SOW 105
Introduction to Medical Social Work

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Course Manual

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COURSE MANUAL

Introduction to Medical Social Work

SOW105

University of Ibadan Distance Learning Centre

Open and Distance Learning Course Series Development

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Vice-Chancellor's Message

The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfilment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.

Vice-Chancellor

Foreword

As part of its vision of providing education for "Liberty and Development" for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

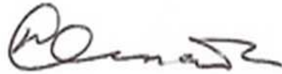
The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop your computer skills by availing yourself the opportunity of training that the Centre's provide and put these into use.

In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high

quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.



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General Introduction and Course Objectives

The over-riding objective of this course is to enable you understand how social work is generally practiced in hospital or health care settings. To this end, you will be introduced first to hospital and health care systems, the nature of social work and medical social work, scope, objectives and methods of medical social work.

The course also includes detailed discussions of the nature of social work practice in hospitals, qualities and responsibilities of medical or clinical social workers, values and ethics in medical social work, description of a typical social services department and theoretical models for medical social work.

The course will end with discussions of health-related issues, such as health and illness behaviour, stress and stress management, pain and pain management, social work in public health and health education.

Unit1: Introduction to Medical Social Work

Expected duration: 1 week or 2 contact hours

Introduction

In this session, you will learn about Medical or Clinical Social Work practiced in a hospital. What then are the different meanings of hospitals? How is hospital different from health care system? What are the different types of health care systems and their components?

Learning Outcomes for Unit 1

When you have studied this session, you should be able to:

1.1 Define hospital (SAQ1.1)

1.2a Define health care system (SAQ 1.2a)

1.2b Mention three different tiers of health care system (SAQ 1.2b)

1.2c List two components of tertiary health care system. (SAQ 1.2c)

1.1 Hospital System

Hospital is a large building where sick or injured people go or are taken for care by trained medical personnel. It is designed to admit patients, provide efficient care and discharge patients promptly.

Figure 1.1 Building showing different structures of a hospital with social workers, nurses, doctors and patients.

The main point you should note from the description given above is that hospital has different structures and perform various functions.

It also shows examples of personnel found working within the hospital.

The scientific interpretation of illness and interest in diagnosis, treatment and care remains dominant whereas, the patient's perception of the illness, the effect on his or her personnel life and the adjustment required are often disregarded.

The integration of social work in medical care therefore shifts the emphasis away from an exclusively scientific to the way the ill person reacts to the illness physically, emotionally and psychologically.

1.2 Health Care System.

Health Care System is a means through which health, wellness, wellbeing or illness of an individual is catered for. It refers to the ways by which health care services are given to the sick and non-sick individuals in the community by the government or its agents (Mojoyinola, 2002)

1.2.1 Types of Health Care System

There are three types of health care system in Nigeria. These are Primary, Secondary, and Tertiary health care systems.

- **Primary Health Care System (PHC):**

PHC is the first level in the National Health System and usually funded by the local government councils in the country. It is the closest to the people and most community based health services that touch the lives of citizens in the community take place.

- **Secondary Health Care System:**

This is the second level of health care system where patients who require more than routine treatment are referred from primary health care level. The services which may involve use of X-ray, Laboratory and others are usually provided in general, state and specialist hospitals. They are funded by state government hospitals and some private owners of such centres.

- **Tertiary Health Care System:**

This is the third level of health care which takes place in the teaching hospitals and provides specialized kind of treatment or services to people. These tertiary centres also provide teaching services and conduct research. They are funded by federal government.

1.2.2 Components of Health Care Systems.

PRIMARY HEALTH CARE SYSTEM

- Food hygiene and nutrition
- Family planning
- Expanded programme on immunization (EPI)
- Oral rehydration therapy
- Health education
- Malarial control
- Prevention and control of communicable diseases
- Housing
- Antenatal and postnatal care
- Outpatient, after care and rehabilitation services

SECONDARY HEALTH CARE SYSTEM

- In and out patient care

- Laboratory services
- X-ray and ultra sound scan services
- Medical and surgical treatment
- Psychosocial treatment and support
- Nursing care and management
- Referral services

TERTIARY HEALTH CARE SYSTEM

- Specialized health care services
- Provision of specialized equipment
- Research work.

Activity 1.1

Take a moment to reflect on what you have read so far. Based on your learning experience, note down the different levels of health care system and their components

Activity 1.1 feedback: Take a look at box 1.1: it describes the three levels of health care system.

Box 1.1

Levels of Health Care System
1. Primary Health Care
2. Secondary Health Care
3. Tertiary Health Care

What then exactly does the tertiary health care stand for? The box 1.2 below spelt out specific things that tertiary health care stand for.

Box 1.2

Components of Tertiary Health Care
1. Research work
2 Provision of specialized equipments
3 Specialized health care services.

Summary of Unit 1

In module one, you have learned that:

1. Medical Social work is practiced in hospital.
2. There are three levels of health care; they are primary, secondary and tertiary health care.
3. The three levels of health care system have their specific functions.

Self-Assessment Questions On Unit 1

Now that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering these questions. You can check your answers with the notes on self assessment questions at the end of this unit.

SAQ 1.1 (tests learning outcome 1.1)

How can hospital be correctly defined?

SAQ 1.2a. (tests learning outcome 1.2a)

How can you define health care system?

SAQ 1.2b. (tests learning outcome 1.2b)

Can you mention the three levels of health care system

SAQ 1.2c. (tests learning outcome 1.2c)

List three components of tertiary health care system

Notes on Self- Assessment questions (SAQS) for Unit 1

SAQ 1.1: It is a large building where sick or injured people go to or are taken for care by trained medical personnel.

SAQ 1.2a: It is a means through which health, wellness, wellbeing or illness of an individual is catered for.

SAQ 1.2b: Primary health care system, secondary health care system and tertiary health care system.

SAQ 1.2c: - Specialized health care services

-. Provision of specialized equipment

- Research work

Unit 2: The Concept/Nature of Social Work and Medical Social Work.

Expected duration: 1 week or 2 contract hours

Introduction.

In this session, you will learn about social work and its practice in hospital or health care setting. What are therefore the nature and concepts of social work? What will then be the concept and nature of medical social work?

Learning Outcomes for Unit 2

When you have studied this session, you should be able to:

2.1a Define social work according to NASW (SAQ 2.1a)

2.1b State the unique nature or characteristics of social work.(SAQ 2.1b)

2.2a Define Medical Social Work according to Skidmore et al, 1997(SAQ 2.2a)

2.2b State the knowledge that Medical social work requires (SAQ 2.2b)

2.1 The Concept and Nature of Social Work

2.1.1 Concept of Social Work

Social work is an art, a science and a profession that helps people to solve personal, group and community problems and to attain satisfying personal, group and community relationships through social work practice (Skidmore et al, 1997). The National Association of Social Workers (N.A.S.W) also defined Social Work as the professional activity of helping individuals, groups or communities enhance or restore their capacity for social functioning and creating social conditions favourable to their goal.

Another view sees social work as an activity that seeks to remediate human problems by helping individuals, groups or communities engage resources to develop capacities and strategies that will improve their social functioning.

All the definitions indicate that social work is an active “doing” profession that brings about positive changes in problems situations through solving or prevention.

2.1.2 Nature or characteristics of Social Work

- Focus is on the wholeness of a person
- Emphasy is on the importance of the family in molding and influencing behavior.
- Utilizes community resources in helping people to solve their problems.
- Has unique educational programme involving class work and practical field work experience
- Has distinctive professional bodies
- Has three major methods namely: Casework, group work and community organization.
- Relationship is the key in social work process
- Has an orientation in psychiatric concepts and places considerable stress upon understanding people.
- Basic aim of social work is to help clients to help themselves.

2.2 The Concept and nature of Medical Social Work

2.2.1 The concept of Medical Social Work

Medical Social Work is defined as social work in health care or hospital setting. That is, it is the application of social work knowledge, skills, attitudes and values to health care (Skidmore et al, 1997). Medical social work applies itself to illness brought about by social and environmental stresses that result in failures in social functioning.

2.2.2 The Nature of medical social work

- Requires knowledge of illness and the psychosocial impact of diseases on the individual and family.
- Requires the application and adaptation of social work concepts, principles and ideas to the special needs of hospital.
- Collaborates with all health care professionals within the hospital setting.
- Carry out health education where immunization, good mental health, antenatal and postnatal care are encouraged.

- Engage in early screening programmes for detection of diseases and encouraging treatment
- Prevention of deterioration of a disease or problem

Activity 2.1

Take a moment to reflect on what you have read so far. Based on your learning experience, note down what all the definitions of social work indicate.

Activity 2.1 feedback:

Social work is an active "doing" profession that brings about positive changes in problems situations through solving or prevention.

Box 2.2: The concept and nature of Medical Social Work.

Medical Social Work is social work in health care or hospital setting.

It is important to note:

Health care professionals that medical social workers collaborate with include:

- Doctors
- Nurses
- Psychologists
- Physiotherapist
- Health educators
- Pharmacists
- Hospital Maids

Summary of Unit 2

In unit 2, you have learned that:

1. Social work is viewed as a helping profession
2. The nature of social work is generally all encompassing
3. Medical social workers are involved in psychosocial functioning of an individual and family in health care setting.

4. The nature of medical social work is all encompassing within the hospital setting.

Self Assessment Questions (SAQs) for Unit 2

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the notes on the Self Assessment Questions at the end of this module.

SAQ 2.1a (tests learning outcome 2.1a)

How can we define social work recording to NASW?

SAQ 2.1b (tests learning outcome 2.1b)

Can you state the unique characteristic of social work?

SAQ 2.2a (tests learning outcome 2.2b)

How will you define medical social work according to Skidmore et al, 1997?

SAQ 2.2b (tests learning outcome 2.2b)

Are you able to state the knowledge that medical social work requires?

Notes on the Self Assessment Questions (SAQs) for unit 2

SAQ 2.1a: It is the professional activity of helping individuals, groups or communities enhance or restore their capacity for social functioning and creating social conditions favourable to their goal

SAQ 2.1b: Has unique educational programme involving class work and practical field work experience

SAQ 2.2a: It is the application of social work knowledge, skills, attitudes and values to health care

SAQ 2.2b: Requires knowledge of illness and the psychosocial impact of diseases on the individual and family.

Unit 3: The Scope, Objectives, Principles And Working Methods Of Medical Social Work

Expected duration: 1 week or 2 contact hours

Introduction:

In this session, you will learn about social work practice in health care carried out directly or indirectly. What then is the scope of medical social work? What are the objectives and working methods of medical social work?

Learning Outcomes for Unit 3

When you have studied this session, you should be able to:

3.1 State the history and scope of medical social work (SAQ 3.1)

3.2 State the specific of objective of medical social work that deals with the institution (SAQ 3.2)

3.3 Identify the principle of medical social work that has to do with environment (SAQ 3.3)

3.4 State the two major working methods in Medical Social Work (SAQ 3.4)

3.1 The History And Scope of Medical Social Work

HISTORY

In England, between 1880 – 1900, after patients were discharged, visitors and nurses were asked to give advice to them. This marked the beginning of medical social work in England.

In 1905, Boston Medical Institutions appointed Medical Social Worker (M.S.W) for the first time. In United States of America, Social work was based in the community in the 1880s primarily through affiliation with agencies (Kerson, 1981). Then, Social Workers addressed public health problems such as tuberculosis and infant mortality, syphilis, polio and unmarried pregnancy.

Direct Social Work practice in health care is traced back to City hospital in Cleveland where outdoor relief workers were used to clear the wards filled with chronic patients and homeless civil war veterans. The professional stature of clinical social work advanced significantly in 1905

when Dr Richard Cabot introduced medical social services at the Massachusetts General Hospital.

From 1918 – 1932, a medical research led to technological advances and hospitals became strategic centres for medical practice. The role of Medical Social Worker evolved (Caroff and Mailick, 1985). In the mid 1920s, the American Hospital Association (AHA) produced the first formalized articulation of Medical Social Work. (Norman, 1977). During colonial rule in Nigeria, the government was more concerned about issues of security and missionaries were concerned about the health of the people especially material and child welfare (Sihram, 1991). Gradually social work practice in hospitals spread to other parts of the world including Nigeria.

Medical social work is not just limited to the treatment of diseases but encompasses prevention, care of diseases and rehabilitation of patients. That is, it deals with those problems of the patients which are related to the physical and psychosocial environment. It is oriented towards the assistance of those people who during their treatment encounter social, physical, economic and psychological problems.

3.2 Objectives of Medical Social Work

The followings are the objectives of social work:

- Helping people having illness, trauma related crisis, disability to understand and manage psychosocial impact of illness on their lives and on significant relationships to make decisions and plans for the future
- Facilitating adaptive coping patterns to chronic illness or disability and assisting with re-integration to new environments.
- Participating in team work and providing insight into the psychosocial dimensions of the medical illness affecting patients and families.
- Identifying and arranging community supports and resources to facilitate discharge from hospital or transfer to alternative care facilities.
- Assisting with anticipatory grief and mourning and providing other bereavement related services to members of the family.
- Assessing the needs of patients, planning and implementing appropriate programmes.

- Identifying potential neglect, abuse and exploitation in vulnerable populations and involving authorized agencies.
- Supporting institutional goals and purposes.
- Encouraging institutional responsiveness to patients' needs.

3.3 Principles of Medical Social Work

What are these principles? Do you know that they are social techniques and humanitarian in nature. These working principles are:

- Enabling patient to solve his/her problems
- Determining social and psychological influence
- Developing will power and determination of the patient.
- Enabling patient to adjust to his/her problem
- Developing proper environment

3.4 Working Methods in Medical Social Work

As there are working principles in Medical Social Work, so there are working methods which terminate in good social work intervention. The major working method in social work is case study method? It means collecting information with regard to specific needs of the patient and working towards their fulfillment in accordance with the available means. Let us also know that case study method could be

1. Direct method of assistance and
2. Indirect method of assistance

3.4.1 Direct method of assistance

This is a method in which the Medical Social Worker is directly involved in the assistance of the patient. This could be in form of social case work or social group work.

(a) **Social case work:** here, assistance is provided by the medical social work to the individual patient and/or his or her family with the aim of developing his/her inherent capacity.

(b) **Social group work:** here, the medical social worker tries to strengthen the social relations of the patient and works towards the development of a healthy social environment for the patient.

3.4.2 Indirect method of assistance

This is simply not a direct method i.e. not individualistic. It is a form of community organization, social administration, social insurance, social security, social action and social work research.

(a) **Community organization:** This is when the medical social worker helps in the organization of community resources with regard to health problems

(b) **Social administration:** This is when the medical social worker guides the public opinion for the enactment of a new social legislation or any amendment in the prevailing legislation.

(c) **Social security and insurance:** This has to do with scientific study of the mind where the medical social worker assists the patient to utilize the facilities under social security and insurance.

(d) **Social action:** This is the participation of the medical social worker in the movements of social action at the national and international levels e.g. National Health programme involvement and World Health days.

(e) **Social Work research:** here, the medical social worker inspires surveys and investigations regarding to social, economic and psychological problems of the patient.

