

BGS Amulree Prize 2007

**The Journey from Diagnosis to Post-
Bereavement of a spouse in Old Age:
Social Perspective**

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FOREWORD

During the second year of the MBChB programme at Birmingham University, I had the opportunity to do a family attachment as part of the Behavioural Sciences Module. The objective was to follow the progress of an elderly gentleman (Kevin) after the bereavement of his wife and produce a dissertation to reflect on any aspect on this phase of his life through a social perspective. This dissertation thus encompasses what Kevin went through after his wife was diagnosed with breast cancer leading up to her death and his experiences post-bereavement. I was encouraged to include lessons learnt which would have a significant impact on my interaction with patients as a clinical practitioner in the future.

To maintain the confidentiality of all persons concerned, their names and the names of some places have been changed.

“All this suffering and distress will come to an end, and that’s another chapter of life gone.”

- Kevin

This is my insight into a disturbing event that took hold of Kevin’s life and changed his world with an everlasting effect; the passing away of his wife. Holmes and Rahe go as far as classing the ‘death of a spouse’ as the most stressful event that could take place in an individual’s lifetime in their Social Readjustment Scale.¹

Meeting Kevin

Prior to our first meeting the family GP had told me about Kevin’s recent loss. Walking up his driveway with the GP, I couldn’t help but think that this was going to be someone who will be too bereaved to even speak, let alone reveal his feelings. The door opened, and the man who opened it wore the warmest smile.

“Hello there, please come in, may I take your coat?”

Kevin stressed right from our first meeting that I could ask him absolutely anything that I needed to know, this was very reassuring.

Here was my first lesson already; I was prejudging Kevin according to my individual experience, stereotyping almost. I should have entered Kevin’s home with an open mind and waited patiently to allow him to explain his account. This was a first hand experience of learning about a behaviour that I would do well to avoid if I am ever to be a good doctor. If I was to take one thing away from this incidence, it would be what I learned about myself and human nature that day. It is easy to have a tendency to prejudge people, sometimes before even meeting them, but we should have the patience to listen to their story, get the real picture behind their concern.

¹ Holmes TH and Rahe RH. The Social Readjustment Rating Scale. Journal of Psychosomatic Research. August 1967; 11(2): 213 – 218

Kevin is 81 and lives alone in a residential area in Solihull. He is of a Caucasian background and contributes to the largest ethnic group in his locality that of White British origin, which stands at 86%². Nationally this group makes up 92% of the total population.³ When compared with other ethnic groups, this group has the highest proportion of people living in their retiring age at 16% (**see appendix 1**).⁴ In Kevin's neighbourhood, the most common type of household is that of 'one person; pensioner' (**see appendix 2**).⁵ These facts illustrate that Kevin forms part of a significant population nationally and locally, where he represents the predominant household type in his locality. Having people of similar age around Kevin explains his good integration within the local community. Indeed he describes his walks to the supermarket as '*...very enjoyable, because I get to meet lots of people...they are very friendly*'.

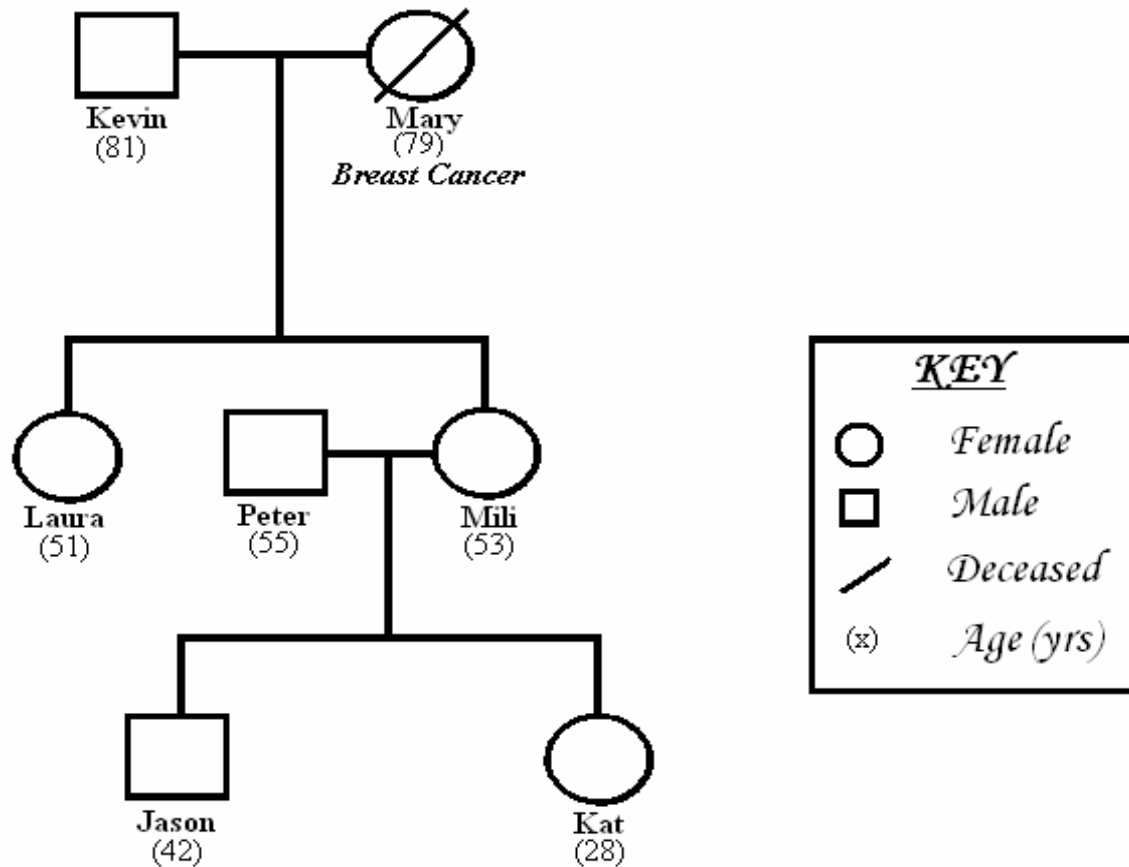
Kevin started working in the newly formed NHS in 1948. Shortly after he married Mary, with whom he had two children (**see figure 1**). Kevin has lead an interesting life upon which I shall elude to serve the purposes of this dissertation. However, looking at his family tree and accounting for the changes in family structure over the past few decades, how common is this family?

