Illness and the sick role as context for social work practice

Health , Disease , Illness , and Sickness

- 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 4^{th} and 5^{th} 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

Information sharing/given

- 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 .

Information sharing/given

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 .

Issue of privacy and opportunity for social interaction

- 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 .