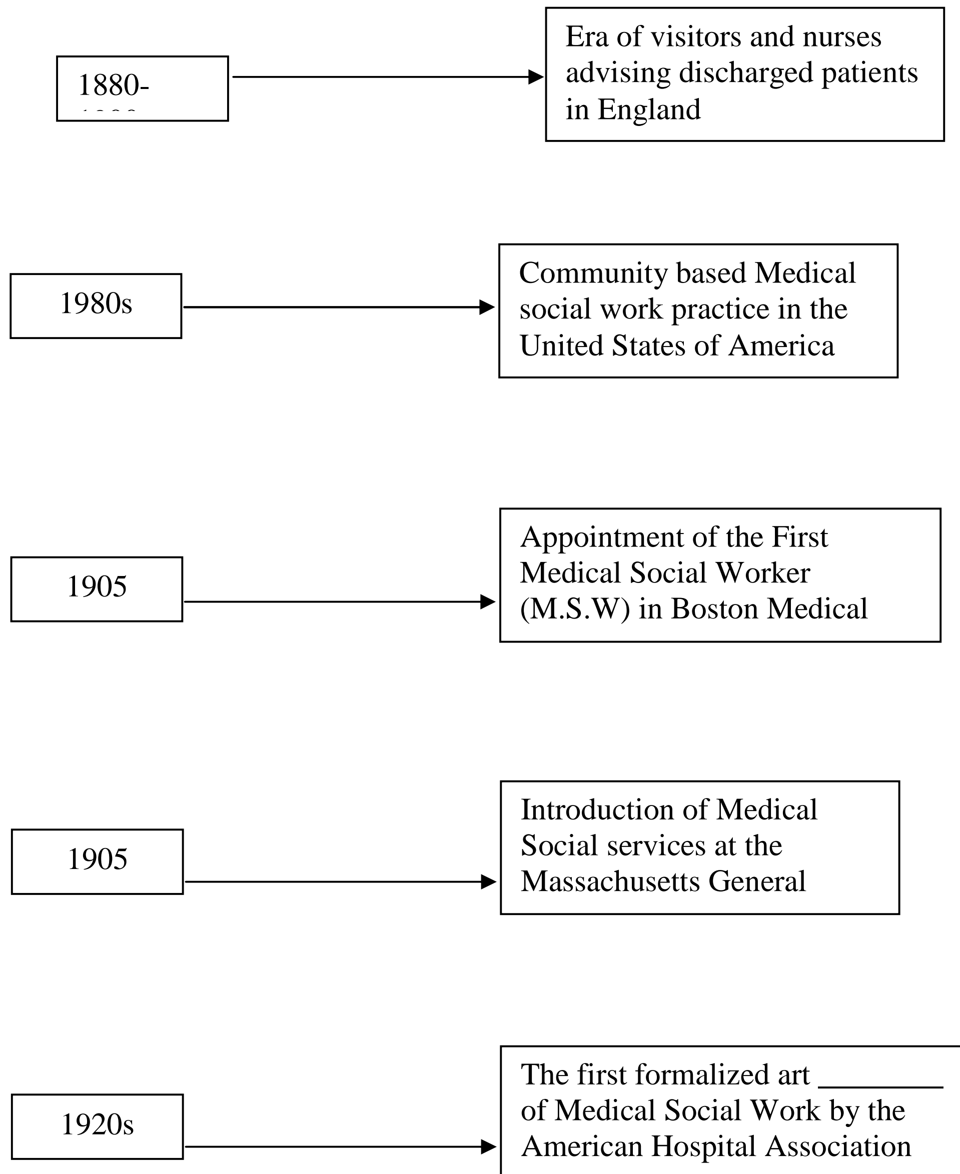
Activity 3.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowing that social work has its history and scope, note down some historical dates in the history of medical social work.

Activity 3.1 Feedback:

Take a look at figure 3.1 which shows the various dates with their records

FIGURE 3.1



For us to meaningfully understand the broadness of Medical Social Work, the scope of practice has to be known. The scope of medical social work is therefore represented in the box 3.1

Box 3.1: The Scope of Medical Social Work

Medical practice is not just limited to treatment of diseases and this is why Medical Social Work is involved in the following assistance in:

- Social problems
- Physical problems
- Economic problems
- Psychological problems
- Preventive services
- Rehabilitative services

To successfully practice Medical Social work, there are certain principles to be followed and these are as stated in Box 3.2

Box 3.2: Principles of Medical Social Work

- Enabling patient solve his/her problem
- Determining social and psychological influence
- Developing will power and determination of patient
- Enabling patient to adjust to his/her problem
- Developing proper environment

For an effective Medical Social Work practice, there are certain methods of practice to be followed. Consider the next box for these methods.

Box 3.3: Methods in medical Social Work	
Direct method	Indirect method
a. Social casework	a. Community organization
b. Social group work	b. Social administration
	c. Social security & insurance
	d. Social action
	e. Social work research

Summary of Unit 3

In unit 3, you have learned that

1. Medical social work has it developmental history dated from 1880 till date
2. There are many areas of involvement in Medical Social Work and not just limited to treatment of diseases.
3. There are 9 specific objectives of Medical Social Work practice
4. There are certain principles that guide medical social work ranging from individual focus to environmental focus
5. The methods of practice in medical social work could be direct or indirect.
6. The direct method of assistance in medical social work is either case work or group work.
7. The indirect method of assistance includes community, organization, social administration, social action, social work research, social security and insurance.

Self Assessment Questions (SAQs) for Unit 3

Now that you have completed the study session, you can assess how well you have achieved is learning outcomes by answering these questions. You can check your answers with the Notes on Self – Assessment Questions at the end of this unit.

SAQ 3.1 (Tests learning outcome 3.1)

State the scope of Medical Social Work

SAQ 3.2 (Tests learning outcome 3.2)

State the specific objective of Medical Social Work that deals with the institution

SAQ 3.3 (Tests learning outcome 3.3)

Identify the principle of Medical Social Work that has to do with environment

SAQ 3.4 (Tests learning outcome 3.4)

State the two major working methods in Medical Social Work.

Notes on the Self-Assessment Questions (SAQs) for Unit 3

SAQ 3.1: The scope includes intervening in social problems, physical problems, economic problems, psychological problems, preventive services and rehabilitative services.

SAQ 3.2: Supporting institutional goals and purposes

SAQ 3.3: Developing proper environment

SAQ 3.4: Direct and indirect methods

Module 4: Social Work Practice in Hospital

Expected duration: I week or 2 contract hours

Introduction

In this session, you will learn about how social work is practiced in hospital setting. Some people have to live with chrome diseases, adjust to pain, change habits, diets, quit smoking, exercise and change employment. In all these, the patient must be a partner in the care of the disease, in the prevention and in its deterioration.

What then is medical social work in the hospital setting? What are the roles of social workers in hospital?

Learning Outcomes for Module 4

When you have studied this session, you should be able to:

4.1 Define medical social work (SAQ 4.1)

4.2 State the nature of social work practice in hospitals (SAQ 4.2)

4.1 Definition Of Medical Social Work

Social work practice in hospital setting is called medical social work and it s the application of method and philosophy of social work in the field of health and medical care. If can also be viewed as a branch of social blank that deals with the social, economical, physical and psychological aspects of patients.

Medical social work is practiced in hospitals, clinics and other health care settings that are commonly identified with the practice of medicine (skidmore et al, 1997).

Our emphasis here is that the clientele of medical social work are those patients within the hospital setting who are in need socially, psychologically and whose functioning is in danger of being impaired because of illness, disease or disability.

4.2 Nature Of Social Work Practice

Social Work practice has its varied nature and these are in form of screening/case finding, crisis intervention plan, counseling, emergency service, on call programmes, documentation and record

keeping, collaboration group work, bereavement services, discharge planning, post discharge, follow up and outreach services.

- **Screening/Case Finding**

In social work practice, we have learnt that every practice has its process. Therefore the nature of social work practice in hospitals is starting with screaming and case finding. To achieve a good screening, brief interviews are necessary to clarify needs. Pre-admission screening is helpful to identify patient who may encounter discharge problems. It may also accelerate preparation for discharge and reduce length of stay in the hospital (Berkman et al, 1988).

- **Crisis Intervention**

Crisis intervention simply means social work practiced in emergency critical situations that involve chaos or uproar. e.g. suicide cases and road accidents.
Social Workers employ crisis techniques to help the patients and their families to cope in the face of adversity by supporting hope. Crisis intervention facilitates processing of immediate fears and concerns in response to a devastating diagnosis e.g. cancer, HIV/AIDS. Once the immediate crisis is resolved, the situation stabilizes and the parties involved (patient and family) become organized, social work intervention shifts from crisis intervention mode.

- **Psychosocial assessment and intervention plan**

Assessment is an important nature of medical social work and it involves gathering and evaluating information. This evaluation is referred to as ASSESSMENT. Psychosocial assessment entails evaluating emotional response to medical event and future plans. This also involves assessment of family patterns of communication, decision making, role flexibility and response to members' need.

- **Brief counseling**

You need to know that counseling is a kind of talking cure and this could be brief or long term. To respond to the immediate need and establish a basis for future work, hospital social workers maintain careful focus on the problem at hand and we brief counseling.
Brief counseling is task focused and often episodic. This may centre on decision making regarding the following.

a. Nursing home care
b. Establishing guardianship
c. Understanding a new physical or cognitive limitation
d. Recognizing a need for on-going assistance with a major adjustment.

- **Emergency services on call programme**

You also need to know that most social work departments in hospitals address problems that arise after normal working hours. These services take the form of on-site emergency coverage and include:

a. Helping medical staff with problem – solving
b. Obtaining resources
c. Identify patients
d. Locating family members
e. Meeting with family in crisis

- **Documentation and record keeping**

It is of importance that social workers' activities are recorded in the patient's medical record. These activities include details of all interactions and interventions carried out with all patients.
It is also worthy of note that these records are kept for several purposes. They serve as records for future references in cases of legal proceedings, clarifications and research.

- **Collaboration**

For Social Workers, collaboration is a corollary of assessment and involves facilitating understanding of the patient and their family, conveying psychosocial aspects and its implications for other health providers so that immediate or follow-up plans are adjusted accordingly.
In the collaborative efforts, Social workers do the following:

(a) Co-ordinate and help to implement team decisions
(b) Provide consultation
(c) Advise and counsel colleagues based on their knowledge of human behavior, entitlements, policies and resources
(d) Consult with the team for the needs and concerns of patients and families.

- **Group work**

This a method of intervention which facilitates peer support for patients and their families faced with illness and disability. This group work is a kind of service that relieves stress and resolves crisis (Northen, 1990) and also provides a setting for problem-solving and facing reality. Group work provides opportunities for socialization and help decrease isolation in patients who might be at risk e.g. disabled and psychiatric patients.

Educationally, focused group provides information about the illness, its treatment resources and practical advice. Groups have been effective in emergency departments, waiting rooms and other sites (Scholper and Galinsky, 1990). Groups have also been used to help identify problems that require more intensive intervention (Ross, 1978).

- **Bereavement services**

Social workers offer services for bereaved people particularly family members in conjunction with colleagues or volunteers.

These bereavement services consist of:

a. Support groups
b. Educational sessions
c. Memorial services
d. Individual counseling
e. Periodic telephoning
f. Assistance with funeral arrangement

- **Discharge planning**

When a patient is admitted, he or she is bound to be discharged or released from the hospital. Social Work activities associated with discharge are assessment, emotional and educational counseling with the patient and his/her family, coordination of services such as home care, procuring of equipment or nutritional supplement and even negotiating with insurance companies to adjust benefits to the needs of the patient. Social Workers obtain funding from the hospital administration for special services and are also noted for referral services which support the patient after discharge.

- **Post Discharge Follow Up and Outreach Services.**

You will have to know that many patients who are discharged from the hospital are less likely to manage their own care hence there is the need for follow up, monitoring and service provision. Follow-up services include telephone calls and sometimes home visits to patients who are considered vulnerable.

The Medical Social Workers may develop programmes that will be offered in the patients community e.g. health education in schools to promote understanding of educates and improve management of a child with a specific illness e.g. cancer (Ross, 1989). As part of outreach services, medical social workers may organize summer camp, retreat, recreation or art programmes for children with burns, cancer or sickle cell anemia to assist with adjustment and emotional growth.

Activity 4.1

Take a moment to reflect on what you have read so far. Based on your learning experience note down the definition of medical social work as stated by skid more

Activity 4.1 feedback

Medical Social Work is practiced in hospitals, clinic and other health care settings that are commonly identified with the practice of medicine.

To understand medical social work, its nature has to be spelt out as represented in Box 4.1

> screening/case finding, crisis intervention plan, counseling, emergency service, on call programmes, documentation and record keeping, collaboration group work, bereavement services, discharge planning, post discharge, follow up and outreach services.

SUMMARY OF UNIT 4

In unit, 4 you have learned that:

1. Medical Social Work is a branch of Social Work that deals with the social, physical, economical, and psychological aspects of a patient
2. The nature of medical social work includes a variety of services e.g brief counseling

SELF-ASSESSMENT QUESTIONS (SAQS) FOR UNIT 4

Now that you have completed this study session, you can access how will you have achieved its learning outcomes by answering these questions. You can check your answer with the notes on the Self-Assessment Questions at the end of this module.

SAQ 4.1 (tests learning outcome 4.1)

How has Skid more et al, 1997 defined Medical Social Work?

SAQ 4.2 (tests learning outcome 4.2)

Which of the nature of Medical Social Work provides information about the illness, its treatment resources and practical advice?

NOTES ON THE SELF-ASSESSMENT QUESTIONS (SAQS) FOR MODULE 4

SAQ 4.1: Medical Social Work is practiced in hospital, clinic and other health care settings that are commonly identified with the practice of medicine.

SAQ 4.2: Group work.

Unit 5 Qualities, Roles and Specific Responsibilities of Medical Social Worker 1

Expected Duration: 1 Week or 2 Contact Hours

Introduction

In this session, you will learn about the qualities, role and specific responsibilities of medical social worker. All these are important in the practice of social work.
What then are these qualities, roles and specific responsibilities?

Learning Outcomes For Unit 5.

When you have studied this session, you should be able to :

5.1 Identify the quality of medical social workers that has to deal with team work (SAQ 5.1)

5.2 State the role of medical social workers in patient's discharge (SAQ 5.2)

5.3 State the first step to be taking by a Medical social worker in any intervention program (SAQ 5.3)

5.1 Qualities Of Medical Social Workers For Successful Social Work Practice In Hospital,

The medical social workers must:

1. Enjoy working with people and helping them to solve their problems.
2. Be able to empathise with people
3. Have a sympathetic coming nature
4. Have ability to win the trust of people from any kind of background
5. Have strong team working scheme i.e. working closely with other professionals like doctors nurses, pharmacists etc.
6. Have good communication, organizational, management skills and must be emotionally balanced and intellectually sound in their profession.

5.2 Roles Of Medical Social Workers.

As you will expect, the roles of medical social workers are many. According to Ross(1995)and skid more et al (1997),

The Roles of medical social workers are as follows:

Assessment of patients

Investigate patients

Supporting role to and their relatives

Advises in financial, social and emotional difficulties

Provide practical help

Help patients and their relatives with problems

Interview and counsel individuals and families

Refer patients to other professionals

Help patients improve personal and social functioning

Coordinate and work with community to solve problems

Help other health professionals understand functions underlying illness

Plan activities that enhance hospital programmes

Ensure proper discharge from hospital

Activity 5.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowing that medical social worker have their qualities, note down some of these qualities.

Activity 5.1 feedback:

Take a look at the list below which state the qualities of Medical social Worker

- Enjoying working with people
- Enjoying solving peoples' problem
- Able to empathize with people
- Have a sympathetic and caring nature
- Have strong team working skills
- Have good communication, organization and management skills

For medical social work profession there are role that must be fulfilled. This is represented in Box 5.1

Box 5.1 Roles of Medical Social workers

- Assessment of patients
- Investigate patients
- Supporting role to patients and their relatives
- Advices in financial, social and emotional difficulties
- Provide practical help
- Help patient and their family with problems
- Interview and counsel individuals and families
- Refer patient to other professionals
- Help patients improve personal and social functioning
- Coordinate and work with community to solve functioning
- Help other help Health professionals understand functions underlying illness
- Plan activities that enhance hospital programmes.
- Ensure proper discharge from hospital

There are different categories or label of medical social workers like medical social workers I and medical social worker 11. The following lists are the specific responsibilities of medical social worker I.