² <http://www.neighbourhood.statistics.gov.uk/dissemination/AreaProfile1.do?tab=2>

³ <http://www.statistics.gov.uk/CCI/nugget.asp?ID=273&Pos=4&ColRank=2&Rank=1000>

⁴ Appendix One

⁵ Appendix Two

Figure 1: Kevin's Family Tree**How common is Kevin's Family?**

Kevin's family conformed to the predominant type of family during the 1950s, which was the 'traditional' nuclear family consisting of a husband, wife and their children (see appendix 3).⁶ Although this has remained the case, the 'typical' family structure is dwindling. The proportion of nuclear families decreased progressively from 52% in 1961, to 39% in 2001.⁴ On the other hand the number of people living alone, or

⁶ Appendix 3

number of lone couples has steadily gone up. This may be due to the fact that more and more people prefer to live alone or as unmarried couples.⁷ This progressive drift towards non-nuclear households has slowly gathered momentum over the last half century as society becomes more tolerant to the idea of divorce; also there is greater freedom for women to live alone, without any attached stigma.

Kevin's family has been very much part of the trend of moving away from the conventional family structure. His younger daughter, Laura is not married and lives alone. However she seems to play an important role in Kevin's life as she lives locally and can visit him regularly. Mili lives with her husband and is situated too far for regular visits to be practicable. Both of Kevin's grandchildren were adopted; Jason is divorced but trying to settle with his girlfriend. Kevin describes his grand-daughter as '*full of life*' and '*a very independent woman*' who is also unmarried and lives alone. In my opinion, despite being non-nuclear, this is a very 'typical' family in the sense that it follows a large proportion of families undergoing similar changes, which is in line with changes observed from censuses over the decades between 1961 through to 2001 (see **appendix 3**).⁴

If Kevin is classified via the National Statistics Socio-economic Classification, he and his family would fall into social class 1.2 in the 8 classes table. This puts him and his family in a higher than average social class with regards to both their ethnic group and the total UK population (see **appendix 4**).⁸

⁷ <http://www.guardian.co.uk/2020/story/0,15047,1309402,00.html> – accessed 14/02/2006

⁸ Appendix 4

The Beginning

One morning, Mary noticed a ‘*small rash*’ on her chest. According to Kevin, Mary had been partially sighted for a long time and thus couldn’t tell how long she might have had the rash for. They went to see their GP the following morning. The GP informed me, that at the time Mary had presented herself with a fairly late stage breast tumour. This delay to go to see the doctor isn’t unheard of. Up to 30% of women with breast cancer put off going to see their GP for at least three months.⁹ Mary knew that something was wrong long before she told Kevin. So what instigated her to tell him and then book the appointment to see the doctor?

Mechanic (1978) (see **appendix 5**)¹⁰ sheds some light in explaining Mary’s behaviour. It is likely that the extent to which she perceived her ‘*rash*’ was simply not serious enough to warrant action. It is also likely that the perception of a mere ‘*rash*’ would not have disrupted her family and other social activities, especially in a place where it is not visible to the third person. This is where Mechanic’s variables interlink with Goffman’s explanation of stigma. Had the rash been on her face, she would have felt the effects of Goffman’s ‘Stigmas of body’¹¹ much earlier on, as the rash would have exposed her to these.

However, there seemed to be a deeper reason for this illness behaviour that Mechanic identifies as the *psychological costs of taking action*.

“*No family should have to go through such pain visited upon by this cursed disease.*”

These were Mary’s words after the death of her brother from cancer, as Kevin told me. By delaying telling anyone about the ‘*rash*’, Mary seemed to exhibit denial out of sheer trepidation of the consequences, if her worst fears did indeed turn out to be true.

⁹ http://www.bbc.co.uk/health/womens_health/issues_breastcancer1.shtml

¹⁰ Appendix 5 - Scambler G. (ed). *Sociology as Applied to Medicine* 5th Edition. London: WB Saunders Company Ltd, 2003. Pp. 41.

¹¹ Goffman E. *Stigma: notes on the management of spoiled identity*. New York: Double Day Anchor, 1963. Pp. 68.

Effect of Illness on the Family

When he found out about Mary's condition, Kevin put off talking about it with his daughters to avoid putting any psychological distress on them. Surprisingly, this communication barrier did not create any strain within the family as such. This is explained by the fact that not all communication has to be verbal. The daughters clearly understood that their parents were going through a difficult time and did not want to put additional pressure on them. This considerate attitude from the family members exemplified their affectionate bond.

Laura found out about Mary's diagnosis by speaking to a nurse who worked at the same school where she taught. This was mainly through verbal description of Mary's symptoms and the treatment she was on. Thereafter, the family seemed to follow the outlay of the illness striking the family model (see **appendix 6**).¹² The model correctly predicted the disruption to Kevin's family life and their response in becoming a relatively more cohesive and socially isolated unit as a result of Mary's chronic condition. Kevin describes those eighteen months after the diagnosis as:

"...very busy ones, so much so that they took over our lives completely. Laura was home after teaching to look after her mother everyday and also did it during the weekends. I would make the lunch and when Laura came, she would only have to make a light meal. It eased the burden on her... Mary had a bell that she would ring during the night to wake me and assist her with anything she wanted."

