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Comments

SICK ROLE, ILLNESS BEHAVIOUR AND COPING

Lack of agreed and precise definitions causes great difficulties for psychiatry. We examine here three borrowings from sociology and psychology, which have become popular despite a lack of informed consideration of their value. If they are to have more than an illusion of meaning we need to consider their proper usage.

Sick role

The concept of 'sick role' was introduced by the American sociologist, Talcott Parsons, in his most important work, *The Social System* (1951), a wide ranging theoretical analysis of roles and norms within western industrial society. This book has been a major, if controversial, influence in the development of modern sociological theory, but has had little application to empirical social research. Parsons examined two aspects of the sick role. First, he used it as an example of the general characteristics of the relationships between professionals and clients, the description of the sick role being complemented by discussion of the doctor's role. Secondly, Parsons attempted to provide a social definition of illness, a definition which he contrasted with other deviant behaviour and particularly with crime.

The sick role is a *theoretical* concept of an *ideal* role and it therefore does not allow us to explain the wide variations in individual behaviour related to the illness. The four main expectations of the patient role are well known and are (in his own words (Parsons, 1951)):

exemption from normal social role responsibilities;

secondly, a "closely related aspect is the institutionalized definition that the sick person cannot be expected by 'pulling himself together' to get well by act of decision or will";

thirdly, "the state of being ill as itself being undesirable, with its obligations to 'want to get well',"

and finally, "the obligation—in proportion to the severity of the condition, of course—to seek technically competent help, namely, in the most usual case, that of a physician and to co-operate with him in the process of trying to get well".

These expectations severely limit the application of the term. They do not apply to trivial illnesses in which medical care is not sought, and cannot easily be extended to chronic illnesses in which recovery is unlikely. It is also uncertain whether the sick role can be used for those neurotic conditions in which the patient himself is seen as responsible for any handicaps and in which motivation to recover is doubtful.

Parson's normative approach to the social definition of illness (as compared with crime) is theoretically informative. Thus, in psychiatry, we are familiar both with patients who have inappropriately been placed by doctors or others in the sick role and also with patients who want the privileges of the sick role without accepting the obligations to want to get well and to use medical help., However, psychiatrists also use sick role incorrectly to describe individual variations in behaviour, thereby giving it a new meaning very similar to illness behaviour (see below). This usage is particularly unfortunate when applied to conditions which appear to fall outside Parsons' restricted view of illness (e.g. hysteria, hypochondriasis). I believe we should condemn the use of 'sick role' and should restrict ourselves to its original theoretical meaning (See Twaddle, 1972 for a review).

Illness behaviour

The description of the sick role stimulated interest in the sociology of illness and of medical care. In contrast to Parsons' narrowly theoretical analysis, David Mechanic has been particularly concerned with the understanding of individual reactions and with empirical research (see Mechanic, 1978).

He introduced the term illness behaviour to refer to all the psychological and social reaction to physical and mental symptoms. Mechanic has made no attempt to develop a theoretical model and instead lists a heterogeneous range of social variables which have been shown to affect illness behaviour (for example, visibility, recognisability of deviant signs and symptoms; the extent to which symptoms disrupt family, work and other social activities; availability of treatment (Mechanic, 1978)).

Mechanic's own definition of illness behaviour is that it is 'the ways in which given symptoms may be differentially perceived, evaluated and acted (or not acted upon by different kinds of persons . . . whether by reason of early experience of illness, differential training in response to symptoms, or whatever' (see

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Mechanic, 1978). This definition indicates an area of practical interest rather than providing a basis for sociological analysis (See Twaddle, 1972). As such it has been found a convenient portmanteau concept by psychiatrists who wish to emphasise the social context of psychological symptoms and disorders. For example, liaison psychiatrists find that 'unnecessary' social handicaps and difficulties in complying with medical treatment are often more prominent than psychiatric symptoms in patients referred by physicians and surgeons. Such patients are often described as showing variations in illness behaviour rather than fitting into any category of psychiatric disorder. Although it can be clinically helpful to avoid the restrictions of symptom-based psychiatric case definitions in this way (see Williams *et al,* 1980), we must accept that description of problems as abnormal illness behaviour does not imply greater understanding of the behaviour, nor does it provide us either with the theory of the methods for further analysis.