Specific Responsibilities of Medical Social Worker1

1 Assesses and provides information.

2 Interprets diagnoses and prognosis

3 Interviews and counsels patients and relatives.

4 Evaluates problems and make treatment plan.

5 Evaluates problem and community behavior

6 counseling services

7 Prepares case records, report and responsibility

8 Participates in conferences, meetings and committees

9 Observes and informs supervisions of gaps in policies

10 Counsels patients on rehabilitation programmes.

11 Participates in research project

12 Arranges follow-up care

13 Demonstrative clinical knowledge and skills in some areas

* Medical Social Worker I receive direction and assistance from higher levels of medical social workers.

Summary Of Unit 5

In unit 5, you have learned that:

1. Medical Social Workers have qualities as professionals.
2. In as much as there are many health professionals that work in the hospital setting, the medical social worker have their own roles they perform in relation to patients care and also has specific responsibilities to perform

Self-Assessment Questions (SAQS) For Unit 5

Now that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering these questions. You can check your answers with the notes on the Self-Assessment Questions at the end of this unit.

SAQ 5.1 (tests learning outcome 5.1)

Identify the quality of medical social worker that has to do with team work

SAQ 5.2 (tests learning outcome 5.2)

State the role of medical social worker in patients' discharge

SAQ 5.3 (tests learning outcome 5.3)

State the first step to be taken by a medical social worker I in any intervention process.

Notes On The Self-Assessment Questions (SAQs) For Module 5

SAQ 5.1: Medical Social Worker should have strong team working skills and work closely with other professionals like doctors and nurses

SAQ 5.2: it is the responsibility of the medical social worker to ensure that patient is properly discharged from the hospital and home care service follows

SAQ 5.3: The first step is performing assessments and providing information for use in diagnosis and treatment.

Unit 6: The Values And Ethics Of Medical Social Work.

Expected Duration: 1 Week Or 2 Contact Hours

Introduction

In this session, you will learn about values and ethics guiding Medical Social Work. You definitely have to know that all professions have their values and ethics, so also social work profession. What then are these values and ethics guiding medical social work practice?

Learning Outcomes For Unit 6

When you have studied this session you should be able to:

6.1a Define value as defined by Breeching et al, 2000

6.1b Identify the values of medical social work that talks of discrimination

6.2a State the code of medical ethics that talks of violence

6.2b Identify the ethical principle of social work practice that deals with right of privacy of patient

6.1 The values of Medical Social Work

6.1.1 Definition Of Values

For one to really understand and practice medical social work, one has to know what the values of medical social work are: What do we mean by Values? A value is commonly described as the quality of something in terms of its usefulness or desirability. Technically, a value is a belief, preference or assumption about what is desirable, useful, good or valuable to man.

According to Breeching et al, 2000, value is a set of beliefs, ideas and assumptions that individuals and groups hold about themselves and the society they live in. values are a part of culture and societal norms that guide people daily lives. In the context of health and Social care, the value base is the framework which informs and supports all systems and process in practice. In other words, it becomes the guide to the way professionals work with their clients or patients.

6.1.2. Values in Health and Social Care.

According to Chaloner et al, (1996) values in health and social care practice include the following:

1. Promoting anti-discriminatory practice – This involves being able to identify prejudices, assumptions, and stereotypes, which are used to devalue people. It involves trying to meet the varied needs of different people, rather than giving everyone the same service.

2. Maintaining the confidentiality of information – Confidentiality is an important value in nearly all professional services for people. The key issues that make confidentiality so important are the issues of trust and client's safety. The value base states that confidentiality of records and information should be discussed with the client wherever possible. However, some clients or patients may not want their spouses, relatives and friends to know about their finances, or their medical details, or even to know about some day-to-day details of their lives. Therefore, the medical health workers in hospitals have to keep these facts as secret as possible. Confidentiality provides the clients with security and also preserves their privacy.

3. Promoting individual rights and choice - Clients or patients' rights include dignity and freedom from discrimination. This means that they have to be treated as being worthy of respect, and that their feelings are duly considered in the care they receive. Adults need to be able to make choices about their lifestyles in order to preserve dignity and independence. Therefore, health care-givers or medical carers need to empower clients or patients to make their own choices and to control their own lives as far as possible. In this regard, the care workers have the responsibility to ensure that their clients are fully informed about the services provided and their rights in relation to those services.

4. Acknowledging an individual's personal beliefs and identity – Gender, ethnicity, culture, religion, social status and sexuality contribute to the way clients perceive themselves. To deny clients any aspect of their identity is to deny their personal uniqueness. Therefore, care workers need to ensure that they do not impose their values on their clients. It is a responsibility to help build clients' self-esteem and to acknowledge and maintain clients' sense of themselves. That is their personal identity.

5. Support individuals through effective communication - The need for the understanding of clients work, in an anti-discriminatory way and meet the self-esteem and emotional security of clients, necessitates effective communication. Communication has to be adapted to the needs of individuals. Hence, it is important that medical careers can convey respect in all their conversations and in all the forms of body language that they use when working with clients.

6.2: Ethics of Medical Social Work

Ethical principles affecting the practice of medical or clinical social work are rooted in the basic values of the social work profession and the responsibilities entrusted to it by the society (National Federation of Societies for Clinical Social Work). Within this context, the principal objective of medical social work is to enhance the dignity and well-being of each individual who seeks its services.

6.2.1: The code of ethics for medical social work includes the following:

1. Responsibilities of Clinical Social Workers. Clinical social workers faithfully carry out the responsibilities entrusted to them. In this regard, they should:

   a. maintain the highest standards of professional competence in all of their professional roles;
   b. value objectivity and integrity and constantly examine, use and attempt to increase the knowledge upon which practice is based;
   c. accept responsibility for the consequences of their work and make every effort to insure that their services are used appropriately; and
   d. not engage in or condone sexual harassment.
   e. refrain from undertaking any professional activity in which their personal difficulties might lead to the inadequate provision of service.

2. Responsibilities to Clients.

The client is the primary responsibility of the clinical or medical social worker. The clinical social workers make every effort to respect the integrity, protect the welfare, and maximize self-determination of the clients and groups with whom they work. Some of their responsibilities to their clients include the following:

   a. The clinical social worker should inform clients of the extent and nature of services available to them as well as the limits, rights, opportunities, and obligations associated with service which might affect the client's decision to enter into or continue the relationship.
   b. They should enter and or continue professional relationships based on their ability to meet the needs of the client appropriately.
   c. They should terminate services to a client, and professional relationships with him/her, when services and relationships are no longer required or not longer serve the client's interest.
   d. They should not exploit relationships with clients for undue personal advantage, profit or interest.
   e. The actions of the clinical social workers must safeguard the interests and concerns of the clients when they act on their behalf.

3. Relationships with Colleagues.

   a. Clinical social workers should act with integrity in their relationships with colleagues and members of other profession.
   b. They should know and take into account the traditions, practices, and areas of competence of other professionals and cooperate with them fully for the welfare of clients.
   c. The clinical or medical social worker should treat with respect and represent accurately the views, qualifications and findings of colleagues and fairly express judgement on them through appropriate channels.
   d. The clinical or medical social worker should ensure that clients are referred to allied professionals who are recognised members of their own discipline and are competent to carry out the professional services required.

e. They should take appropriate measures to discourage, prevent, expose, and correct unethical or incompetent behaviour by colleagues.
f. They should assist and defend colleagues that are unjustly charged with unethical or incompetent behaviour.

4. Confidentiality.

The safeguarding of the client's right to privacy is a basic responsibility of the clinical or medical social workers. Hence, it is their responsibilities to:

a. maintain the confidentiality of materials that has been transmitted to them in any of their professional roles including the identity of the client;
b. reveal confidential information to others only with informed consent of the client, except in those circumstances in which not to do so would violate the law or would result in clear and immediate danger to the client or to others;
c. conceal the true identity of the client when confidential information is used for the purpose of professional education, research, consultation and so forth; and
d. make provisions for maintaining confidentiality in the storage and disposal of records.

5. Moral and Legal Standards.

Medical or clinical social workers show sensible regard for social codes and moral expectations in their communities; recognising that violation of accepted moral and legal standards on their part may compromise the fulfilment of their professional responsibilities or reduce public trust in the profession. Some of the moral or legal responsibilities of the clinical social workers are the following:

a. They should not in any of their capacities practice, condone, facilitate or collaborate with any form of discrimination on the basis of race, sex, sexual orientation, age, religion, social economic status, or national origin.
b. They should normally adhere to the relevant laws and regulations. However, when such laws are in conflict with the principles and standards of the progression, the clinical social workers have to make known the conflict and work towards change that will benefit the public interest.
c. They should participate in activities that contribute to improved social conditions within their communities.

6. Pursuit of Research and Scholarly Activities.

a. The clinical or medical social workers have to participate in research and scholarly activities on health-related matters. In doing this, they have to abide with the research ethics like informed consent, voluntary participation and others.
b. Their research findings must be presented accurately and completely with full discussion of their usefulness and limitations.
c. The clinical social workers have to take credit only for work actually done in scholarly and research endeavours, and give appropriate credit to the contributions of others.

7. Public statement.

a. When making public statement, the clinical social workers should make clear which are personal opinions and which are authorised statements on behalf of the organisation.

b. They should adhere to professional rather than commercial standards in making known their availability for professional services. For instance, they should limit professional announcement or advertising to their names, highest relevant academic degree and so forth.
c. They should not offer to perform any service beyond the scope permitted by law or beyond the scope of their competence.
d. They should not engage in any form of advertising which is false, fraudulent, deceptive, or misleading.
e. They should not solicit or use recommendations or testimonials from clients.

Activity 6.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowing that medical social work has it values, note down some definitions of value and these values of medical social work.

Activity 6.1 Feedback:

Take a look at table 6.1, it states the definitions of values and lists the values of medical social work

Definition s of value	Values of medical social works
1. Quality of something in terms of its usefulness or desirability	1. Promoting anti-discriminating practice
2. A belief, preference or assumption about what is desirable, useful, good or valuable to man	2. Maintaining the confidentiality of information
3. Value is a set of beliefs, ideas and assumptions that individuals and groups hold about themselves and society they live in (Breeching et al, 2000)	3. promoting individual rights and choice
4. a part of culture and societal norm that guide peoples' daily lives	4. Acknowledging an individual's personal beliefs and identity
5. A guide to the way professionals work with their clients or patients	5. Support individuals through effective communication

Table 6.1: Definition and specific values in health and social care

In as much as there are ethics that guide medical social work profession in the health setting, it is important to have in-depth knowledge of the general ethics of health workers. This is represented in Box 6.2

Box 6.2.1: Code of Medical Ethics (CME)
CME 1: Sanctity of human life is paramount
CME 2: Integrity of medical profession be honoured.
CME 3: Survival of patient to be assured
CME 4: Continuity of medical services to be guaranteed
CME 5: Authority and power of hospital management must be respected
CME 6: No violence in hospital premise
CME 7: Strike action as a last resort
CME 8: Induction programmes in hospitals for health workers

Having had a general knowledge of general medical ethics, you now need to know the specific ones for the medical social work profession and these are represented in the list below:
Ethical decision for social work practice in hospital includes:

1. Responsibilities of medical social workers
2. Responsibilities to clients
3. Relationship with colleagues
4. Confidentiality
5. Moral and legal standards
6. Pursuit of research and scholarly activities
7. Public statement

Summary of Unit 6

In unit 6, you have learned that:

1. There are various definitions as stated by different authors.
2. There are values of medical social work
3. General ethics of practice for medical workers must be known and well understood.
4. The specific ethical principles for medical social work practice must be known and complied with.

Self – Assessment Questions (SAQs) For Unit 6

Now that you have completed this study session you can access how well you have achieved its learning outcomes by answering these questions. You can check your answers with the Notes on the self-assessment questions at the end of this unit.

SAQ 6.1a (Tests learning outcome 6.1a)

Define value as defined by Breeching et al, 2000

SAQ 6.1b (Tests learning outcome 6.1b)

Identify the value of medical social work that talks of discrimination

SAQ 6.2a (Tests learning outcome 6.2a)

State the code of medical ethics that talks of violence

SAQ 6.2b (Tests learning outcome 6.2b)

Identify the ethical principle of social work practice that deals with right of privacy of patient

Notes on the Self-Assessment Questions (SAQs) For Unit 6

SAQ 6.1a: Value is a set of beliefs, ideas and assumptions that individuals and groups hold about themselves and the society they live in

SAQ 6.1b: promoting anti-discriminatory practice

SAQ 6.2a: there should be no violence in the hospital premises therefore, health workers should hold their union congresses outside the hospital

SAQ 6.2b: confidentiality

Unit 7 : History, Aims, Nature And Administrative Set Up Of The Medical Social Services Department, University College Hospital, (UCH),Ibadan.

Expected Duration: 1 Week or 2 Contact Hours

Introduction.

In this session, you will learn about the history of medical social service in University College Hospital (UCH) Ibadan. Also its aims, the nature and the administrative set up of the medical social services department will be mentioned. Social services have an origin and all things that have to do with the origin should be understood.

What then is the history, the aims, the nature and the administrative set up of the medical social services department, UCH Ibadan?

Learning Outcomes For Module 7.

When you have studied this session, you should be able to:

7.1 State the date the medical social services department, UCH was established.(SAQ 7.1)

7.2 Identify the aim of MSSD, UCH that relates to atmosphere(SAQ7.2)

7.3 Site examples of patients that medical social workers counsel(SAQ 7.3)

7.4 Mention the most senior staff of the MSSD, UCH, Ibadan.(SAQ 7.4)

7.1 History Of MSS, UCH, Ibadan.

The University College Hospital (UCH) Ibadan was established in 1957. It was established to complement the work of the medical school of the University of Ibadan, which was established in 1948. The Medical Social Service Department was earlier also established in 1957 the same year the University College Hospital was established. The first medical social worker at that time was Mrs. M. Omitowoju. The medical social workers by then were known as “Almoners” meaning the officers in charge of payments (i.e. payments of hospital bills, drug fees, operation charges etc.). With professional training in social work (Master of Social Work MSW) more qualified health, clinical or medical social workers are now working in the department.

7.2 Aims of the Agency/Department

The Medical Social Services Department was set up to achieve the following aims:

1. to make medical facilities available to the patients;
2. to help the indigent patients in getting medical treatment;

3. to help the clients psychologically, regarding critical or terminal illness;

4. to create conducive atmosphere for the patients, both in the hospital and at home (i.e. for in-patients and out-patients); and

5. to provide extra-medical therapy for the patient.

The Nature of services of the Medical Social Services Department

The medical social services department offers the following services in and outside the hospital:

1. **Locating and Contacting the Relations or Family of the Patients –** Medical social workers in the department help in tracing relations or members of the family of the patients, especially, victims of road traffic accidents, unconscious patients, and other helpless ones.

2. **Advocating for Waiver, Exemption and Sourcing for Financial Assistance –** On behalf of poor and helpless patients, the department advocates that the hospital authority should waive certain amount of money for those that cannot meet their payments or that they should be exempted from the payment. Also the medical social workers in the department source for funds, to help those that cannot afford paying their hospital bills, purchase their drugs or pay for their surgical operations.

