Explanatory models of illness

Basic framework
Applications for care of people with FGIDs

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Learning goals

• Basic framework of explanatory models
• Strategies to elicit patients’ explanatory models
• Applications to patients with chronic conditions and “medically unexplained symptoms”
• Hypothesis: learning patient’s view of the course of illness can improve care
How culture affects health care

Macro-scale influences

Broad understandings of illness, suffering and healing

Social roles and the bureaucratic and economic context of health care services

Micro-scale influences

Face-to-face interaction at front-lines

Successful and failed communication
Definition of explanatory model

“[T]he notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process”

Kleinman 1980: 105
Patient’s explanatory model

1. What caused my sickness?
2. Why did I become sick at this particular time?
3. How does this illness work inside my body?
4. What will happen to me? What will this illness do to me?
5. How should it be treated?
Physician’s explanatory model

1. Etiology
2. Time and mode of onset
3. Pathophysiology
4. Course (including symptom severity & trajectory: acute, chronic, impaired)
5. Recommended treatment.
Characteristics of patient’s explanatory model

- Specific to each episode of illness
- Calibrated to practical realities and pressing problems
- Focused on one’s own experience, frustrations, sources of knowledge, and resources at hand
<table>
<thead>
<tr>
<th>Expert’s model</th>
<th>Patient’s model</th>
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<tr>
<td>• Formal logic, explicit connections</td>
<td>• Informal logic, tacit connections</td>
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<tr>
<td>• Driven by therapeutic imperative</td>
<td>• Driven by immediate, practical needs</td>
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<td>• Applied in “routine” contexts</td>
<td>• Applied in “emergency” contexts</td>
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Expert’s model  
- Source: professional training and norms
- Justified by textbook knowledge and clinical experience

Patient’s model  
- Source: family, friends, community
- Justified by embodied experience and utility in mastering symptoms and disabilities
Eliciting patients’ explanatory models

- **Attitude**: non-judgmental interest in patients’ point of view
- **Technique**: 8 recommended patient interview questions
  1. What do you call your problem? What name does it have?
  2. What do you think has caused the problem?
  3. Why do you think it started when it did?
Eliciting patients’ explanatory models

• 4. What does your sickness do to you? How does it work?
• 5. How severe is it? Will it last a long or short time?
• 6. What do you fear most about your sickness?
• 7. What are the chief problems your sickness has caused for you?
• 8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment? (Kleinman 1980: 106)
Explanatory models: application to IBS and functional GI disorders

- There is no standard model for all such disorders
- Rationale for using explanatory models for patients with medically unexplained medical symptoms.

“Is There a Better Term than “Medically Unexplained Symptoms?””
Characteristics of explanatory models for chronic illness

- How do patients understand chronicity?
- Does their understanding stay the same, or vary over time?
- How can learning their explanatory model of course of illness improve patient care?
Phases in patients’ understanding of illness course

1. Interruption
2. Intrusion
3. Immersion

Charmaz 1997
1st phase: Interruption

- Expect a full recovery
- Do not relinquish pre-morbid sense of self

Implication for care-giving encounter:
Try to be a “good patient”
2\textsuperscript{nd} phase: Intrusion

• Learn to expect symptoms and how to manage them

• Forced to craft a different sense of self in the present, and to re-think the future
2nd phase: Intrusion

• Patient: I’d rather be making a lot of money and I’d like to have more energy. But I’ve reached a balance, and I’ve accepted the illness and I’m working around it.

• Researcher: What does “acceptance” mean to you?

• Patient: Accepting that I’m not what I used to be.
2nd prase: Intrusion

Reconciliation, but with nagging anxiety:
Can I keep illness in the background?
Will I control the illness,
or will it control me?

Implication for care: re-negotiation of expectations and opportunity for dialogue and alliances
3rd phase: Immersion

- Reconstruct one’s life around the illness
- Pull back from all other relationships

Implication for care: resistance and mutual frustration
Using explanatory models to improve clinical outcomes

• Elicit understandings of course

• Hypothesis about 2\textsuperscript{nd} phase: moment of danger \textbf{and} opportunity for care-giving
  * Stave off the immersion phase
  * Overlap of expert and patient’s explanatory models
  * 2\textsuperscript{nd} phase as “critical period” for the patient’s experience of chronic illness
Thank you

Please send comments to Paul Brodwin (brodwin@uwm.edu)
Works cited