Being the twenty-four hour care that it was, Kevin had to accept the disrupted sleeping patterns. He was also responsible for the shopping and had some help with the cooking and cleaning from Laura. When Laura wasn't able to care for Mary on some occasions, Mili would always travel down from Lancashire to cover for her. The constant care also meant that Kevin's socialising with the local community reduced significantly to brief conversations whilst out shopping.

¹² Appendix 6 - Litman TJ. The family as a basic unit. *Journal in Medical Healthcare: A social and behavioural overview*. Social science and medicine 1974; 8: 495-519

This family furthers Litman's model in that the whole family is not affected in the same way. Rather, different members of the family respond to the illness in their own individual way. For instance Laura had a closer relationship with Mary than any other member of the family and was more involved in caring for her than her older sister. Equally, demographic and geographic factors also explain the sisters' roles in the level of participation they could exhibit. Mili for instance, used to take compassionate leave from work and drive very long distances to be with her mother; hence regular visits were not feasible.

Kevin's Relationship with the Health Services

Kevin has an excellent relationship with his General Practitioner (GP) and the fact that he is on Christian name terms with her portrays their close bond. The foundations of their relationship seem to be trust, respect, and most importantly, Kevin's conviction of his GP's indisputable competence. He admires her patience, describing her as someone who devotes a lot of time to her consultations and is good at letting him ask questions. As a result Kevin feels that he is able to fully open up to her without the fear of time constraints.

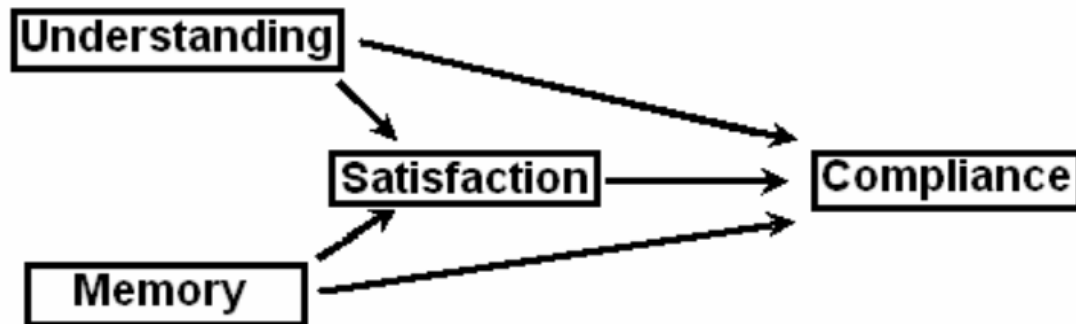
Kevin has been on a pharmacological regime for rheumatoid arthritis, which has been gradually reduced by the doctor over a period of time. Kevin recalled when he wanted the drug dosage to be reduced significantly because he was suffering from its profound side-effects. However, this opinion clashed with the GP's, who was adamant that the time was not right. Subsequently Kevin willingly followed her professional advice. Two things emerge from this; Kevin's relationship with the GP and his compliance. The high level of practitioner control relative to the patient control projects their doctor-patient relationship in a paternalistic light (see appendix 7).¹³

"...she is quite definite about the type of treatment that she prescribes."

It was interesting to find that the GP's paternalistic attitude does not go hand in hand, as might be expected, with a doctor-centred consultation style. As I gathered from Kevin, she seems to put the patient at the centre of the consultation by encouraging them to express any concerns they may have. In modifying her paternalistic manner and adapting it to the patient's needs, she justifies her course of action and makes the patient understand the situation from her own perspective. This understanding is integral in achieving high patient compliance. Indeed it forms a key factor in Ley's model of compliance (see figure 2).¹⁴

¹³ Appendix 7 - Scambler G. (ed). *Sociology as Applied to Medicine* 5th Edition. London: WB Saunders Company Ltd, 2003. Pp. 54.

¹⁴ Ley P. Understanding, Memory, Satisfaction and Compliance. *Brit J Clin Psychol* 1982;21:241-254

Figure 2: Ley's Model of Compliance¹⁴

Kevin is a very compliant patient; he understands that the treatment is for his own benefit and can retain that information to follow given instructions. However, the satisfaction and the consequent compliance seem to stem from a high level of confidence in his GP.

Kevin feels he has no “*jurisdiction*” to challenge the practitioner’s professional opinion. He shares his thoughts with the GP, and then follows her advice unwaveringly. This attitude has mainly been the influence of working within the NHS at a time when the doctor’s advice was taken unquestioningly.¹⁵ It is only in the last few decades that other ideologies such as consumerism and mutuality have emerged. Media and the World Wide Web have played a fundamental role in increasing patients’ awareness of treatment options available to them.

There were times during Mary’s radiotherapy course when Kevin got very frustrated at the hospital doctors. He believed they kept putting him off “...*and evading the questions. I needed some straight answers*”. Its effect was a drastic adjustment in the type of consultation because Kevin exchanged his tolerant behaviour which essentially resulted in paternalistic consultations, to one that was driven by Kevin, analogous to that of the consumerist model (see **appendix 6**).¹²

¹⁵ <http://lifeandhealth.guardian.co.uk/experts/drsimonatkins/story/0,16979,1683413,00.html>

When there was a clash between Kevin's own beliefs of always trusting the doctor's professional advice and seeing the treatment as too burdensome to continue the consultation pattern changed, akin to that of the mutuality concept.¹³

*"I could see the doctor's point of view, but surely he could see, as any other lay person could see that she needed a temporary stop to this. So we **made a pact** with Dr L, and the pact was to have a 3 month gap and after that see if chemotherapy was the way forward in future."*

The End

Kevin's worst experience with the health services came at a time when he required the greatest support; during Mary's terminal care. At the time the Macmillan nurse and both the daughter's were home caring for her, Mary's condition was deteriorating at a phenomenal rate. Kevin was in two minds about calling the GP because at the time he felt he did not want to cause any unnecessary commotion, especially as she was going on a holiday that weekend. The family had tried their utmost to get a bed at **[hospice]** but to no avail. They found out too late that there was a system of emergency beds; the last one had gone on that same day.