3. **Counselling Services –** The department offers counselling services to patients with chronic, critical or terminal illnesses, such as cancer, HIV/AIDS, diabetes, chronic arthritis and so on. Counselling is provided to individual patients and their families on how to reduce negative emotions, or stress, follow medical regimen and so on.

4. **Rehabilitation Services –** The department provides rehabilitation services to patients. This is applicable to the patients who suffer disability (e.g. chronic arthritis, fractures, limb or leg amputation etc), and need to be rehabilitated. The department organizes occupational therapy for the patients before their discharge from the hospital. This affords those with one form of disability or another to learn a particular trade or job with which they can earn a living or depend on themselves.

5. **Re-integration Services –** The department helps to re-integrate the patients into the society. To this end, the social workers working in the Department conduct visits to the home or environment of the patients before and after being discharged, to prepare the family for accepting the patient back into their midst, and for helping the patient to become well adjusted to the society.

7.3 Departmental Structure and Organizational Set up

According to Oyelakin (2004), the Department of Medical Social Services of the University College (UCH) Ibadan is structured into five units; namely:

a. **Surgical Outpatient Unit (S.O.P) -** This unit is also called Casual and Emergency Unit. It deals with emergency cases, such as road traffic accidents, domestic accidents, suicide cases, burns, gunshot wounds and so on. The unit provides welfare services to both in and outpatients.

b. **Paediatric or Children Outpatient Unit** – The unit is popularly called Otunba Tunwase Clinic. The unit deals with children related cases, such as anaemia, febrile convulsion, nutritional problems and so forth.

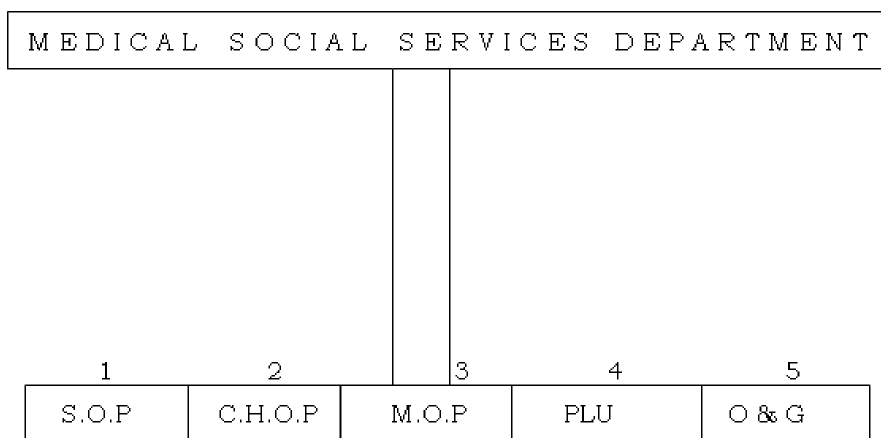
c. **Obstetrics and Gyneacological Unit** – The unit handles women problems, such as infertility, childbirth problems and other problems common to women.

d. **Medical Outpatient Unit (M.O.P)** – The unit provides social services to in and outpatients. It deals with medical cases or terminal illnesses, such as ulcer, hypertension, cancer, diabetes and so forth.

e. **Psychiatric Unit** – This is popularly called Professor Lambo unit (PLU). It deals with mental illness or disorders. The unit provides psycho-social services, such as individual and group psychotherapy, family therapy, counselling, psycho-education and recreational programmes to the mentally-ill patients and their families.

7.3 The Structure Of The Department

Fig. 1: The Structure of Medical Social Service Department



Placement at the University College Hospital (UCH) Ibadan, Ibadan

Organisational/Departmental set up –

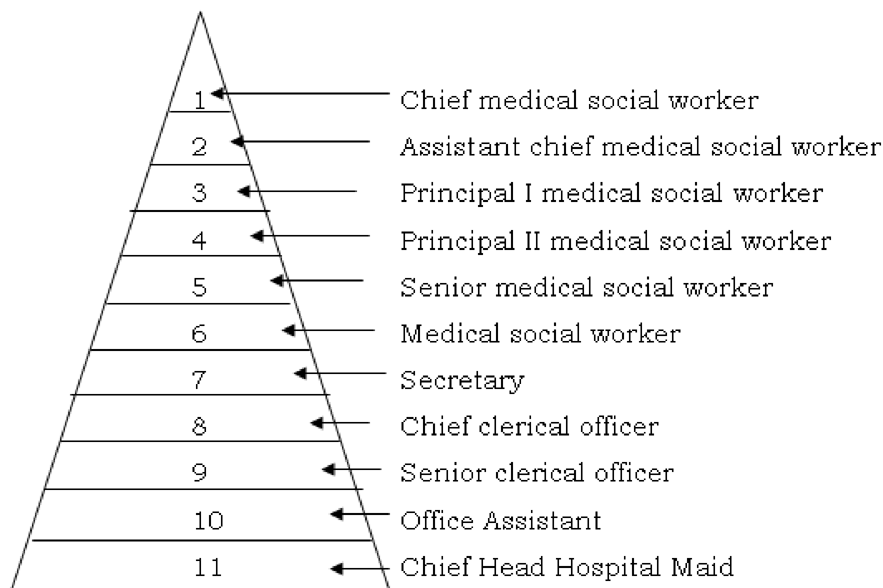
The management structure of the Department is organised hierarchically as follows.

1. The chief medical social worker (C.M.S.W)
2. The assistant chief medical social worker (A.C.M.S.W.)
3. Principal 1 medical social worker (P.1. M.S.W)
4. Principal II medical social worker (P.II. M.S.W)
5. Senior medical social worker (S.M.S.W)

6. Medical social worker (M.S.W)
7. Secretary
8. Chief clerical officer
9. Senior clerical officer
10. Office assistant
11. Chief Head Hospital Maid.

The above arrangements are illustrated in Fig. 2 below.

Fig. 2: Organizational chart



Source: Oyelakin, S.O. (2004) Report of social work field placement at the University College Hospital (U.C.H) Ibadan, Ibadan

As shown above, the organisational set up is divided into two. The first group of workers in the department is composed of the professional staff (nos. 1-6), who take care of all the case works with the patients and their families. The second group of workers is composed of the administrative staffs (nos. 7-11) that are responsible for the secretarial and clerical duties. Each unit in the department is supervised by a principal medical social worker and in some cases by the senior medical social worker. Both the professional and administrative staff works together as a team to provide adequate social welfare services to the patients in order to ensure holistic health care.

Activity 7.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowing that medical social services has origin, note down important dates and names related to these origins.

Activity 7.1. Feedback.

Date	Event	Name
1948	Medical School, University of Ibadan was established.	________________________
1957	University College Hospital was established	________________________
1957	Medical Social Services department, UCH established	________________________
1957	First Medical Social Worker	Mrs M. Omitowoju.

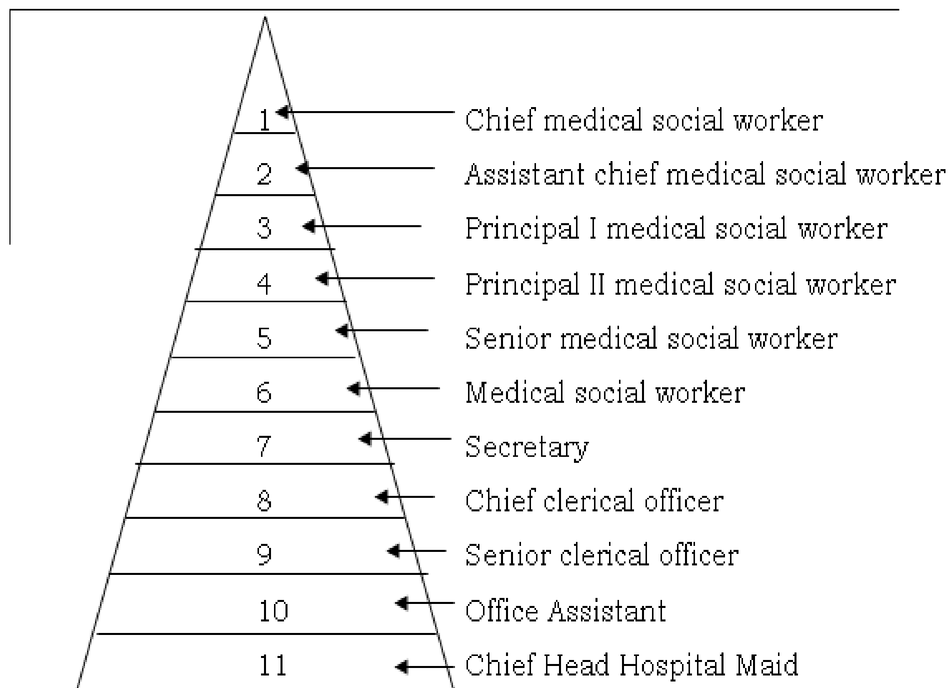
Figure7.1 History of MSSD, UCH, Ibadan.

In any set up , there must be aim that the members of that set up will focus to achieve, so also is the MSSD ,UCH, Ibadan. The aims are represented in box 7.2

Box 7.2 Aims of MSSD, UCH, Ibadan

1. To make medical facilities available to the patient
2. To help indigent patient in getting medical treatment
3. To help units psychologically regarding critical or technical illness
4. To create conducive atmosphere for patients
5. To provide extra medical therapy for patients

The organogram or hierarchy of the staff of MSSD, UCH, Ibadan is represented with chart below.



Summary of Unit 7

In unit 7, you have learned that:

1. There is an origin of MSSD , UCH, Ibadan which started in 1957
2. There are five identified aims of the MSSD, UCH, Ibadan.
3. The nature of services of the MSSD, UCH, Ibadan starts from locating patients' relatives and terminates in re- integration into the society.
4. There is hierarchy in MSSD, UCH, Ibadan for effective services.

Self-Assessment Questions (SAQs) For Unit 7

Now that you have completed this study, you can assess how well you have achieved its learning outcomes by answering these questions; you can check your answers with the Notes on the Self- Assessment Questions at the end of this unit.

SAQ 7.1 (tests learning outcome 7.1)

State the date the MSSD, UCH, Ibadan was established.

SAQ 7.2 (tests learning outcome 7.2)

Identify the aims of MSSD, UCH, Ibadan that relates to atmosphere.

SAQ 7.3 (tests learning outcome 7.3)

State examples of patients that medical social workers counsel.

SAQ 7.4 (tests learning outcome 7.4)

Mention the most senior staff of the MSSD, UCH, Ibadan.

Notes on the Self-Assessment Questions (SAQs) For Unit 7.

SAQ 7.1: 1957

SAQ 7.2: To create conducive atmosphere for the patients both in the hospital and at home.

SAQ 7.3: Patients with cancer, diabetes, chronic arthritis, HIV/AIDS.

SAQ 7.4: Deputy Director medical social services.

Module 8: Theoretical Models for Medical Social Work.

Expected Duration: 1 Week Or 2 Contact Hours.

Introduction.

In this session, you will learn about some theories that offer useful ways of understanding the profession of medical social work. These help us to understand why the sick persons behave the way they do and how they expected to respond to medical treatment or their rehabilitation.

What then are these theories? How do these theories explain these different behaviours in patients? How are these patients expected to respond to services being rendered to them?

Learning Outcomes For Unit 8.

When you have studied this session, you should be able to:

8.1 Define theory as stated by Barney and White, 2004.(SAQ 8.1)

8.2 List the theoretical models of medical social services.(SAQ 8.2)

8.1 What Is A Theory?

We can define the concept of theory either broadly or narrowly. Broadly speaking, a theory is a statement or set of statements about the relationships among variables (Burney and White, 2004). According to them, if the statements concern only a single relationship between variables, it is called a law. However, sometimes a number of laws are tied together into a more general set of statements, which is called a theory (e.g. Skinner's theory of operant conditioning). Skinner's system is a theory in the broader sense of a set of interrelated laws.

More often, the term "theory" is used in a second and stricter sense(narrowly). In this sense, it is defined as a statement or a set of statements about relationships among variables that include at least one concept that is not directly observed but that is necessary to explain these relationships. Schweigert (1994) describes a theory as a set of related statements that explain and predict phenomena. The statement used in a theory can be laws, principles or beliefs. A theory must not only be testable but must be capable of being proven wrong (falsifiable).

A theory plays three crucial roles. These include (1) organising knowledge and explaining laws; (2) predicting new laws; and (3) guiding research.

8.2 Theoretical models

According to Ross (1995), five theoretical models inform and organise the knowledge base of direct social work practice in health care. They are psychiatric model, medical model, health promotion and promotion model, developmental model and integrative model.

1. Psychiatric Model – The psychiatric model builds on psychoanalytic theory and makes clinical (medical) social work practice synonymous with counselling and psychotherapy (Frank, 1979). It concentrates on the internal psychic resources in people and the curbing of psychological abnormalities and disorders. However, most social work scholars in health care reject this model as too narrow. They believe it limits practice to a method that is generic to many professions and does not adequately address the bio-psychosocial elements required in the direct social work practitioner's task (Briar and Miller 1971, Carlton, 1984).

2. Medical Model – This is the dominant model in direct social work practice in health care. It emphasizes the study, diagnosis, and treatment of diseases and illness. In medicine, the success of the model relates to its diagnostic power in determining the identity of a disease or illness, ascertaining the cause or nature of a disorder or malfunction from its symptoms, and classifying medical conditions on the basis of scientific examination (Briar and Miller, 1971).

The model has been criticised for its bio-pathological interpretation of disease and its reward of professional accomplishments in curative roles (Moroney, 1986 and Saleebey, 1992).

3. Health Prevention and Promotion Model – The model is used to organise the knowledge base of direct social work practice in health care. Its theoretical roots can be traced back to public health (Kumabe et al 1977, and Caplan, 1989). In this model, health rather than illness is the primary locus. Hence, social work interventions aim either at averting or discouraging the development of specific social problems (primary prevention) or at delaying or controlling the course of such problems, once symptoms become evident (secondary and tertiary prevention).

Social workers who practice within this model engage in preventive social work. They seek to enhance and preserve the physical, mental and social health of patients as well as families, neighbourhoods and other natural support systems. One disadvantage of this model is that outcomes are difficult to measure and test.

4. Developmental Model - This model shares some common ground with the strengths perspective in social work practice, which focuses on capacities and empowerment, and not problems or pathologies (Saleebey, 1992). The development model builds on theories of human development formulated by scholars such as Erickson and Bronfenbrenner (1979). Both assume that clients and families develop in fairly orderly stages and that each stage gives them opportunities for healthy growth and development.

They observed that stresses are common in each stage and have potential for crisis. According to them, the professional task is to support clients and families throughout the life cycle by helping them anticipate these events, prepare to meet them and deal with new roles and relationships. Social workers in direct practice using this model normally begin by asking clients and families what services or resources they need and then find ways to provide them. Although, this model is not as well developed as other models, it has far-reaching implications for direct practitioners in health care. It is useful in preparing mothers for healthy childbirth, preparing parents for effective

parenting, facilitating successful entry of children into schools and supporting natural care givers of people with chronic disabilities.

5. Integrative Model – This model includes theoretical efforts to repair the individual environment split in social work. Hence, concepts such as human behaviour and the social work environment, person-in-environment, client as a social system, and human ecology emerge from these efforts to maintain the bio-psychosocial integrity of the profession (Coulton, 1981). One weakness of these conceptualisations is that person and environment are treated separately, while trying to maintain a connection between the two.

Activity 8.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowing about theories note down some definition of theory.

Activity 8.1 Feedback.

