity and dignity.
The central issue for F is the withholding of information from the P and family. Without information, the P can’t evaluate what is being done to her/him, why she/he feels as she/he does, what to expect next, how long the wait is likely to be, and whether changes she/he observes in her/his care and medication are errors or by order. Without information not only is she/he incompetent in judging the competence of her role partners, but she can’t fully competent even in carrying out the responsibilities of the patient role.
SW, by assessing the coping capacities of patient and family, can suggest to the physician or the team when information is needed or is likely to be helpful and when it is not. SW may collaborate with the physician by helping the P and family deal with their feelings about the information, repeating it to them from time to time until it is completely “heard” and assimilated, and helping them consider ways to act constructively on the information. Workers can mediate between P and other health care professionals in order that Ps and families will have the information needed for competent coping with the stress of the illness.
the lack of privacy is a loss of dignity. The absence of opportunity for social interaction and the consequent loss of relatedness compound the problem. Schuster (1976) identified 4 major variables influencing the P’s ability to control the interpersonal boundary process: decreased mobility, impairment of consciousness, relaxation of the boundary vis-à-vis other Ps, and perception of role.
Issue of privacy and opportunity for social interaction

Schuster suggests that staff awareness of the problem may help them to reduce unnecessary violation of the P’s control. The task involves striking a balance between protecting the P’s privacy as much as possible and meeting the P’s need for emotional support from staff. Again, workers are often in a position to be in the hospital to listen and to collaborate with team members in the dual task involved in the P’s control of his interpersonal boundary. A practice implication for the SW is that opportunities must be provided, in every episode of service, for maintaining relatedness, self-directedness, self-esteem, and the sense of competence to the degree permitted by the P’s condition and the family’s capacities.