From the past to the future of Health Care Education and its Practices

Natascia Bobbo

Journal Director

In the last fifty years, the improvement of hygienic life conditions coupled with an easier access to antibiotics and vaccines for a wider section of the population led to an increase of life expectancy in all western industrialized countries. This phenomenon, along with the significant reduction of births, triggers important changes in the demographic structure of our societies: particularly, there has been a significant proportional increase in the number of older people (moreover, this figure is projected to continue its very sharp rise over the coming decades). The aging of our society is necessarily linked with the emergence and the diffusion of many chronic-degenerative conditions: diabetes, respiratory diseases, cardiovascular diseases, or neurodegenerative conditions, such as Alzheimer, Parkinson, SLA, etc. Moreover, a prevalent sedentary lifestyle combined with an unhealthy diet (too rich in fat and sugar) contributed to a significant proliferation of food disorders (obesity) and consequent cardiovascular diseases (strokes, heart attacks and disability outcomes).

On the other hand, in the last century many economic, social and cultural changes brought about the emergence of new social awkwardness and psychopathologies: firstly, the crisis of the Modern ideology and the transitions to Postmodernism (Reinhardt, 2004), characterized by a deep criticism addressed to any certainty of the past, and which led to a widespread symbolic poverty; secondly, the migratory phenomena (both international and intra-national) and the consequent weakening of social networks which made people feel more and more alone and deprived of all social support needed to cope with daily difficulties; thirdly, the economic crisis and extensive unemployment led to the increase of economic poverty (Giustini & Tolomelli, 2012). All these phenomena and the interaction between them caused the spread of social and psychological distress within the most underprivileged groups of society. This situation required further effort on the part of social and health workers having to cope with an assistance request, which became increasingly complex from day to day. Behavioral problems, criminality, abuses and violence against women and children; drugs, alcohol or gambling addictions; food disorders (anorexia and bulimia); depressions and other anxiety disorders are only some of the new health emergencies of our societies. Last, but not least, the aging of the population also affected many disabled people by depriving them of the care of their parents, who became too old to be able to give them the assistance they needed and consequently were forced to entrust them to dedicated structures.

According to a report published in 2003 by the World Health Organization (WHO) chronic diseases, non-communicable diseases, mental health disorders, HIV/AIDS and tuberculosis combined represented 54% of all illnesses worldwide in 2001 (WHO, 2002) and will exceed 65% of the total of diseases in 2020.

Considering the Italian context, the percentages of people who reported at least one chronic disease in 2017 were 39,1%; the percentages increase when considering elderly people (53% of

people aged between 55-59 years reported to suffer from at least one chronic condition; regarding people aged more than 75 years the percentage is 85,3%%) (ISTAT, 2017).

For a sick and chronic patient, the access to medical resources is just the first condition (sine qua non) for his wellbeing. However, national welfare is not always able to meet all requests. Italy has a relatively young Public Health System only since 1978, but the new enormous request coming from the aged, disabled or mentally ill population risks to overtax its ability to satisfy all the requests.

In the last half of the century, from 1960 to 2010, the majority of the financial and human resources invested in medical research has been focused on diagnosis seeking and the discovery of new therapies for numerous newly emerged pathologies (Alzheimer, Parkinson, SLA, etc.). Many additional studies were conducted to find new therapeutic cures for incurable pathologies, which are responsible for the patients' death (for example: cancer, HIV, HCV, etc.), or to improve the scientific technology and surgical know-how and expertise (neurosurgery, heart surgery, organ transplantation, etc.). Nevertheless, less attention was given to the chronic patient's psychological, social and educational needs.

Concerning chronic conditions (such as diabetes, HIV, kidney failure, consequences of stroke or heart attacks, etc.), receiving a diagnosis or living with a chronic illness could have numerous consequences for the person's identity and quality of life. First, there could be many changes in the family networks, due to refusal attitudes, abandonments, separations or divorces, dependence or aggressive behaviors, etc.). Secondly, some of the patient's vital needs, such as finding and keeping a job, could also be affected. Thirdly, even the patient's need or simple desire to spend her/his free time with friends or in some other activities (that could give her/him a self-efficacy feedback or a feeling of social participation) could suffer as well (Kleinman & Seeman, 2000; Charmaz, 2000; Bury,1982; Williams, 2000). In light of the above, the follow-up of a chronic patient could become a very complex question, with many different targets: it should imply not only a medical monitoring of physical condition, but also psycho-educational support on a very difficult human path. The chronic patient must pass from the denial of her/his new identity (an ill woman or man) to an equilibrium in which her/his chronicity becomes part of her/his existence (Radley, 1989; Frank, 2002; Bobbo, 2012).

Regarding mental illness, in Italy, the new approach to patients, proposed by Basaglia (see: Basaglia, 2013) and formally ratified by law no. 180 (May 13th, 1978), led to the disclosure of mental hospitals and the diffusion of another kind of assistance, no longer institutionalized but distributed in the urban and peripheral area. The new assistance was organized within daytime centers or stable residences (basing the decision on the patient's condition and need of assistance); moreover, in the last years, many instances of supported housing solutions have emerged in many Italian towns.