Take a look at the box 8.1 below. It states some definitions of theory.

Box 8.1. Definition of theory

1. A theory is a statement about the relationship among variables. Bruney and White, 2004
2. A theory could be said to be a number of laws put together into a general set of statements
3. A theory is a set of related statements that explain and predict phenomenon (Schweigert, 1994).
4. A theory is a statement about relationships among variables that include at least one concept that is not directly observed.

For effective and successful medical social work practice, some theoretical models must be understood. These theories are represented in Box 8.2.

Box 8.2 Theoretical Models

1. psychoactive model
2. medical model
3. Health prevention and promotion model
4. Development model 5.Integrative model

Summary of Unit 8

In unit 8, you have learned that:

1. A theory can be defined in various ways as being state by different authors.
2. There are fine theoretical model upon which medium social services are based.

Self Assessment Question for Unit 8

Now that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering these questions. You can check your answers with the notes in the Self-Assessment Question at the end of this module.

SAQ 8.1 (tests learning outcome 8.1)

Define theory, as stated by Burney and White (2004).

SAQ 8.2 (tests learning outcome 8.2).

List the theoretical models of medical social service.

Note On The Self- Assessment Questions (SAQs) For Unit 8

SAQ 8.1: A theory is a statement or set of statements about the relationships among variables.

SAQ 8.2 Psychoactive model

Medical model

Health prevention and promotion model

Developmental model

Integrative model.

Unit 9: Health and Illness

Expected Duration: 1 Week or 2 Contact Hours

Introduction

In this session, you will learn about the concepts of health and illness. Their nature will also be discussed. Though, health and illness are universal phenomenon, both concepts are variables, relative and do not have universal definitions. What is health for one person at one time may be an illness for another or even for the same person at another time

What then are the various submissions of the concepts of health and illness? What is also their nature?

Learning Outcomes For Unit 9:

When you have studied this session you should be able to:

9.1 Define health and list its dimensions.(SAQ 9.1)

9.2 Define illness (SAQ 9.2)

9.3 State the categories of physical illness (SAQ 9.3)

9.4 Highlight causes of mental illness.(SAQ 9.4)

9.1 Health And Its Dimensions.

What is Health?

According to Payne and Hahn (2000), health refers to the virtual absence of disease (low levels of mortality) and the ability to live a long life (reduced risk of mortality). Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity (WHO, 1947). This is a multifaceted view of health that encompasses physical, mental, and social dimensions. This definition indicates that health extends beyond the structure and function of our bodies to include feelings, values, and reasoning. It also embraces the nature of our interpersonal relationships and interactions.

A currently popular conception of health expands on the WHO's definition to embrace two additional components; namely, intellectual and spiritual dimensions (Lederman, 1997). The holistically healthy person functions as a total person.

Dimensions of Health

Health has been viewed for many decades as being multi-dimensional. Hence, the dimensions of health could be physical, emotional, social, intellectual, occupational, spiritual and environmental. We shall examine them one after the other.

1. Physical dimension - This has to do with the physical health of a person. It refers to the conditions or state of health of an individual or the physical characteristics of the individual, such as our body weight, visual ability, strength, co-ordination, level of endurance, level of susceptibility to diseases, and power of recuperation or recovery.

2. Emotional dimension – This encompasses our ability to cope with stress, remain flexible and calm.

3. Social dimension – This encompasses social skills and insights. It has to do with our ability to interact comfortably and meaningfully with other people in the society.

4. Intellectual dimension – This refers to the ability to process and act on information, clarify values and beliefs and exercise decision-making capacity. This ranks among the most important aspects of total health.

5. Spiritual dimension – Originally, the spiritual dimension of health includes religions beliefs, and religious practices. However, many young adults would expand it to include more diverse belief systems, including relationships with other living things, the nature of human behaviour, and the need and willingness to serve others.

6. Environmental dimension – This has to do with the conditions in the air, water, land and climate and how they affect our health, growth and development (e.g. how air pollution, erosion etc, negatively affect health, growth and development).

7. Occupation dimension – This has to do with the importance of workplace to the physical and mental well-being of workers. It deals with the level of security, safety, and job satisfaction, and how all these contribute to the welfare and health of workers.

9.2 Illness

Since there is health, there is bound to be illness. Life is not static. The Webster's International Dictionary defines illness as a state of being ill or sick, bodily indisposition or diseases. According to the Longman Dictionary of contemporary English (1995), illness is a disease of the body or mind. Illness encompasses medical, social, economic, psychological and even spiritual components; it affects people in many ways, directly or indirectly, and it is of particular consequence to individuals, families, and communities (Skidmore et al, 1997).

Broadly speaking, illness impairs role function, and may result from factors like biological (e.g. infections) social, psychological, cultural and economic factors. It forces dependency and reduces usefulness to the family and other significant people. It cuts off the individual access to normal enjoyment and satisfaction. It also renders the individual incapable of normal role performance.

9.3 Types Of Illness

Illness can be mainly classified into two; namely, physical illness and mental illness.

1. Physical Illness – This implies a state of being unwell, characterised by bodily dysfunction (Mojoyinola, 2002). It refers to the conditions affecting systems or organs of the body, such as respiratory, circulatory, excretory, reproductive, digestive, skeletal, endocrine and muscular systems. Physical illness can be categorised as follows:

   a. Medical illness – This includes illnesses such as malaria fever, headache, pneumonia, hypertension, diabetes, and so forth.
   b. Surgical illness – This includes illnesses that require surgical operation. Examples of these are hernia, fractures, gunshot wounds, intestinal obstruction, appendicitis, etc.

c. Psychosomatic illness – This refers to illnesses, such as peptic ulcer, migraine, hay fever, duodenal ulcer and so forth.

Physical illness may be caused by infections of the body by pathogenic or micro organisms (bacteria, fungi or virus), and injury or trauma to the body organs. Generally, physical illness may be characterised by fever, pain, diarrhea, nausea or vomiting, dizziness etc. Physical illnesses are usually treated by drugs, surgical operations, and radiotherapy. Psychosocial treatments also play significant roles in the management of physical illnesses.

2. Mental Illness – This is a type of mental disorder affecting the brain or mental processes. It is a type of illness or disease in which there is a disturbance in the brain, especially, in the cerebral cortex (Portnov et al, 1965). This kind of illness also affects the whole body as it is manifested by metabolic, visceral and endocrine disorder. Mental illness is characterised by disturbance in mood and personality, hallucination (false perception), delusion (false beliefs), distortions, loss of contact, etc.

9.4 Causes Of Mental Illness

According to Mbanefo (1991) several factors cause mental illness. Some of the causes are examined below:

1. Natural causes – These are hereditary factor or genetic factor, causing acute psychosis, mania, agitated delirium and schizophrenia.
2. Malignant magical practices – Malignant magical practices of witchcraft, sorcerers, curses, evil spells, food poisoning can cause schizophrenia.
3. Supernatural causes – Mental illnesses such as psychosis, and psychiatric disturbance are caused by ancestral spirits, gods and goddesses (e.g. goddess of small pox).
4. Body constitution – The physical and mental make up of an individual can predispose him or her to mental illness. For instance, an individual who has reduced or no coping ability to handle frustration can easily break down with severe stress.
5. Damage to the central neurons system (brain) – Damage or injury to the brain (e.g. severe fall from a height or road traffic accident), diseases affecting the brain such as meningitis, encephalitis), new growth or tumour in the brain or hardening of the blood vessels supplying the brain (arteriosclerosis) can lead to mental illness.
6. Unknown cause – sometimes the cause of some mental illness may not be known.

Types of Mental Illness

Two major types of mental illness are neuroses and psychoses.

1. Neuroses – These are minor mental disorders, in which the victim has developed certain behaviour patterns that avoid rather than cope with problems. Thus, when an individual experiences conflict or frustration which is not quickly resolved, he or she either remains in a state of severe anxiety or uses one of the defense mechanisms to avoid the problem. Anxiety is the chief symptoms of all neurotic conditions. This anxiety does not prevent the individual from performing his daily activities. Hence, he does not need to be hospitalised.

Neurotic reactions may be anxiety, conversion, obsessive-compulsive and phobic reactions. Neurotic reactions can be characterised by anxiety, guilt-feeling, excessive fear, restlessness, agitation and so forth.

2. Psychoses – These are major mental disorders, which involve more serious disturbances of thought, and behaviour than neurotic conditions. The personality of a psychotic individual is disorganised and his normal social functioning greatly impaired (Hilgard et al, 1979). Psychoses are quite different from neuroses as they involve physiological changes in the brain. Psychoses are characterised by distortion of perception, and thoughts, loss of contact with reality, withdrawal into fantasies, hallucinations, delusions and so forth. For these and other reasons, psychotic individuals need to be hospitalised for proper care and treatment. Psychoses may be organic or functional in nature

a. Organic psychosis – This refers to a mental illness, which results from damage to the brain, diseases or infection of the brain, new growth or tumour in the brain, lead poisoning and so forth.

b. Functional psychoses – These are disorders that are presumed to be primarily psychological in origin, or have genetic contributions and environmental conditions. Functional psychoses can be grouped into two, namely;

i. Affective disorders – These are disorders in which there is disturbance of mood, and no evidence of a specific lesion in the brain. In affective disorder, the individual may become elated (manic) or severely depressed. He or she may alternate between periods of depression and elation (bipolar disorder or manic – depressive psychosis).

ii. Schizophrenia – This refers to the label given to psychotic disorder characterised by distortion of reality, withdrawal from social interaction, disorganization of thoughts, emotion, motor behaviour, hallucination, delusion and so on.

Schizophrenia usually appears in young adulthood and the peak of incidence is between ages 25 and 35 (Hilgard et al, 1979). Sometimes, it develops slowly or may be of sudden onset, marked by intense confusion. Schizophrenia may be simple, hebephrenic, catatonic and paranoid schizophrenia

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ACTIVITY 9.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowing that health has various definitions and dimensions, note down some of these definitions and its dimensions which are represented in table 9.1 below.

DEFINITIONS	DIMENSIONS
Health refers to vital absence of disease and the ability to live a longlife (Payne andHann,2000).	Physical dimension
Health is a complete state of	Emotional dimension

physical, mental and social wellbeing and of merely the absence of disease and infirmity (WHO,1947).	
Health is a complete state of physical, mental, spiritual, intellectual and social well being and not merely the absence of disease and infirmity (Lederman,1997).	Social dimension
	Intellectual dimension
	Spiritual dimension
	Environmental dimension
	Occupational dimension

Now that you know about health, the other side of it should also be understood. Therefore, the definitions of illness are represented in box 9.2.

Box 9.2 Definitions of illness
Illness is a state of being ill or sick, bodily indisposition or disease. Illness is a disease of the body and mind. Illness impairs role function and may result from factors like biological, social, psychological, cultural and economic factors.

9.3 Illness is in two types physical and mental. Both types have their different categories. The categories of physical illness are represented in box 9.3.

Box 9.3 Categories of physical illness
Medical illness Surgical illness Psychosomatic illness

Having known the two types of illness and their categories, one type being mental illness, there is the need to know the causes of mental illness. These causes are therefore represented in table 9.4 below.

Table 9.4 Causes of mental illness
Natural
Malignant margical practices
Supernatural causes
Body constitution
Damage to the central nervous system
Unknown

Summary of Unit 9

In unit 9, you have learnt that:

1. Health is all encompassing in the physical, social, spiritual, intellectual and mental well being.
2. There are seven dimensions of health
3. Illness is such that it renders the individual incapable of normal role performance.
4. The types of illness are physical and mental.
5. Physical illness can be categorized into three: medical, surgical and psychosomatic.
6. Mental illness could be neurosis or psychosis.
7. Mental illness is caused by several factors.

Self Assessment Questions (SAQs) For Unit 9

Now that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering these questions. You can check your answers with the notes on the self assessment questions at the end of this unit

SAQ 9.1 (Tests learning outcome 9.1)

List the dimensions of health.

SAQ 9.2 (Tests learning outcome 9.2)

State the definition of illness that brings mind into consideration.

SAQ 9.3 (Tests learning outcome 9.3)

Mention the categories of physical illness.

SAQ 9.4 (Tests learning outcome 9.4)

Highlight causes of mental illness.

Notes on Self Assessment Questions (SAQs) For Unit 9.

SAQ 9.1: Physical, emotional, social, intellectual, spiritual, environmental and occupational.

SAQ 9.2: Illness is a disease of the body and mind.

SAQ 9.3: Medical, surgical and psychosomatic.

SAQ 9.4: Natural, malignant margical practices, supernatural, body constitution, damage to central nervous system and unknown.

Unit 10. Stages of Illness and Their Significance in Medical Social Work.

Expected Duration: 1 Week Or 2 Contact Hours.

Introduction

In this session, you will learn about stages of illness and their significance in Medical Social Work. Illness occurs in stages; namely, the stage of transition from health to illness, the stage of accepted illness, and stage of transition from illness to wellness. Each of these stages has useful implications or significance to the sick individuals, their families and the health care-givers (social workers).

What then are those things that constitute the different stages in medical social work?

Learning Outcomes For Unit 10

When you have studied this session, you should be able to:

10.1 Identify the stages of illness (SAQ 10.1)

10.2a State the first function of the social worker in the stage of transition from health to illness.(SAQ 10.2a)

10.2b Identify the last function of the social worker in the stage of accepted illness.(SAQ 10.2b)

10.2c State the main function of the social worker in the stage of transition from illness to wellness.(SAQ 10.2c)

10.1 Stages Of Illness

Illness exists in different stages. According to Lederer (1952), there are three stages in the social experience of illness.

These are:

1. transition from health to illness;
2. stage of accepted illness; and
3. transition from illness to wellness (convalescence or recovery stage)

1. Transition from health to illness – This is the first stage of illness. It is characterised by "illness behaviour", which is the behaviour an individual engages in, when he or she feels ill. For instance, the individual may do nothing about the illness, engages in self-medication, consult quack doctors, and so forth. It should be noted here that if the sick person, after recognising the symptoms of his or her illness, (e.g. headache, pains, etc) and report them quickly to a competent doctor in the hospital, he or she will receive prompt medical treatment and overcome his illness on time (Mojoyinola, 2002). On the other hand, if he or she delays too much in reporting such symptoms early, his/her illness may become worsened and immediate cure and recovery may be difficult to achieve.

2. Stage of accepted illness – This is the second stage of illness. It is a stage where the sick person is seen by the doctor, who made diagnosis and prescribed treatment for his or her ailment. It is the stage the sick individual is expected to perform specific role called the "sick role". The sick role may be medical or psychiatric role.

a. Medical sick role (Parsonian model).

The medical sick role model was conceptualised by Taccot Parsons (1951). According to this model, the sick individual assumes the following roles during illness:

he is not held responsible for his incapacity;

he is released from varying degrees of normal role obligation;

he must recognise that illness is undesirable and have expressed desire to get well;

he must seek competent help and cooperate with treatment; and

he must relinquish the right to make decisions to the physician and to other health care professionals.

The medical sick role is applicable only to acute physical illness. Hence, it does not apply to chronic physical illness and permanent physical disability.

b. Psychiatric sick role.

When a condition or illness has psychological connotations, the question of personal responsibilities arises. Hence, the mentally-ill individual's roles are different from the roles of the physical or medically-ill patients. In other words, on the parameters of helplessness, passivity, submission and dependency, the psychiatric sick role tends to be in opposition to the medical sick role. The psychiatric patient is generally expected to be active, independent and self-directed in interacting with the health care-givers (doctor, nurses, social workers, etc.