Eventually they called the district nurse, who could only do so much and tried to contact the out-of-hours services. Here, the system failed drastically because no matter how hard they tried, the family could not get through to a doctor on the phone; the district nurse had been given the wrong number. They were put on hold on many occasions and after waiting for a long time would get through to yet another nurse trying to get their details; name of patient, date of birth etc. This was understandably a very harrowing experience for the family. The district nurse ultimately ended up physically going to the hospital just to get hold of a doctor. Its bureaucratic disposition undermined the whole idea of what the out-of-hours care services should have been all about.

Fortunately, in the end the doctor did visit and the Macmillan nurse managed to arrange a bed at the **[hospice]** for the following day. However the ambulance service let the family down again by arriving four hours late. When they did arrive, they asked Kevin to take full responsibility should anything happen to Mary during her transport to the hospice. Kevin expressed that this was one of the most difficult decisions he had ever had to make. The backing he received from his daughters helped Kevin to remain steadfast at this time of high emotion and he signed the form with a heavy heart. Mary made it to the hospice and died later that day.

How has Kevin coped with the Bereavement?

Kevin described it as “...*an ongoing process*”.

Much of the literature that attempts to explain coping behaviour with regards to bereavement supports this idea. Stroebe (1992)¹⁶ refers to it as the ‘grief work hypothesis’, which implies that the experience of bereavement has to be confronted in order to come to terms with the loss and avoid any serious health consequences.

Parkes’ (1970)¹⁷ four-phase model of bereavement describes it as a sequential progression via the following phases:

Phase	Description
1	Phase of numbing
2	Phase of yearning and searching
3	Phase of disorganisation and despair
4	Phase of reorganisation

This model starts off very well in describing Kevin’s experiences. The first ‘phase of numbing’ conforms to Kevin’s psychological distress, when Mary died, and his feelings of dejection in the weeks that followed the funeral. He described his mental state as very confused. He couldn’t concentrate whilst watching TV and frequently locked himself out of his house because he would forget his keys indoors. The second phase of yearning and searching for his wife presented when Kevin would look at the photographs of their holidays together “...*yes, those were the happy times we had together*”. The model then goes awry because Kevin did not progress on to phase 3 and then phase 4 as the model suggests. He seems to be fluctuating between the third and fourth phase.

¹⁶ Stroebe M. Coping with Bereavement: A review of the grief work hypothesis. *Omega*. 1992; 26: 19-42

¹⁷ Parkes CM. The first year of Bereavement: A longitudinal study of the reaction of London widows to death of husbands. *Psychiatry* 1970; 33: 444-467

Bowlby (1980)¹⁸ furthers the model by recognising the difficulty to distinguish between the different stages, but maintains that the stages must be passed through for the mourning process to resolve.

I tend to agree with Worden (1991) in criticizing the stage model as being too simplistic, and exact. My concern would be for Kevin, who deviates from the stage model and thus risks being labelled dysfunctional or unwell. The stage model's portrayal of itself as a passive body that all bereaved must pass through is its downfall. Worden (1991) picks up on this weakness and proposes his 'four tasks of mourning' to explain Kevin's grieving process.¹⁹ (see table 1)

Table 1: Worden's Four Tasks of Mourning¹⁹

Task I	To accept the reality of the loss
Task II	To work through to the pain of grief
Task III	To adjust to the environment in which the deceased is missing
Task IV	To emotionally relocate the deceased and move on with life

Kevin's accomplishment of Task I is reflected when he underwent a phase of yearning and searching as previously discussed. Task II is well underway as Kevin describes the "*periods of depression*" as becoming shorter as time goes by. When Mary was ill, Kevin did most of the cooking and taking care of financial affairs. This helped immensely in his adjustment to an environment without Mary, hence completing task III with minimal adverse effects. Currently, Kevin is at task IV and is trying to get on with his life.

"...the frame of mind I am in now is that why be negative? You don't get anything out of it."

¹⁸ Bowlby J. Attachment and Loss: Loss, Sadness and Depression (Vol III). New York: Basic Books, 1980. Pp. 85.

¹⁹ Worden JW. Grief Counselling and Grief Therapy: A handbook for the mental health practitioner. New York: Springer, 1991. Pp. 10.

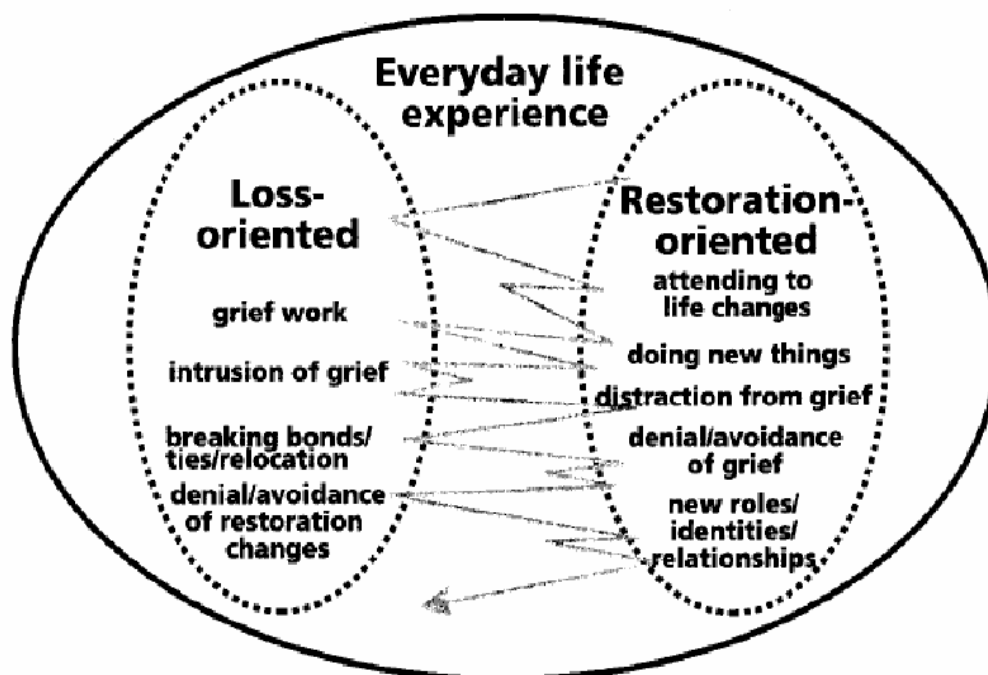
Kevin is actively seeking voluntary work. He is keen to help out as a driver for the hospice that cared for Mary as well as helping out with recording audio news articles for the blind community. He is grateful for the comfort these audio newspapers gave to Mary when she wasn't able to read.