In public or private neuropsychiatric services, children and adolescents with mental diseases or disabilities are placed under the care of doctors and health professionals, specifically, educators, physiotherapists, speech therapists, psychomotor rehabilitation technicians, etc.

Adult or aged disabled people are cared for by health professionals, first in the hospital setting or in a local health service facility and, after diagnosis, in daytime centers or stable residences, placed in the urban or peripheral context. Often, the residence solution is chosen when the patients' family could no longer care for them.

Other structures, in our geographic areas, are dedicated to the care of those children and adolescents who appear not to have a family. Sometimes this is due to their parents' death or abandonment, in other cases, they have to be removed from the care of parents who are afflicted with mental health problems or addictions, or involved in criminal activities (abuse, theft, drug dealing, rape, violence, imprisonment, etc.). In these structures, many social educators try to offer to these fragile kids a new chance of normality every day (Milani, 2018). Nevertheless, often,

even these children or adolescents are afflicted with some psychological disorders or mental diseases, due to the abuses or any other kind of parents' negligence they suffered. Consequently, social educators must possess some specific knowledge and acquire suitable expertise to cope with health and mental problems or disabilities they have to deal with on a daily basis.

Within the social services, health services, residences, daytime centres, day-hospital or therapeutic units and mental health services, different health professionals (such as social and health care educators, nurses, doctors and psychologists) care for patients and fragile people, trying to go beyond the mere assistance by pursuing rehabilitative goals, in order to offer to these vulnerable men, woman, children or adolescents a chance of social participation, job reintegration or, simply, the possibility of feeling pride in what they are or may become. Nevertheless, all these professionals must fight every day against many problems and difficulties due to the shortage of economic and human resources above all. The endemic lack of resources allocable to welfare often becomes one of the causes of job dissatisfaction for social and health workers: firstly, it is the lack of a sufficient number of operators in service which makes the work harder for everyone; secondly, it influences work practices, forcing people to do a routine job (aimed at satisfying people's minimum needs) and impeding any opportunity to reflect on the practices or to implement knowledge through research paths (Ruch, 2002). Beyond the lack of economic and human resources, other kind of problems afflict daily the work of these operators, often derived from misunderstandings emerging between them. Sometimes, their distinct scientific perspective brings out these conflicts; in other cases, it is the different levels of influence over the decision-making power held by each of them, according to his/her professional profile, that causes contrasts and frustrations (Gross & Etzioni, 1985). Indeed, educators, physiotherapists, nurses and other health professionals must often struggle to find and achieve autonomy and a negotiation position with psychologists and doctors. Educators, more than other professionals, pay the price of having a shorter professional history and an insufficiently strong scientific knowledge and procedural skills background.

Sometimes, injustice phenomena can emerge in these work places: a non-transparent distribution of resources, lack of fairness in the formal procedures (such as performance appraisals and layoff notifications) or in the interpersonal relationships (definition and enactment of organizational norms) which can impact an operator's ability to do their job to the fullest (Fujishiro & Heaney, 2009).

Many other elements threaten the social workers' job satisfaction every day: often they don't have a competent supervisor (Griffin et al., 2001) and have to work without suitable feedback coming neither from their employers or supervisors, nor from the social environment; in many contexts, health or social workers have no possibility to employ a high variety of skills, being asked to perform only certain standardized routines; for the same reason, they fail to enjoy any autonomy, having few opportunities to express their viewpoint or to decide what kind of approach they have to use with the patients; in the end, they risk losing that job significance which made them choose their job in the first place (Hackman & Lawler, 1971). More specifically, the vocational motivation of the social worker often arises from an idealized desire to save people from their destiny of vulnerability or pathology, but it seldom manages to include all the difficulties and obstacles characterizing these work environments. The gap between the job they would like to do and the job they have to deal with could be very wide and deep, making many of these operators feel discomfort and frustration, with outcomes of anger, depression or anxiety (Fujishiro & Heaney, 2009).

Social workers and health worker are constantly exposed to vicarious disorders, such as compassion fatigue, secondary traumatic stress disorder, vicarious trauma or burnout, due to their emotional response to dealing with traumatized and suffering patients (Figley, 1995). These kinds of disorders can emerge from emotional exhaustion, interpersonal problems or emotional involvement. The consequences could negatively affect the social and health workers' health and functioning: the most common symptoms are hypersensitivity, isolation, often associated with the production of intrusive and anxious images or nightmares. Furthermore, other symptoms have

been documented such as irritation and restlessness, widespread and generalized anxiety, sleep disturbances, instability, mood changes, anger, depression and sadness, a sense of worthlessness, loss of objectivity, a sense of loneliness (Conrad, Kellar-Guenther, 2006; Kearney et al., 2009).