The psychiatric patient is expected to:

i. take care of him/herself (bathe himself, go to the toilet etc);
ii. tidy up his/her bed and lockers;
iii. go to the table and eat by him/herself;
iv. go out for group work, group therapy, and occupational therapy;
v. go out for games, spots and other recreations; and
vi. participate in other ward activities and so on.

By performing these roles, the mentally ill patients can be assessed whether there is an improvement in their conditions or not.

3. Transition from Illness to Wellness -

This is the third stage of illness. It is the stage of convalescence, recovery or rehabilitation. The stage involves a change from sick role to well role. At this stage, the sick individual is expected to assume well roles, which among others include the following:

i. attempt to relinquish the sick role; and
ii. physical and emotional readiness to resume well roles (e.g. willing to get out of bed, walking round the ward, bathing him or herself etc).

It should be noted here that patients who wish to resume their well roles earlier than is medically advisable are common, possibly because of an earlier essential discomfort with dependency. On the other hand, patients who do not wish to resume their well roles when they are medically considered capable of doing so are probably over-comfortable with the dependency legitimated by illness or they are much satisfied with the secondary gains they receive from the sick role (e.g. attentions, gifts, money and other material gains).

10.2 Functions Of Social Worker At Each Stage Of Illness

The three stages of illness discussed above are very important in caring for or helping the patients to get over their illness as quickly as possible. Each stage of illness also has useful implications for medical social workers. The significance or implications of each stage are discussed below. At this stage, the medical social worker has to perform the following professional functions:

i. helping the sick person to recognize symptoms of his/her illness;
ii. encouraging the sick persons to report symptoms of illness early in hospitals;
iii. allaying the fears and anxiety that accompany symptoms of illness;
iv. helping the patients to cope with feelings of shame, guilt or disgust;
v. encouraging the patient to have faith, trust, and confidence in the helping people (e.g. social workers, nurses, doctors, relatives, etc) that care for him or her and in the treatment or care they give to him or her; and
vi. disseminating accurate information regarding health and illness to public audiences, thereby helping to make the transitional phase less ambiguous.

2. At this stage, the primary functions of the medical social workers are:

i. gathering information regarding patient's internal or external environment;
ii. modifying the external environment until the patient is able to adapt to it;
iii. helping the patient to accept the fact that he or she is ill;
iv. helping the patient to accept his/her illness;
v. allowing the patient some degree of dependency;
vi. assessing the coping abilities of the patients
Vii. reinforcing motivation to get well.

3. The responsibilities of the medical social workers at this stage include:

i. moving the patient to a maximally independent level of functioning;
ii. reinforcing the patient's incentive to get well and decreasing the secondary gain from the illness; and
iii. preventing patients from having residual disturbances in psychosomatic adjustment due to unresolved conflicts or feelings.

ACTIVITY 10.1

Take a moment and reflect on what you have read so far. Based on your learning experience, note down the stages of illness.

Activity 10.1 Feedback: Transition from health to illness, accepted illness and transition from illness to wellness.

To practice successfully as a medical social worker in illness and health, there is the need to know the functions of social worker in the stages of illness. These functions are represented in the table 10.2 below.

Box 10.2 Functions of medical social worker.

1. Helping patient to recognize symptoms.
2. Encouraging patient to report symptoms.
3. Allaying fears and anxiety.
4. Help patient cope with shame
5. Building confidence of patients in social workers.
6. Disseminating accurate information on health.
7. Gathering information about patient's environment.
8. Modifying the patient's environment
9. Helping patient to accept illness.
10. Allow patient some degree of depending.
11. Reinforcing motivation to get well.
12. Making patient independent.
13. Preventing patient from having residual disturbances.

Summary of Unit 10

In unit 10, you have learned that:

1. There are three stages of illness.
2. The responsibilities or functions of medical social workers are spelt out in the session.

Self Assessment Questions On Unit 10

SAQ 10.1 (tests learning outcome 10.1)

Identify the stage of illness.

SAQ10.2a (tests learning outcome 10.2a)

State the first function of the social worker in the stage of transaction from health to illness.

SAQ 10.2b (tests learning outcome 10.2b)

Identify the last function of the social worker in the stage of accepted illness.

SAQ 10.2c (tests learning outcome 10.2c)

State the main function of the social worker in the stage of transition from illness to health.

Notes on Self Assessment Questions On Unit 10

SAQ 10.1: Transmission from health to illness
Accepted illness
Transmission from illness to health

SAQ 10.2a: Helping the sick person to recognize the symptoms of his or her illness.

SAQ10.2b: Reinforcing motivation to get well.

SAQ 10.2c: Moving the patient to a maximally independent level of functioning.

Unit 11. Stress and Stress Management

Expected Duration: 1 Week Or 2 Contact Hours.

Introduction

In this session, you will learn about stress and its management. When there is an excessive demand made upon the body of an individual or when an object or any event threatens a human life or throws an organism out of balance, a state of in equilibrium ensues. Under such a situation, the individual becomes tensed and apprehensive. It is imperative therefore, that an individual that is being stressed must adapt or cope with it. What then is stress, its types, causes and how to cope with it.

Learning Outcomes For Unit 11

When you have studied this session, you should be able to:

11.1a Define stress according to Payne and Han, 2000.(SAQ 11.1a)

11.1b Identify the sources and different types of stress.(SAQ 11.1b)

11.2 State the effect of stress on the heart.(SAQ 11.2)

11.3 List the dimensions of coping with stress.(SAQ 11.3)

11.1 The Concept And Types Of Stress.

11.1.1 The Concept of Stress.

Stress is a word derived from the latin word “stringere” meaning to “draw tight”. Stress is a threat of anticipation of future harm, either of physical or psychological events that lower an individual’s self-esteem. It is a state within the organism, which manifests itself by general adaption syndrome.

It is a physical condition, which is characterised by tiredness, irritability lack of clear thinking, difficulties in sleeping and physical illness (Chaloner et al 1996). According to Payne and Han (2000), stress refers to physiological and psychological state of disruption caused by the presence of an unanticipated, disruptive, or stimulating event.

11.1.2 Sources of Stress

According to Brannon and Feist (1997), both environmental and personal sources contribute to stress. These are briefly examined below.

1. Environmental factors -

Many people associate environmental sources of stress with urban life. They think of noise, pollution, crowding, fear of crime and personal alienation as being associated with city living. However, these are not limited to urban cities as rural life can also be noisy, polluted, hot, cold, humid or even crowded.

a. Crowding - Crowding can be defined as one’s view of high density living conditions and people’s perception of being crowded is related to their feelings of stress. Studies on how residential density affects the psychological health of male heads of household living in crowded conditions in India revealed that density led to excessive, unwanted social interactions and

insufficient privacy. The combination of insufficient privacy, unwanted social contacts and crowded living conditions produce more stress and social withdrawal.

b. Pollution - This is a second environmental condition that may produce stress. Pollution causes direct health effects as well as through increased stress. Studies on the psychological effect of pollution have implications for stress and health.

c. Noise - In addition to crowding and pollution, exposure to much noise may produce stress. Noise is considered a type of pollution because it is a noxious, unwanted stimulus that intrudes into a person's environment.

2. Personal Sources

a. Occupation - The job an individual does may be a source of stress for him or her. For instance, jobs in which there is high level of demand and low level of control (e.g. construction workers, secretary, laboratory technicians, nursing etc) or middle-level managers (e.g. foreman or supervisor) are highly stressful. Jobs in which the demand and level of control are high (e.g. business executives) is also stressful.

High demands and low control also combine with other workplace conditions (e.g. job dissatisfaction, rotating shift work, etc) to increase on-the-job stress.

b. Personal Relationships - These are other potential sources of stress, but they can also buffer against stress. For instance, people who have fewer personal relationships are at increased health risk compared to those with more relationships (Hibfoll and Vanx, 1993).

c. Sleep Problems - Voluntary or involuntary sleep deprivation is associated with a variety of behavioural and health problems. People who do not get sufficient sleep often feel tired, anxious, drowsy, weary and fatigued. Therefore, sleep deprivation can be both a cause of stress and a result of stress, with effect on both psychological and physiological functioning.

Types of Stress

Stress can be physical, psychological, emotional, social, occupational, acute or chronic in nature. Stress may be any one of the following:

1. Psychological/Emotional Stress - This refers to a kind of stress in which an individual responds or reacts to aversive stimuli in the environment. That is, it is affective, behavioural, and physiological responses to aversive stimuli in the environment (e.g. failure in an examination, loss of a job, death of a spouse, etc.).

2. Sociological Stress - This is a kind of stress caused by what happens in or to a society, and it is characterised by the fact that it affects many people simultaneously. That is, it is due to events like war, famine, drought, poverty, overcrowding and the like.

3. Occupational Stress - This is also called job-related stress. It is caused by the excessive demand made upon workers in industries, factories or any workplace. It is usually caused by job dissatisfaction, rotating shift work, poor working conditions and low pay.

11.2 Effects Of Stress On Human's Health

Both physical and mental healths of individuals are affected by high level of stress. Such effects are in negative dimensions and they include the following:

1. Coronary Heart Disease - Stress increases the level of cholesterol in the blood resulting in coronary heart disease.

2. Change in Blood Cells - Prolonged stress causes increase in level of the eosinophils.
3. High Secretion of Hormone - During a high stress or tension, and, individual may engage in aggressive or hostile behaviour, fear and phobic reactions. All these reactions increase the level of epinephrine or norepinephrine produced by the adrenal medula.
4. Bodily Changes - High level of epinephrine and norepinephrine secreted by adrenal medula during stressful conditions can cause high pulse rate, increased heart beat, high blood pressure and heart disease, changes in blood and so forth.
5. Impaired physical health - High level of stress, anxiety or tension can bring about headache, insomnia, diarrhoea, increased pulse and heart beat rate, dizziness, fainting spells. All these affect physical health negatively and can lead to physical illness (e.g. myocardial infarction, peptic ulcer, etc).
6. Impaired Mental Health - Stress brings about state of confusion, dejection, disorientation, apathy and so forth.

These conditions can lead to neurosis, affective disorders (manic-depressive illness) or psychosis. Uncontrollable life stress (e.g. sudden death of a lived one, sudden loss of job, etc) can make a person become depressed.

11.3 Adaptation And Coping With Stress

In order to maintain one's internal equilibrium, the individual has to adapt and cope successfully with the various stressors in his/her environment. The various ways to adapt and cope with stress are discussed below:

1. Adaptation to Stress - People adapts to stressful events or situations by using defense mechanisms. These include rationalization, displacement, denial, projection, repression, suppression, sublimation, regression and so forth. It should be noted that these mechanisms do not provide permanent solutions to a man's problems; they only offer Coping with Stress temporary relief.

2. Coping with stress is about achieving a balance between its positive and negative aspects. It is the strategy or means by which an individual attempts to control the perceived level of demand, threat or stress.

Scheier et al (1986) identified seven dimensions of coping with stress. They are the following:

a. Denial/Distancing - Refusal to believe that the problem has happened. Try to forget the whole thing.
b. Problem-focused Coping - Make plan of action and follow it. Take action quickly, before things could get out of hands.
c. Self-blame - Realize you bring the problem on yourself. Blame yourself.
d. Acceptance/Resignation - Accept it, since nothing could be done. Make light of the situation; refuse to get too serious about it.
e. Positive re-interpretation - Change or grow as a person in a new way. Find new faith or some important truth about life.
f. Escape through fantasy - Daydream or imagine better fantastic or unreal things that make you feel better (e.g. finding a million dollars).
g. Social support - Talk to someone about how you are feeling. Seek social support from a reliable other who is genuinely interested in helping you overcome the stress.

ACTIVITY 11.1

Take a moment and reflect on what you have read so far. Based on your learning experience, note down the sources and different types 0f stress.

Activity 11.1 feedback

For us to fully and successfully manage stress, the sources and the different types have to be understood. Thus, the sources and types of stress are represented in table 11.1

SOURCES OF STRESS	TYPES OF STRESS
ENVIRONMENTAL FACTORS:	Psychological / Emotional
Crowding	Sociological
Pollution	Occupational
Noise	
PERSONAL:	
Occupation	
Personal relationship	
Sleep problems	

Having understood the sources and types, it is important also to know the effects of stress on human health. These effects are listed below in box 11.1

Box 11.1: Effects of stress on human health

1. Coronary heart disease
2. Change in blood cell
3. High secretion of hormone
4. Bodily changes
5. Impaired physical health
6. Impaired mental health

When we talk of stress management, we cannot downplay the role of coping mechanisms are represented in box 11.2

Box 11.2: Coping mechanisms

Denial

Self blame

Acceptance

Positive re-integration

Escape through fantasy

Social support

Summary of Unit 11

In unit 11, you have learnt that:

1. Stress is a phenomenon that affects physical and psychological states.
2. Sources of stress are from both the person and his or her environment.
3. Types of stress are psychological, sociological and occupational.
4. Stress affects human health physically, mentally and biologically.
5. There are devised ways of coping with stress.

Self Assessment Questions (SAQs) For Unit 11

Now that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering these questions. You can check your answers with the notes on the self assessment questions at the end of this unit

SAQ 11.1a: (tests learning outcome 11.1a)

Define stress according to Payne and Hann,2000

SAQ 11.1b: (tests learning outcome 11.1b)

Identify the sources of stress that are environmental

SAQ 11.2: (tests learning outcome 11.2)

State the effects of stress on the heart.

SAQ 11.3: (tests learning outcome 11.3)

Explain denial as a coping mechanism with stress.

Notes on Self Assessment Questions (SAQs) For Unit 11

SAQ 11.1a: Stress refers to psychological and physiological state of disruptions caused by the presence of an anticipated disruptive event.

SAQ 11.1b: Crowding, pollution and noise

SAQ 11.2: Coronary heart disease

SAQ 11.3: Refusal to believe that the problem has happened.

Unit 12: Pain and Pain Management

Expected Duration: 1 Week Or 2 Contact Hours.

Introduction

Pain is an unpleasant experience, which one tries to avoid or do something about it, such as taking pain killers, seeking medical help or avoiding movements or positions that bring about pain or make it worse. We all experience pain to a greater or lesser degree at various points of our lives. Each person perceives pain differently and as a result, each person also responds to painful stimulations differently. For instance, children are quicker to cry after a relatively minor injury than the adults.

Pain is highly subjective to the individual experiencing it. It is part of the body's defense system triggering a reflex reaction to retract from a painful stimulus and helps to adjust behaviour to increase avoidance of that particular harmful situation in the future. Given its significance, physical pain is linked to various biological, social-cultural and psychological issues. Hence, it can be managed physically and psycho-socially.

Therefore, in this lecture I shall discuss the concept or nature of pain, its causes, types and how it could be effectively managed by the medical social workers, medical social workers.

Learning Outcomes For Unit 12.

When you have studied this session, you should be able to:

12.1 Explain the concept of pain as stated by Turk et al, 1983.(SAQ 12.1)

12.2 List different causes of pain.(SAQ 12.2)

12.3 Highlight different types of pains and their symptoms. (SAQ 12.3)

12.4 State the management stages of pain. (SAQ 12.4)

12.1 The Concept Of Pain

To understand what pain actually is, you have to know what different authors have stated about it. Thus, pain can be defined as an unpleasant sensory and emotional experience caused by real or potential injury or damage to the body. According to Turk et al (1983), pain is the most universal form of stress.It is usually experienced as an unwanted physical stimulus, located in a specific organ or anatomical region of the body (Branon and Feist, 1997). It is a direct consequence of physical injury or a person's reactions to sensations.

Pain can have different sensory qualities, such as shooting, burning or throbbing pain, or it can be a dull ache that is just annoying enough to distract us from what we want to do (Baum et al, 1997).