“I can have times when I'm quite happy and relaxed, that can be 3pm in afternoon...and then 3.30pm I'm in the doldrums...it can happen as quickly as that. It's like the ocean coming in, and then the tide going out.”

Going back to where the stage model failed, the rationale behind this oscillatory pattern between two psychological orientations is explained by Stroebe and Schut.²⁰ They propose that the coping mechanism of bereavement does not occupy the individual's time completely. Indeed coping is embedded in everyday life experiences, which involves taking time off from grieving to engross in other activities, hence shifting from a loss-orientated state to a restoration-orientated one (see **figure 2**). This correlates with Kevin going out with his friends every week, watching his favourite sports on TV and looking forward to Laura's regular visits, when they would enjoy sharing a meal together. The reversal in shift towards loss-orientation is apparent when Kevin has flashbacks of his time with Mary whilst going about his daily tasks:

‘...when you see people of advancing age still with a partner shopping or having a chat...that hits you.’

²⁰ Stroebe M and Schut H. The Dual Process Model of Coping with Bereavement: Rationale and Description. *Death Studies* 1999; 23: 197-224

Figure 2: Dual Process Model of Coping with Bereavement²⁰

When asked, Kevin expressed that he tried to join in conversations whenever he went out with his friends. He was afraid that if he isolated himself, his friends would get the wrong impression that he wanted to be left alone. Kevin's sanguine personality, which is moulded by his strong spiritual beliefs, and the level of support from friends and family have prevented him from enmeshing into Bowlby's third phase of bereavement completely, that of total despair.

"You can't influence the situation, its there and it will happen and nobody's going to alter it. All this suffering and distress will come to an end, and that's another chapter of life gone. This opinion was greatly supported by people from the church, and that was a source of great comfort from my point of view."

As a result Kevin hasn't had any real problems coping with his loss, being far removed from any signs of pathological bereavement (see appendix 8). There is conclusive evidence that people like Kevin with strong spiritual beliefs tend to cope better with the bereavement process than those who profess no religious beliefs.²¹

²¹ Walsh K, King M, Jones L, Tookman A, Blizard R. Spiritual beliefs may affect outcome of bereavement: prospective study. *BMJ* 2002;324: 1551-6

Conclusion

Kevin recounted how lucky he has been in having very caring people around him. According to him they seemed to have gone overboard with the level of support they have shown. Then Kevin said something that surprised me, and will probably stay with me for the rest of my life.

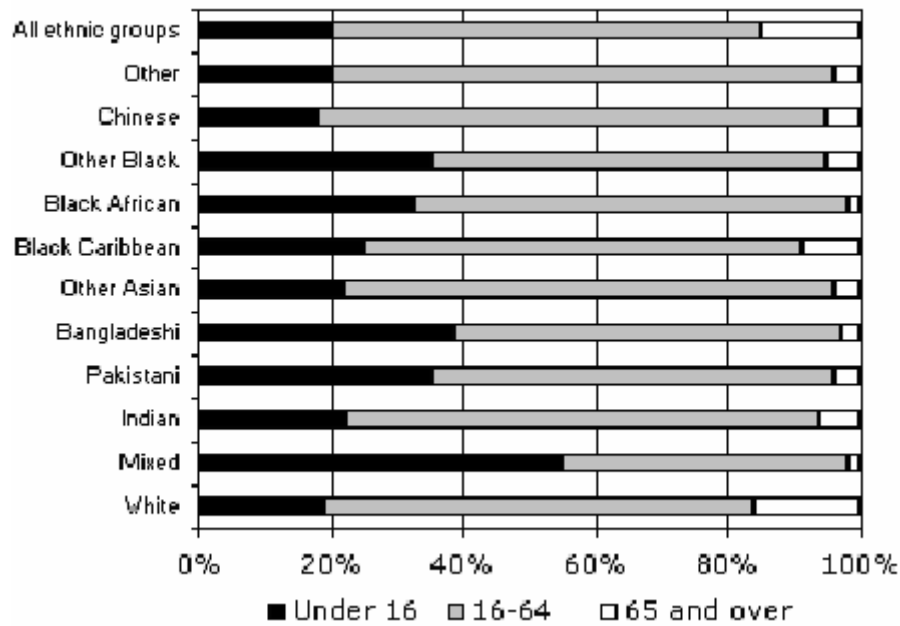
“...I like an afternoon like this... it is very pleasant just to tell someone about it without them overdoing it”

I had no idea that simply listening to him recounting his past experiences would have any benefit for him. As far as I was concerned, Kevin was kindly sparing some of his free time to allow me the benefit of gaining an insight into what he went through following Mary's death. The fact that our meetings proved to be therapeutic for Kevin made the whole experience all the more worthwhile. As a result, I am obliged to conclude that effective listening is the most potent tool any medical practitioner can have, especially when it comes to delivering the best quality of care.

Appendix 1

Age Distribution of Ethnic Groups

United Kingdom



Age distribution of UK population by ethnic group, 2001 - 2002

Minority ethnic groups have a younger age structure than the White population, reflecting past immigration and fertility patterns.