A description of abnormal illness behaviour is not in Mechanic's definition an evaluative judgement: it implies no more than a statistical variation from a norm. However, a series of papers by Pilowsky (e.g. 1969, 1978) propose a special medical usage to cover a number of overlapping *psychiatric disorders* which are common in the general hospital (Pilowsky, 1969). He defines abnormal illness behaviour as 'the persistence of an inappropriate or maladaptive mode of perceiving, evaluating and acting in relation to one's own state of health, despite the fact that a doctor (or other appropriate social agent) has offered a reasonably lucid explanation of the nature of the illness and the appropriate course of management to be followed'. This definition clearly excludes much other distressing and disabling illness behaviour which requires extra help by doctors and others.

Pilowsky originally described abnormal illness behaviour as a useful framework within which to consider conditions often labelled hypochondriacal, hysterical, malingering and so on, but has now (1978) elaborated a classification of somatic and psychological symptoms which are subdivided into three main subgroups (1) illness-affirming (2) illness-denying, (3) neuropsychiatric. This scheme brings together diverse behaviours which have little in common, a conclusion exemplified by Pilowky's own factor analysis of abnormal illness behaviour into seven independent factors. It is even wider and more heterogeneous than the traditional psychiatric term hypochondriasis. It remains to be demonstrated that the illness behaviour questionnaire has clinical value in the general hospital.

Coping

Psychiatrists often use the word coping in the same contexts as sick role and illness behaviour. It has been variously used to describe the processes by which people attempt to manage to adjust to stress and is usually restricted to *acute* responses and to *severe* stress. It is seen as having two main constituents, intrapsychic mechanisms; and behaviour (see Ray *et al,* 1982). There is no agreed definition but R. S. Lazarus has defined coping as 'the cognitive and behavioural efforts made to master, tolerate or reduce external and internal demands and conflicts among them' (see Cohen and Lazarus, 1979).

Coping needs to be distinguished from several other overlapping terms: adaptation, defences and mastery. The most general term and perhaps the most useful one is *adaptation* since this also includes the slower process of adjustment to chronic illness and to other continuing problems. It is also less burdened by contradictory theory than are other terms and deserves wider use (White, 1974).

The intrapsychic mechanisms of coping are similar to the *defences* described in psychodynamic theory as protecting the ego against conflict (Freud, 1950). Some writers have emphasised the negative features of defences which result in the distortion of reality and compared them with the adaptive processes that enable the person to funtion effectively. However, both defences and coping can be adaptive or maladaptive and it is difficult to make any sharp distinction between them. A further psychological term, *mastery,* is more narrowly applied to successful adaptation to an event.

Lazarus (see Cohen and Lazarus, 1979) has described two aspects to a comprehensive theory of psycholocal stress: *Appraisal,* the cognitive process of evaluating an event and the available options and *coping,* the intrapsychic (defensive) and behavioural efforts (coping strategies) to master or otherwise deal with the event. There is no agreed nomenclature for the components of coping, but it is usual to distinguish between coping processes in response to stress and *coping styles,* which are persistent personality traits.

Apart from the problems which arise from the contradictory definitions of coping, there are serious difficulties in the application of theory to practice. These include lack of reliable measures and unwarranted assumptions that a person's coping is consistent in different situations at different times (Cohen and Lazarus, 1979; Folkman and Lazarus, 1980). This means that although coping theory has commonsense and clinical value, its value in empirical research is uncertain. Thus, the commonly described coping strategies, such as denial tackling, avoidance, minimisation (Lipowski, 1970), are clinically useful in formulating the problems of patients referred from medical wards, but in research with acutely ill medical

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patients we have always been unsuccessful in defining and measuring coping behaviour. Research based on classifications of coping behaviours should be viewed with considerable scepticism.

These three terms, sick role, illness behaviour and coping, perhaps provide valuable alternative perspectives to a narrowly medical view of mental state and behaviour. Psychiatric diagnostic categories are sometimes inadequate to classify adjustment or adaptation to physical illness or to other stress, and the use of the vocabulary of other disciplines can be, but is not necessarily, more helpful. Psychiatrists use all three terms loosely and often inappropriately, and we cannot therefore assume that they have any real meaning unless authors indicate the ways in which they use the terms and the ways in which they have quantified them.

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