Stages of pain:

Pain is not a single entity but can be seen according to various stages and types. Keefe (1982) has identified three stages of pain; namely, acute, prechronic and chronic stages. Each stage is associated with a particular pain. Hence, acute stage is associated with acute pain, prechronic stage with prechronic pain and chronic stage with chronic pain.

1. Acute pain - Acute pain is ordinarily adaptive. It signals to the person to avoid further injury. It is a kind of pain that comes and goes relatively quickly in about two weeks or less. It usually lasts less than 6 months. It includes pain from cuts, burns, surgery, dental work, childbirth and injuries.
2. Pre-chronic pain - This is experienced between the acute and the chronic stages. This period is critical because the person either overcomes the pain at this time or develops feelings of helplessness that lead to chronic pain.
3. Chronic pain - This is a type of pain that endures beyond the time of healing. It is more or less constant and is often self-perpetuating. That is, it frequently leads to behaviour that is designed to elicit reward and comfort. It is frequently experienced in the absence of any detectable tissue damage.

12.2 Types Of Pain

Turk et al (1983) classified pains into five types. These are: (1) acute pain (2) chronic recurrent pain (3) chronic interactable, benign pain (4) chronic progressive pain and (5) experimentally induced pain.

1. Acute pain which is of a sudden onset and characterized by sharp pains.

2. Chronic recurrent pain is characterized by intense episodes of pain interspersed with the periods of no pain. Example of this is migraine headache.

3. Chronic interactable, benign pain is pain that is always present but not always severe (e.g. low back pain).

4. Chronic progressive pain is omnipresent pain that gets stronger as the medical condition worsens. It is frequently associated with rheumatoid arthritis and cancer.

5. Experimentally induced pain. It usually consists of electric shock, radiant heat, cold-water immersion or pressure administered in the laboratory setting to voluntary participants with no previous pain problems.

According to Brannon and Feist (1997), pain can also be categorised according to location or syndromes. Hence, we have pain conditions or syndromes, such as headache, low-back, myofacial, arthritis, cancer or phantom limb pain.

1. Headache pain - The most common forms of headache pain are migraine, tension and cluster headache.

   a. Migraine headache - This is common among women. It is characterized by recurrent pain attack on one side of the head, loss of appetite, vomiting and mood disturbance. The pain is high in intensity, frequency and duration.
   b. Tension headache - This is muscular in origin: There is contraction of the muscle of the neck, shoulder, scalp and the face. There is sensation of tightness with steady ache on both sides of the head. It is high in intensity, frequency and duration.
   c. Cluster headache - This is a severe form of headache, which occurs daily in clusters for 4-16 weeks (Pearce, 1994). It is characterised by severe pain and vomiting. The headache may not last longer than 2 hours. It is located on one side of the head, and often the eye on the other side becomes bloodshot and waters. The headache is more common in men than women with a ratio 10:1 it recurs every year or two.

2. Lower back pain - This type of pain is caused by infections, degenerative diseases, malignancies, injury, stress, or job-related activities, resulting into musculoskeletal and neurological disorders in the low back.

3. Arthritis pain - This simply means joint inflammation. Rheumatoid arthritis is an autoimmune disorder characterised by swelling and inflammation of the joints as well as destruction of cartilage, bone and tendon. These affect the joints, producing direct pain and changes in joint structure and movement.

4. Cancer pain - This is a type of pain caused by any malignant neoplasm or as a consequence of therapeutic intervention for the disease or both (e.g. x-ray or radiology).

5. Phantom Limb pain - This refers to pain after limb amputation. That is the experience of chronic pain in an absent body part (Loeser, 1990). It is characterised by feeling of shooting, cramping, burning or crushing pain.

6. Myofascial pain - This is the most common type of chronic pain. According to Sola and Bonica (1990), myofascial pain is a large group of muscle disorders characterised by extremely sensitive trigger points within the muscle or connective tissue. It is experienced as a continual dull ache in nearly any part of the body, but the most common parts are the lower back, shoulders, neck and head. Myofascial pain can result from sustained muscle contraction, muscle trauma and muscle weakness.

12.3 Management Of Pain

For centuries, physicians have used a variety of means for alleviating pains. However, many of these procedures are now supplemented by psychological or behavioral procedures. Therefore, pain could be managed medically and psychologically.

1. Medical treatment for pain - This consists of drugs, surgery and acupuncture.

a. Drugs - Analgesic drugs (pain relieving drugs) are very effective in managing pain of various sorts. They relieve pains without causing any loss of consciousness.

The two major groups of drugs that are commonly used are the aspirin type and the opium type. Examples of these are aspirin, acetammophen, morphine and so on.

b. Surgery - This is the most extreme form of treatment for pain and is usually used only when other treatments have failed. The most common use of surgery is to alleviate chronic low back pain.

c. Acupuncture - This is an ancient Chinese form of analgesia. It consists of inserting a needle into specific points on the skin and continuously stimulating the needle. This treatment for pain relief remains an experimental therapy as existing literature does not give conclusive reports of its effectiveness.

2. Psycho-social treatments - These consist of psychological procedures and social support.

a. Hypnosis - This is the oldest treatment for pain. It was used in the early 19th century as analgesia during surgery (Hilgard and Hilgard, 1975).

According to Hilgard and Hilgard (1975), hypnosis is an altered state of consciousness in which the person's stream of consciousness is divided or dissociated. To them, the process of induction (i.e. being placed into a hypnotic state) is central to hypnosis. After induction, the responsive person enters a state of divided or dissociated consciousness that is essentially

different from the normal state. This altered state of consciousness allows people to respond to suggestions and to control physiological processes that they cannot in their normal state of consciousness.

Hilgard (1975) and Barber (1980) agreed that hypnosis or the hypno suggestive procedure is an important clinical tool, especially for the control of pain. The lists of pains that are responsive to hypnotic procedure include childbirth pain, headache pain, cancer pain, low back pain myofascial pain and laboratory induced pain.

b. Progressive muscle relaxation - This is only one of several types of relaxation techniques. With progressive muscle relaxation, patients are first given a rationale for the procedure, including an explanation that their present tension is mostly a physical state resulting from tense muscles. The patients are asked to be in a comfortable chair, instructed to breathe deeply and exhale slowly. After this, they are instructed to tense a particular muscle group (e.g. hand, leg muscles etc), and to hold the tension for about ten seconds. They repeat this exercise several times and once they learn the relaxation technique they may practice independently at home.

c. Meditation relaxation - This approach was derived from various religious meditative practices. However, as used by psychologists, it has no religious connotations. It was developed by Benson et al (1974). This approach combines muscle relation with a quiet environment, comfortable position, a repetitive sound and a passive attitude.

Participants usually sit with eyes closed and muscles relaxed. They then focus attention on their breathing and repeat silently a sound like “om” or “one” with each breath for about twenty minutes. Meditation involves conscious intention to focus attention on a single thought or image along with effort not to be distracted by other thoughts.

d. Guided Imagery - With guided imagery, patients conjure up a calm, peaceful image such as the repetitive rhythmic roar of an ocean or the quiet beauty of a pastoral scene. Patients then concentrate on that image for the duration of a painful or anxiety - filled situation. The assumption underlying guided imagery is that a person cannot concentrate on more than one thing at a time. Therefore, the patient must imagine an especially powerful or delightful scene, which can avert attention from the painful experience. However, it should be noted that some forms of guided imagery do not involve pleasant images (e.g. unpleasant situations like embarrassing childhood experience, the death of a friend etc). Whether pleasant or unpleasant, the image must be sufficiently intense to block any feeling of pain.

Another form of guided imagery is called “in vivo” imagery, in which the patient is asked to concentrate on real-life situations. The patient maybe asked to re-call experiences that have contributed to their feelings (e.g. pride, self-esteem, self-assertion, etc). By concentrating on these images, the patient is able to cope with the pain by inhibiting most of its unpleasant effects.

e. Social support - This refers to a variety of material and emotional supports a person receives from others. It includes such things as perceived emotional concern from others, health-related advice and information, material aid, self-enhancing words, and behaviours received from others and many other factors (Brannon and Feist, 1997).

Social support has been linked with stress and chronic pain. Some people react better than others to stress and chronic pain. There are those who have greater personal resources for coping. One of the most beneficial personal resources appears to be social support from family members, friends, and health care-givers. Therefore, when adequate social support (e.g. financial, materials and other supports) is given to those in painful conditions, they may experience some degrees of relief from such pains.

ACTIVITY 12.1____

Take a moment and reflect on what you have read so far. Based on your learning experience, note down the various types of pain and how to manage pain.

Activity 12.1 feedback

For us to fully and successfully manage pain, the stages and the different types have to be understood. Thus, the types of pain are listed below.

Turk et al (1983) classified pains into five types. These are: (1) acute pain (2) chronic recurrent pain (3) chronic intractable, benign pain (4) chronic progressive pain and (5) experimentally induced pain.

Having understood the types, it is important also to know how to manage them.

Activity 12.2 feedback

Pains could be managed medically or psychologically.

Summary of Unit 12

In unit 12, you have learnt that:

1. There are various strategies that can be employed to manage pains.
2. Pains can be managed medically or psychologically.
3. Its medical management includes use o drugs, surgery and acupuncture.
4. Psychological pains can be managed through hypnosis, relaxation, breathing exercises and social support.

Self Assessed Questions (SAQs) On Unit 12

SAQ 12.1(tests learning outcome 12.1)

Explain the concept of pain as stated by Turk et al 1983.

SAQ 12.2 (tests learning outcome 12.2)

List different stages of pain

SAQ 12.3(tests learning outcome 12.3)

Highlight different types of pains and their symptoms.

SAQ 12.4 (tests learning outcome 12.4)

State the management stages of pain.

Notes on Self Assessment Questions (SAQs) For Unit 12

SAQ 12.1 pain is the most universal form of stress. It is usually experienced as an unwanted physical stimulus, located in a specific organ or anatomical region of the body

SAQ12.2 Acute pain, pre chronic pain and chronic pain

SAQ 12.3 Headache pain, lower back pain, arthritis pain, cancer pain, phantom limb pain and myofascial pain.

SAQ 12.4 Medical and psychological.

Unit Thirteen: Adhering To Medical Advice

Expected Duration: 1 Week Or 2 Contact Hours.

Introduction

Some people comply with medical advice, while others fail to comply. Several factors may be held responsible for this. For instance, non-adherence or failure to comply with medical advice may be due to illness characteristics, duration of the treatment and complexity of the treatment among others.

In this study, you will learn about the concept of adherence, factors predicting adherence and possible ways of improving adherence.

Learning Outcomes For Unit 13

When you have studied this question, you should be able to:

13.1define compliance or adherence;(SAQ 13.1)

13.2identify the factors predicting compliance or adherence;(SAQ 13.2)

13.3 list some ways by which compliance or adherence can be improved.(SAQ 13.3)

13.1 concepts Of Compliance Or Adherence

Traditionally, the term compliance refers to the patient's behaviour that conforms to physician's orders. But, because the term connotes reluctant obedience, many health psychologists and some physicians advocate the use of other words and terms such as "adherence", "cooperation", "obedience" and "collaboration". However, the terms 'compliance' and 'adherence' are still the most frequently used words. Both words are used interchangeably to describe the patient's ability and willingness to follow recommended health practices (Turk and Meichenbaum, 1991).

Haynes, (1979b) defined compliance as the extent to which a person's behaviour in terms of taking medications, following diets, or executing lifestyle changes, coincides with medical or health advice. This definition expands the concept of compliance beyond merely taking medications to include maintaining healthy life style practices, such as abstaining from smoking cigarettes, eating properly, getting sufficient exercise, avoiding undue stress, and not abusing alcohol.

13.2 Factors Predicting Compliance Or Adherence

Possible predictors of adherence to or compliance with medical advice, or health practices can be of three categories; namely, characteristics of the disease, characteristics of the person, and characteristics of the relationship between the health care provider and the patient.

1. Illness characteristics – characteristics of the disease include the unpleasantness of the medication's side effects, the duration of treatment, the complexity of treatment and the severity of the disease.

    a. Side effects of the medication - A drug with few or no unpleasant side effects will produce greater patient compliance. A study by Kirscht and Rosentock (1977) revealed that unpleasant side effects are associated with a greater likelihood of non-compliance.

b. Duration of the treatment - This is the second illness characteristic. In general, the longer people must submit to treatment or preventive regimens, the more they are to drop out of treatment. According to Haynes (1976a), in most cases, non-compliance increases as duration of therapy increases.
c. Complexity of the treatment - Another illness characteristic is the complexity of the treatment. In general, the greater the variety of medication, the greater is the likelihood of that person's non-compliance. Haynes's (197a) showed that compliance decreases as the number of daily doses increased from one to four.

2. Personal characteristics -Individual characteristics such as age, gender, social support, personality traits and personal beliefs about health determine how people comply with medical advice.

a. Age - The relationship between adherence and age is complicated by several factors. Depending on the specific illness, the time frame, and the adherence regimen, studies show that compliance either increases or decreases with age.
b. Gender - With regard to gender, researchers have found few differences between overall adherence rates of women and men but some differences in specific recommendations. Lynch et al (1992) found that men and women were about equal in their tendency to drop out of or stay with an exercise programme. However, women seem to be better at adhering to healthy diets and taking some types of medication than men do.
c. Social support - One of the strongest predictors of adherence is the level of social support one receives from friends, and family. In general, people who are isolated from others are likely to be non-compliant. Those whose lives are filled with close interpersonal relationships are more likely to follow medical advice. For instance, Christensen et al (1992) found that heamodialysis patients who saw their family as cohesive and expressive of feelings were more likely to adhere to fluid-intake restrictions than those who perceived conflict within their family.
d. Personality Traits - Some studies have shown that personality traits such as authoritarianism, neuroticism and impulsivity are associated with non-compliance. However, most these studies did not use standardised personality inventories.
e. Personal Beliefs and Cultural Norms - Some evidence suggests that patients' beliefs are related to compliance. Therefore, personal beliefs that one's own behaviour can produce a health benefit is positively related to adherence. One other factor that definitely relates to compliance is the patients' cultural beliefs and attitudes. For instance, if one's family or tribal traditions include strong beliefs in the efficacy of witch doctors or herbalists, individual's compliance with modern medical recommendations might be very low.

3. The Practitioner - Patient Interaction - A more satisfactory group of predictors of adherence are those subsumed under the category of practitioner-patient interaction. Within this category are such factors as the verbal communication between the health-care provider and the patient, the perceived practitioner's level of competence, the amount of time between referral and treatment and the length of time a patient has to spend in the practitioner's, waiting room.

a. Verbal communication - Lack of accurate verbal communication is probably the most serious problem in patient's compliance. Many patients fail to understand or fail to remember instructions because of inaccurate or inadequate communication between them and the health care providers.

b. The practitioner's personal characteristics - This has to do with the level of competence of the physician. As might be expected, patients compliance improves as confidence in their physician's technical abilities increases (Gilbar, 1989).

   Although, patients are more likely to adhere to recommendations from competent and knowledgeable physicians, they become less eager to comply when the physician's expertise is expressed in an authoritative fashion (Brannon and Feist, 1997).

c. Time spent by the patient before seeing the physician - The length of period the patients must wait to secure an appointment and the amount of time they must spend in the practitioner's waiting room are two final predictors of compliance. In both cases, the longer the wait, the greater is the possibility of a patient's non-compliance. A delay of about one hour can bring about non-compliance.

13.3 How To Improve Adherence

Several methods can be used to improve adherence. Among such methods are educational and behavioural strategies (Haynes, 1976b).