In contrast, the White group had the highest proportion of people aged 65 and over at 16%. 9% of Black Caribbeans were aged 65 or over, reflecting the first large-scale migration to Britain back in the 1950s.

Source: Annual Local Area Labour Force Survey 2001/02, Office for National Statistics.

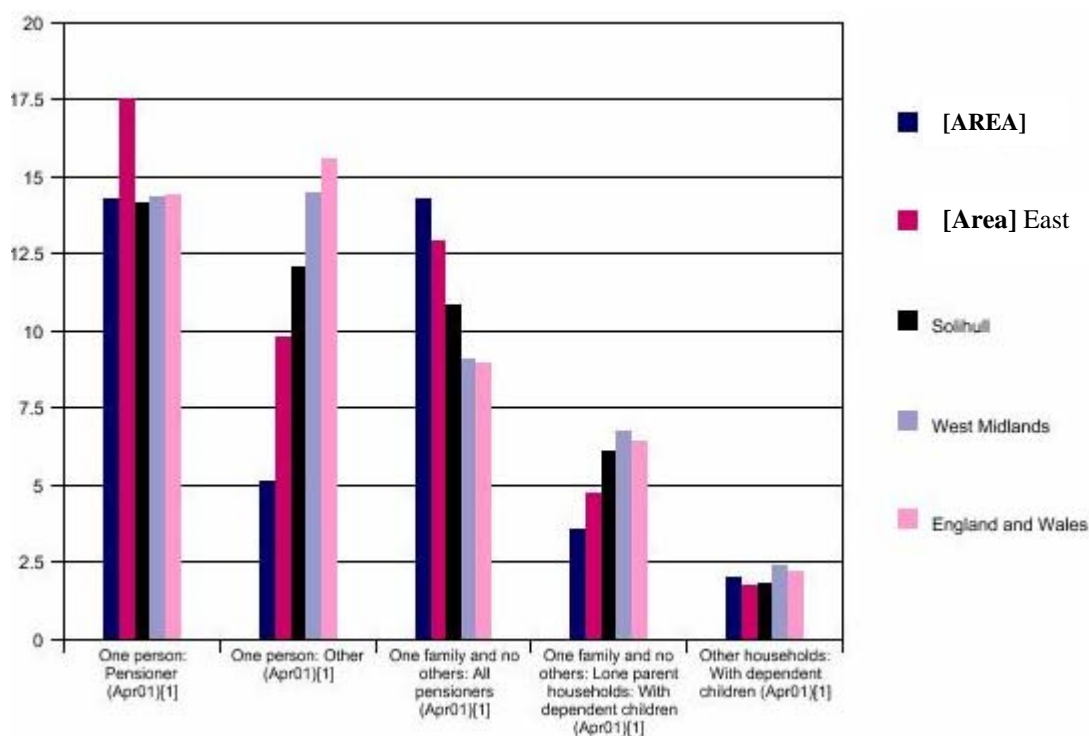
Available at:

<http://www.statistics.gov.uk/cci/nugget.asp?id=272> – accessed 14/03/06

Appendix 2

In Lower Layer Super Output Area Solihull [AREA] there were 587 households in April 2001. 100% of the resident population lived in households and 0% lived in communal establishments. [A communal establishment is one providing managed residential accommodation, for example in supervised hostels, hotels, large hospitals and prisons]. The average size of households in the LSOA area of Solihull [AREA] was 2.7 people compared with an average of 2.4 people for England and Wales.

Type of Household: percentage of each type, April 2001



* Solihull [AREA] refers to Kevin's Locality.

In the Index of Multiple Deprivation 2004, it was ranked at 25,626 out of 32,482 LSOAs in England, where 1 was the most deprived LSOA and 32,482 the least deprived.

Source: Office for National Statistics, Census Data 2001

Available at: <http://www.neighbourhood.statistics.gov.uk/dissemination/AreaProfile1.do?tab=7> - accessed 14/03/2006

Appendix 3

People in Households: by Type of Household and Family in which they Live 1961-2000

	1961	1971	1981	1991	2000 ²
One family households:					
Living alone	4	6	8	11	12
Couple					
No children	18	19	20	23	25
Dependent children ³	52	52	47	41	39
Non-dependent children only	12	10	10	11	9
Lone parent	3	4	6	10	10
Other households	12	9	9	4	6
All people in private households (=100%) (millions)	..	53.4	53.9	55.4	57.0
People not in private households (millions)	..	0.9	0.8	0.8	..
Total population (millions)	51.4	54.4	54.8	56.2	..

* Values should be read as percentages unless otherwise stated.

The table shows that almost three-quarters of people living in private households were in a couple family household. The nuclear family household was the most common type of family in which people lived in Spring 2000. However, during the last four decades of the 20th century, the proportion living in such households fell by a quarter and the proportion of people living in couple family households with no children increased from less than a fifth to a quarter. One in ten people in Great Britain in Spring 2000 and one in seven people in Northern Ireland in 1998-99 lived in a lone parent household.

Source: Census, Labour Force Survey, Office for National Statistics

Available at:

<http://www.statistics.gov.uk/StatBase/ssdataset.asp?vlnk=3419&Pos=4&ColRank=2&Rank=272> -
accessed 14/03/2006

Appendix 4

NS-SEC classes and collapses

***National Statistics Socio-economic Classification** - new classification, with a defined conceptual basis, that has been developed to replace SC and SEG.

***SC** - Social Class based on occupation, formerly Registrar General's Social Class

***SEG** - Socio-economic Group

Eight, five and three-class versions

The number of classes used depends both upon the analytic purposes at hand and the quality of available data. Within the conceptual model, it is possible to have eight, five and three class versions of NS-SEC. The nested relationship between the 8, 5 and 3-class versions is given below.