Chronicity, disability, mental illness, behavioural and various kind of social problems are all afflicting our society: some of these problems have an ancient origin, others are emerging in these years; nevertheless, workers and academics, politicians and health organization managers, we all request a new perspective to cope with these challenges, which must be able to orient both our thoughts and our actions. Chronic or mentally ill patients, disabled people, misfits, vulnerable children and adolescents need to be cared for as persons rather than as an illness, disease or simply a problem. They need a chance to reach a better quality of life throughout the optimization of their residual resources, acquiring, as far as possible, a participatory social life, accessing to the right of play as children, to the right of finding an employment adequate to their different abilities as adults, to the right of a good death as aged people. In synthesis, having their fundamental rights as persons recognized, be they children, adolescents, adults or elderly.

Nevertheless, in order to make this possible, it is first necessary to re-think the training paths dedicated to health and social worker and supervisors, employers and organization managers: it is necessary to provide the worker with a wealth of skills and knowledge suitable not only to be put into practice but also to enable them to reflect about the practices and about the self, as a worker and as a person (Dewey, 1933; Kolb & Kolb, 2005; Ruch, 2002); collaboration skills, self-care strategies and coping strategies are just few of the competences that will become indispensable in the near future (Dillenbourg, 1999; Lane & Rollnick, 2007; Lloyd et al., 2019). Besides, it is necessary to train supervisors in authentic leadership, characterized by insightful, self-aware and high ethical and moral standards, all necessary to let them engage in balanced decision-making and present their genuine selves to others (Avolio & Gardner 2005). In the same way, it is necessary to train employers and organization managers in transformative leadership, provided with a vision based on the solidarity mission of their services, not only on economic business tasks (Reinhart, 2004). Managers, supervisors and employers have to foster continuous job enrichment in the services, enabling the workers to express themselves and their competences as a chance for self-realization (Hackman & Odlman, 1980; Lu et al., 2019).

Every social change need time to be put into practice, but we think now is the time to start.

This journal emerges from this cultural, social and scientific background and its main aim is to give a name to the new perspective we need: this name, according to us, is just education. We firmly believe that education can become the keystone to better care for the fragility that afflicts many vulnerable individuals and our society as a whole: education, which must be understood as a chance of participation in a more equitable and inclusive world (Freire, 1980-1996). Moreover, education can also become the keystone to re-thinking worker training too, because it is time not to instruct people to do a job but to make people able to express themselves through their work (Gini, 1998).

Education, which must be understood as the will to trust the ability of others to express a new, different, personal care of themselves; as an ethical duty to give back to a fragile person the power to choose who she/he is and who she/he wants to be and become. Education as caring for a person who needs to be respected and empowered as human being, to let her/him attain a chance of resilience (Mayo, 2007; Freire, 1980-1996; Cyrulnik & Duval, 2006).

This journal would like to make educational practices and competences a discussion topic in the academic field and in the communities of health and social services, by sharing the process of ideation, implementation and empirical testing of good practices in the caring for fragile people and in the training of the health and social worker. HCEP needs to work together with all

professionals (doctors, nurses, health and social educators, psychologists, etc.) for a gradual expansion of the theoretical knowledge of health education, therapeutic education and rehabilitation practices.

This first edition presents four scientific articles and four educational experiences, all exploring different contexts of educational practices. The authors are all health professionals, educators and nurses, who would like to share their studies and experiences with other professionals and students with the aim to develop a new way of understanding this complex, difficult and every day changing work of care.

The scientific articles presented in this issue explore four different contexts of care and training: the first article describes a scientific empirical path realized with the aim to support, by means of educational strategies, the fragility of some adolescents with a liver transplant transiting from a pediatric to adult health services; the second presents an observational study oriented towards understanding mental health operators' and service users' perception about ward atmosphere, within some supported residential facilities (CTRP); the third is a review study that explores, by the means of an international and interdisciplinary bibliography revision, the vulnerability of young men afflicted by AIDS, trying to reach a balance between their body perception and image and their consciousness. The last article presents a quantitative observational study that tries to provide a glance at the training needs of the students who are preparing to become health educators throughout their internship experiences.

The experiences described in the second part of the journal regard four contexts of educational actions. The first describes the accompanying of a young disabled woman during her admission into a community; the second experience explores the obstetrician and gynaecological setting in hospital, trying to envision a role for health educators in these kind of contests; the third describes the strategies employed in evaluating the change stages of young people afflicted by addictions and treated with the proximity method; the last presents the educational path dedicated to a vulnerable child within the PIPPI project and its procedures aimed at reducing the institutionalization of children from vulnerable families.

Finally, this edition closes with five abstracts of degree theses of health educators, focused on the same objectives as our journal.

We choose to give space to young authors, without specific experience in publishing, because we would like to facilitate the understanding of the actual state of educational practices and problems in the real context of actions and in the environments genuinely defined by vulnerability.

Education could be the keystone of a new perspective on care, and the keystone to re-thinking the training of the health and social worker as well, but we need to investigate the real education, not only what theorists think. For this reason, we must give voice to professionals and young operators, those who have the chance of making a different future for the fragile people.

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