1. Educational strategies and instructional procedures - These are procedures that impart information, sometimes in an emotion-arousing manner designed to frighten the non-compliant patient into becoming compliant. Such strategies and procedures include:

   a. health education messages;
   b. Individual patient counselling with various professional health care providers (counselling by doctors, clinical psychologists, medical social workers, nurses, counselors, etc.);
   c. programmed instructions;
   d. lectures;
   e. demonstrations; and
   f. Personal instruction.

   Although, educational programmes increase patients' knowledge about their disease, non of these programmes has been found to bring about long-term compliance.

2. Behavioural and cognitive strategies - The ineffectiveness of educational and instructional procedures has instigated a growing interest in various behavioural and cognitive strategies for improving patient's compliance. These interventions include:

   a. self-monitoring;
   b. home visit;
   c. cues and rewards; and
   d. Peer group discussions.

   Haynes et al (1987) found that cues and rewards seem to be the most consistently effective means of improving compliance. Cues include using one's toothbrush or a completed meal as a signal to take one's medication. Rewards might include small sums of money given by the health care provider or self-reinforcement such as seeing a movie or treating oneself to a nice meal. Both cues and rewards have been shown to increase the chances that patients will take their prescribed medication.

Activity 13.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowing what adherence is, note down some of the definitions of adherence.

Activity 13.1 Feedback

The sentences below tell us some accepted definitions of adherence.

1. The patients' behavior that conform to physicians' orders.
2. Patients' ability and willingness to follow recommended health practices (Turk and Meichenbaum, 1991)
3.the extent to which a person's behavior in terms of taking medication, follow diets or executing lifestyle changes, concludes with medical advice(Haynes, 1979b)

For us to meaningfully learn about adherence to medical practices, factors predicting adherence will have to be considered. These factors are listed below:

1. Illness characteristics-
   (i) Side effect of medication
   (ii) Duration of treatment
   (iii) Complexity of treatment
2. Personal characteristics-
   (i) Age
   (ii) Gender
   (iii) Social support
   (iv) Personal trait
   (v) Beliefs and cultural norms
3. The practitioner-
   (i) Verbal communication
   (ii) Personal characteristics
   (iii) Time spent before seeing physician

To improve knowledge of adherence, we also have to look into the ways of improving adherence. These ways are also represented in table 13.1

MAJOR WAYS	MINOR WAYS
Educational strategies and instructional procedures.	Health education
Behavioural and cognitive strategies	Individual counselling
	Programmed instructions
	lectures
	demonstrations
	Personal instructions

	Self monitoring
	Home visit
	Cues and rewards
	Peer group discussions

Summary of Unit 13

In unit 13, you have learnt that:

1. There are different submissions on the concept of adherence.

2. Factors predicting adherence have to do with the illness characteristics, patients' personal characteristics and the practitioners' characteristics.

Self Assessment Questions (SAQs) On Unit 13

SAQ 13.1(tests learning outcome 13.1)

Define adherence as stated Turk and Meichenbaum, 1991

SAQ 13.2 (tests learning outcome 13.2)

List the personal characteristics that could predict adherence

SAQ 13.3(tests learning outcome13.3)

Highlight the major ways of improving adherence.

Notes on Self Assessment Questions (SAQs)

SAQ 13.1: Patient's' ability and willingness to follow recommended health practices.

SAQ 13.2 Age, gender, social support, personality trait, beliefs and cultural norms.

SAQ 13.3: Educational strategies and instructional procedures.

Behavioural and cognitive strategies

Unit 14 Roles of Social Workers in Public Health.

Expected Duration: One Week or 2 Contacts hours

Introduction

In this session, you will learn about the nature of public health, nature of social work and roles of social workers in public health.

What then are the nature of public health, the nature of social work in public health and the roles of social workers in public health?

Learning Outcomes For Unit 14

When you have studied this question, you should be able to:

14.1 Explain public health in the context of achieving health for all.(SAQ 14.3)

14.2 List the group of people which are to be rehabilitated (SAQ 14.2)

14.3 Mention what the community is mobilized for.(SAQ 14.3)

14.1 Nature of Public Health

In its present form public health is a combination of scientific disciplines such as epidemology, biostatistics, laboratory sciences, demography etc. It is the organised application of local, state, national and international resources to achieve health for all people, or address major health problems (e.g. infectious and nutritional diseases, mental illness, etc).

According to Mojoyinola (2002), public health by its nature involves the following:

1. control and prevention of diseases e.g. malaria, household pests, disease vectors etc;
2. control and prevention of communicable diseases (e.g. typhoid, yellow fever, guinea worm, etc);
3. health resources administration (planning, staffing, etc);
4. health services administration;
5. alcohol, drug abuse and mental health administration;
6. sanitary and waste disposal;
7. environmental sanitation and control of environmental pollution; and
8. primary health care services (e.g. immunisation, antenatal or postnatal care, Etc).
9. Health education or public enlightenment campaign on health-related matters (e.g. epidemics, drug abuse, HIV/AIDS, mental illness, etc.).

14.2 The Nature of Social Work in Public Health

There are personal and social health problems in the community, which require the services of social workers. Such problems include the following:

1. chronic illness in infants, children, adults and the elderly;
2. emotional disorders, including family disequilibrium and inter-relationship problems;
3. Social diseases resulting from bad life style and environmental factors (hypertension, coronary disorder, AIDS, etc.);

4. social disorders like violence, suicides, substance abuse, accidents etc; and
5. stress, anxiety, fear, worry, etc.

Social work practice in public health is preventive and rehabilitative in nature. This comprises the following:

1. Public enlightenment - Campaign on health-related matters or health education/talk on immunisation of infants and nursing mothers, drug abuse, HIV/AIDS, etc.
2. Control of epidemics and eradication of communicable diseases - Mobilisation of the public on how to stop outbreak of cholera, typhoid fever, yellow fever, guinea worm, etc.
3. Prevention of disease/mental illness – Organisation of seminars, conferences, and workshops on how to prevent sexually transmitted disease, mental illness, etc.
4. Rehabilitation of disabled and destitute – Ensuring that disabled persons are well rehabilitated to become useful to themselves and the society.
5. Promotion of mental health – Ensuring that public experience positive mental health by emphasizing good health habit, or positive life style.

14.3 Roles of Social Workers in Public Health

Social workers in public health centres are called health/community/rural social workers. They work in primary health care where they render valuable health care services to people with psychological, emotional, physical and mental health problems. They also provide essential services to the groups of individual, the community, or the society at large.

The services of this group of social workers are therefore, indispensable. Their roles among others include the following:

1. By applying their knowledge and skills in casework, group work and psychotherapy, they help many people to overcome their psycho-social problems.
2. They help people to recognise symptoms of mental illness and how to reduce them.
3. They help in promoting positive physical and mental health through health education, health talk or enlightenment campaigns against drug abuse, self-medication, sexually transmitted diseases (HIV/AIDS).

Activity 14.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowledge about social work and public health, note down some of the nature of public health.

Activity 14.1 feedback

Take a look at box 14.1. it highlights the nature of public health.

Box 14.1: nature of public health
1. Control and prevention of diseases
2. Control and prevention of communicable diseases
3. Health resources administration.

4. Health services administration.
5. Alcohol, drug abuse and mental health administration.
6. Sanitary and waste disposal
7. Environmental sanitation and control of environmental pollution.
8. Primary health care services.
9. Health education.

Nature of general public health has been explained and for a social worker, the actual nature of social work in public health must be known and understood. Box 14.2 represents the nature of social work in public health.

Box 14.2: nature of social work in public health
- Public enlightenment
- Control of epidemics and eradication of communicable diseases.
- Prevention of disease or mental illness
- Rehabilitation of disanled and destitute
- Promotion of mental health.

Aside the nature of social work in public health, the social workers has specific roles to play \in the nature of their profession an public health. These roles are stated below:

(a) Helping people overcome psychological problems through casework, group work and psychotherapy.

(b) Helping people to recognize symptoms of mental illness and how to reduce them.

(c) Promoting positive physical and mental health through health education.

(d) Organize and mobilize the community for control, eradication and prevention of communicable diseases.

(e) Serve as linkage between people and a system of support.

(f) Help in early detection of symptoms of illness or in preventing deteriorating of illness.

Summary of Unit 14

In unit 14, you have learnt that:

1. Public health has its nature cutting across all aspects of health.
2 .Social works in public health has its own peculiar nature.
3 Social workers have their roles in public health.

Self Assessed Questions (SAQs) On Unit 14

SAQ 14.1(tests learning outcome 14.1)

Explain public health in the context of achieving health for all.

SAQ 14.2 (tests learning outcome 14.2)

Which group of people, are to be rehabilitated?

SAQ 14.3(tests learning outcome 14.3)

What is the community mobilized for?

Notes on Self Assessed Questions (SAQs)

SAQ 14.1 Public health is the organized application of local, state, national and international resources to achieve health for all people.

SAQ 14.2 Disabled and destitute

SAQ 14.3 For control, eradication and prevention of communicable diseases.

Unit 15 Health Education

Expected Duration: 1 Week Or 2 Contact Hours

Introduction

An individual's state of health can have an effect on all the things he or she does. Health can affect a person's ability to work and consequently his or her earning potential, which in turn has an effect on his/her lifestyle. Health is also something that changes, more often for some people than others. It is imperative, therefore, that every individual be educated to remain healthy and be free from diseases. The individual also has to be educated on how to enhance his/her physical and mental health.

Therefore, in this module, I shall discuss the concept, nature, aims, levels and issues in health education campaign.

Learning Outcomes For Unit 15

When you have studied this session, you should be able to:

15.1 define health education; (SAQ 15.1)

15.2 explain its aims and objectives;(SAQ 15.2)

15.3 describe the levels of health education;(SAQ 15.3)

15.4 discuss the various issues in health education campaigns.(SAQ15.4)

15.1 The Concept of Health Education

Health education is a helping, motivating, self-help and self-reliant process. It has been defined as any combination of planned learning activities that enable people voluntarily to behave in ways that promote health, prevent diseases and recovery from illness. According to Brieger (1996), health education refers to any combination of learning activities that promote voluntary adaptation in health and health related behaviours. The World Health Organisation defined it as the combination of planned social action and learning experiences designed to enable people gain control over the determinants of health and health behaviours.

Health Education can also be defined as the science, and art of preventing diseases, prolonging life, and prompting health and efficiency through education of the individual in personal hygiene, prevention and treatment of diseases. According to Oladepo (2002), health education is a helping, motivating; self-help and self-reliant process and focuses on people's voluntary and self-imposed behaviour. It motivates people as individuals or groups in community settings to attain health as a valid asset achieve health by their own efforts, make intelligent choice and use of the available health services and medical products.

Health education occurs in a number of different ways and through a range of different people. The common factor is that people and methods all aim to improve health, either through education or prevention.

15.2 Aims and Objectives of Health Education

Health education can be given on a range of topics from personal health to personal safety. According to Chaloner et al (1996), the aims and objectives of health education programmes may include the following:

1. Self-empowerment - This involves giving the individual the knowledge and understanding to be able to make an informed choice about something.
2. To change behaviour or attitude - The aim being to bring about change in some way (e.g.) bad habit like smoking.
3. To provide knowledge - This means to increase understanding about a topic (e.g. increasing understanding on what causes a disease or how to prevent, control or cure it).
4. To raise awareness - This might not involve a behaviour change as such, but it is an attempt to increase a person's awareness of a topic. For instance, in AIDS education, health professionals aim to inform people who may be at risk of contracting the HIV virus and about how they can protect themselves.
5. To promote the interests of a particular group - This may be in form of raising support for charities who research into cancer problems. It may also be in form of waging war against teenage pregnancy and so forth. Moronkola (1999) gave the aims of health education as:
   a. to instill in people the need for a healthy life for quality living that will ensure high productivity;
   b. to teach people how to take care of their personal and community health;
   c. to change people's attitudes towards health to positives ones;
   d. to encourage people to use available health services;
   e. to make people see the need for preventing diseases rather than spending more time and money for treatment;
   f. to change people's negative health practices to positive ones; and
   g. to encourage people to continue with their local ways of life that promote health.

15.3 Levels of Health Education

Health Education occurs on different levels. These are:

1. Primary health education (prevention) - This level involves health promotion aimed at informing different groups about health-related issues, with the aim of prevention. For example, telling children about the risks related to smoking in the hope that they will not take up the habit.
2. Secondary health education (curative) - This level involves health advice which encourages people to change the habits they already have. This may be a result of symptoms and/or illness connected with a habit where an individual needs to ensure it does not get worse. For instance, an overweight person may receive health promotion advice on healthy eating, weight loss and how to eat a diet to prevent him or her becoming obese (i.e. too fat).

3. Tertiary health education (adjustment) - This level involves educating the individual to get the most out of life when he or she has an irreversible or chronic illness or condition. For example, rehabilitating an individual who has had a heart bypass operation and advising him or her on necessary changes in lifestyle (e.g. diet and exercise).

15.4 Issues in Health Education Campaigns

Common issues in which health education campaigns have focused on include the following:

1. Promotion of healthy - living practices, such as healthy diet, the need to increase exercise, the role of contraception;
2. Campaigns to reduce diseases, such as immunisation programmes;
3. Minimising the risk from potentially harmful living practices, such as substance abuse, smoking, alcohol, unsafe sexual practices and sexually transmitted diseases; and
4. Promoting personal safety and security. For example, home security, road safety, safe use of electricity, gas and appliances.

Activity 15.1

Take a moment to reflect on what you have read so far. Based on your learning experience and knowledge, note down some of the definitions of health education.

Activity 15.1 feedback

The different definitions of health education as stated by different authors will be represented in box 15.1 below.

Box 15.1: the concept of health education

1. It is a helping, motivating, self help and self reliant process.

2. Refers to any combination of learning activities that promote voluntary adaptation in health and health related behaviours (Brieger, 1996)

3. A helping, motivating, self help and self reliant process and focuses on peoples' voluntary and self imposed behavior(Oladepo 2002)

4. An art and science of preventing diseases, prolonging life and prompting health and efficiency.

Having understood the concept of health education, the objectives are represented in box 15.2 below

Box 15.2: Objectives of health education

1. Provides knowledge

2. Creates awareness

3. Promotes interest of a particular group

4 Self empowerment

5. Change behavior or attitude

Health education has three different levels as listed below:
1. Primary health education
2. Secondary health education
3. Tertiary health education

Summary of Unit 15

In unit 15, you have learnt that:
1. Health education is aimed at promoting health, preventing disease and recovery from illness.
2. There are five objectives of health education
3 .The levels of health education are primary, secondary and tertiary
4. The issues in health education campaign include:
    Promoting of healthy living practices
    Campaign to reduce disease
    Promoting personal safety and security
    Minimizing risk from potentially harmful living practices.

Self Assessment Questions (SAQs) For Unit 15

SAQ 15.1(tests learning outcome 15.1)
Define health education as stated by Oladepo, 2002.
SAQ 15.2(tests learning outcome 15.2)
Explain self empowerment, an objective of health education
SAQ 15.3(tests learning outcome 15.3)
State the first level of health education
SAQ 15.4(tests learning outcome 15.4)
Identify the issue that relates to diseases.

Notes on Self Assessment Questions (SAQs)

SAQ 15.1 Health education is a helping, motivating, self help and self reliant process and focuses on peoples' voluntary and self imposed behavior.
SAQ 15.2 Giving an individual the knowledge and understanding to be able to make an informed choice about something.
SAQ 15.3 Primary health education
SAQ 15.4 Campaigns to reduce diseases such as immunization programmes.

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