8 classes	5 classes	*3 classes
1 Higher managerial and professional occupations	1 Managerial and professional occupations	1 Managerial and professional occupations
1.1 Large employers and higher managerial occupations		
1.2 Higher professional occupations		
2 Lower managerial and professional occupations		
3 Intermediate occupations	2 Intermediate occupations	2 Intermediate occupations
4 Small employers and own account workers	3 Small employers and own account workers	
5 Lower supervisory and technical occupations	4 Lower supervisory and technical occupations	3 Routine and manual occupations
6 Semi-routine occupations	5 Semi-routine and routine occupations	
7 Routine occupations		
8 Never worked and long-term unemployed	+ ----- Never worked and long-term unemployed	+ ----- Never worked and long-term unemployed

* 3-classes names revised 5 October 2001

+ Presentation of 'Never worked and long-term unemployed' altered on the table above in the five and

three class versions. This corresponds more closely to the cautionary notes below.
Revised 14 January 2004.

Some cautionary notes about the five and three class versions

The three class version may be assumed to involve some kind of hierarchy. However, none of the other versions can be regarded as ordinal scales, not least because of the recognition of self-employment as a separate class. *It is not recommended* that users create an ordinal scale by combining the self-employed in Class 4 with the intermediate Class 3. This is because the self-employed are distinctive in their life chances and behaviour. It is strongly recommended that users accept the theoretical and measurement principles of the new classification, take advantage of the conceptual base of the model for developing hypotheses linking it to outcomes of interest, and use appropriate analytic techniques for nominal data.

Users should consider carefully whether to allocate the 'never worked' and 'long-term unemployed' to semi-routine/routine and manual occupations respectively or keep them separate. For example, users performing health analyses would need to be very careful about how the 'long-term unemployed' and the 'never worked' were defined since including the permanently sick would clearly not be sensible. They should be classified on the basis of last main job and the 'long-term unemployed' should include only those who are seeking or available for work. Of course, this may still leave some people who are permanently sick or disabled in the never worked category, hence this warning.

From:

http://www.statistics.gov.uk/methods_quality/ns_sec/class_collapse.asp - accessed 14/03/06

Appendix 5

Mechanic's Variables Known to Influence Illness Behaviour

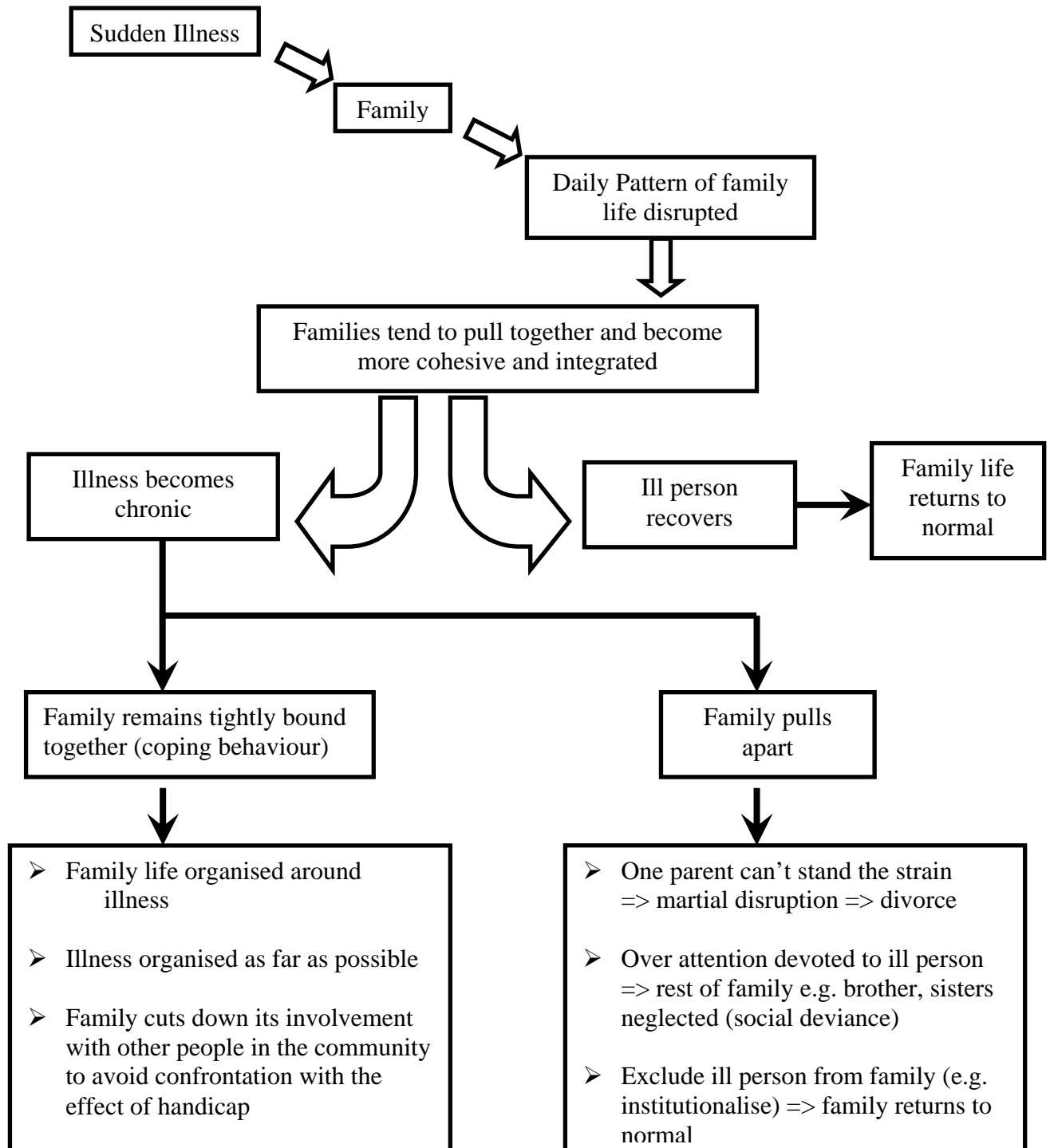
1. Visibility, recognizability or perceptual salience of signs and symptoms
2. The extent to which the symptoms are perceived as serious (that is, the person's estimate of the present and future probabilities of danger)
3. The extent to which symptoms disrupt family, work and other social activities
4. The frequency of the appearance of signs and symptoms, their persistence, or their frequency or recurrence
5. The tolerance threshold of those who are exposed to and evaluate the signs and symptoms
6. Available information, knowledge and cultural assumptions and understandings of the evaluator
7. Basic needs that lead to denial
8. Needs competing with illness responses
9. Competing possible interpretations that can be assigned to the symptoms once they are recognized
10. Availability of treatment resources, physical proximity, and psychological and monetary costs of taking action (not only physical distance and costs of time, money and effort, but also such costs as stigma, social distance and feelings of humiliation)

From:

Scambler G. (ed). *Sociology as Applied to Medicine* 5th Edition. London: WB Saunders Company Ltd, 2003. Pp. 41

Appendix 6

A Model of Illness Striking the Family



Source:

Litman TJ. The family as a basic unit. *Journal in Medical Healthcare: A social and behavioural overview*. Social science and medicine 1974; 8: 495-519

Appendix 7

Types of Doctor-Patient Relationships

Patient Control	Doctor Control	
	Low	High
Low	Default	Paternalistic
High	Consumerist	Mutuality

Explanations

Default relationship: occurs when the patient continues to adopt a passive role even if the doctor reduces some of his or her control upon the consultation. This very often results in both parties lacking direction.

Paternalistic relationship: involves high physician control and low patient control. The doctor is dominant and acts as a 'parent' figure who decides what he or she or she to believe to be in the patients' best interests.

Consumerist relationship: is best described by a situation in whereby there is reversal of power in the relationship to the patient. The patient takes an active role whilst the doctor tends to conform to a passive one, acceding to the patient's request for a second opinion. This request may be a referral to an institute of secondary care or a sick note etc.

Mutualistic relationship: is characterized by the active involvement of the patients as more equal partners in the consultation and has been described as a meeting between experts. Both parties participate in the exchange of ideas and sharing of belief systems. The doctor brings their clinical knowledge and skills to the consultation and the patient brings their own expertise in terms of their explanation of their illness, experiences, social circumstances and attitudes.

Adapted From:

Scambler G. (ed). *Sociology as Applied to Medicine* 5th Edition. London: WB Saunders Company Ltd, 2003. Pp. 54

Appendix 8

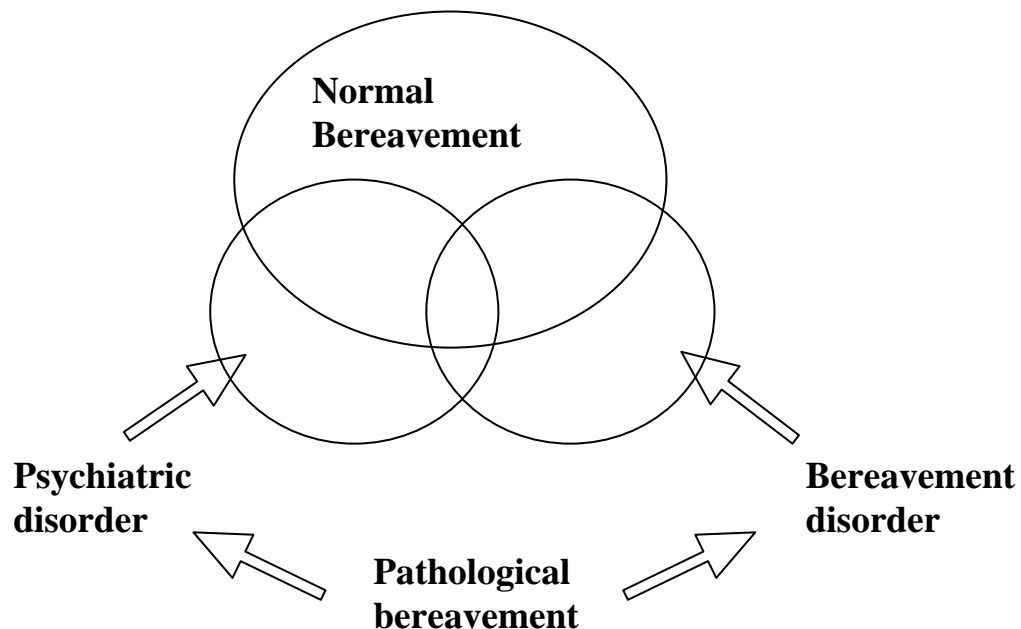
Notes on Pathological Bereavement

The boundary between the normal emotions of grief and those exaggerated responses that would constitute abnormality, has been the subject of considerable debate. For severe psychiatric disease, the notion of the abnormality is straight forward (e.g. suicidal activity, alcohol abuse etc.). However, for more minor affective disorders (e.g. depression, anxiety), it could be said that the symptoms represent normal bereavement.

Recently an attempt to reach some international consensus was made and the following three conditions seemed to have achieved some recognition as pathological bereavement reactions.

Absent	Individuals show no evidence of the emotions of grief developing, in spite of the reality of the death. This can appear as an involuntary reaction or the result of active blocking
Delayed	This initially presents in a similar way to absent grief. However, this avoidance is always a conscious effort and the full emotions of grief are eventually expressed after a particular trigger. This may be seen in more compulsive self reliant individuals.
Chronic	In this instance, the normal emotions of grief persist without any diminution over time. It is postulated that this is most often seen when relationships that were particularly dependant.

The complex interplay between abnormal and normal bereavement is illustrated in the intersecting Venn diagram below. The overlapping sections represent shared symptomatology, uncertainty of disease definition and mis-diagnosis. It is hoped that future research will make definitions that assist in our understanding and management of bereavement.



Source:

Year 2 MBChB Behavioural Sciences Lecture: Bereavement. by Dr Woof

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