NATIONAL OPEN UNIVERSITY OF NIGERIA

FACULTY OF HEALTH SCIENCES

COURSE CODE: NSC 301

COURSE TITLE: HUMAN BEHAVIOUR IN HEALTH AND ILLNESS

Course Code	NSC301
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ISBN 978-978-058-040-7

Printed: 2020

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MODULE 1 DEFINING CONCEPTS: HUMAN BEHAVIOUR AND MODELS

Unit 1 Behaviour: Basic Concepts
Unit 2 Conceptualizing Health and Disease
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UNIT 1 BEHAVIOUR: BASIC CONCEPTS

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1.0 INTRODUCTION

Welcome to NSC 301 (Human Behaviour in Health and Illness). For a better appreciation of this course, we shall start from the most basic term , 'human behaviour '. Some may argue why bother defining behaviour since it appears very obvious and simple. However, this assumption may be wrong, especially in trying to assess the underlying factors influencing behaviour . This unit therefore hopes to systematically analyze the term 'behaviour ' and specifically , 'human behaviour'

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Define 'behaviour' in a more general term
- Discuss principles of behaviour
- Define human behaviour

- Identify features of human behaviour
- Identify distinctions between human and animal behaviour

3.0 MAIN CONTENT

3.1 Defining Behaviour

- The term behaviour generally refers to the actions or reactions of a person or animal or plant in response to external or internal stimuli.
- Behaviour is also viewed as an external change or activity exhibited by an organism.
- It is also a manner in which something functions or operates.
- Behaviour can also be viewed as the way a person, animal, a plant or chemical behaves or functions in a particular situation. (Wikipedia - The Free Encyclopedia, 2007)

The above definitions are pointers that plants as well as animals (including humans), display behaviour patterns which can also be observed and measured.

3.2 Principles of Behaviour

The following are therefore basic principles guiding behaviour.

3.2.1 Stimulus and Response

A stimulus is any phenomenon that directly influences the activity or growth of a living organism. *Phenomenon*, meaning any observable fact or event, is a broad term and appropriately so, since stimuli can be of so many varieties. Chemicals, heat, light, pressure, and gravity can all serve as stimuli, as indeed can any environmental change. In some cases an internal environment can act as a stimulus. A good example is when an animal reaches the age of courtship and mating and responds automatically to changes in its body.

All creatures, even humans, are capable of automatic responses to stimuli. When a person inhales dust, pepper, or something to which he or she is allergic, a sneeze follows. The person may suppress the sneeze (which is not a good practice, since it puts a strain on blood vessels in the head), but this does not stop the body from responding automatically to the irritating stimulus by initiating a sneeze. (Nebraska Behavioural Biology Group, 2007).

3.2.2 Innate and Learned Behaviour

In general, behaviour can be categorized as either innate (inborn) or learned, but the distinction is frequently unclear. In many cases it is safe to say that behaviour present at birth is innate, but this does not mean that behaviour that manifests later in life is learned.

Behaviour is considered innate when it is present and complete without any experience. At the age of about four weeks, human babies, even blind ones, smile spontaneously at a pleasing stimulus. Like all innate behaviour, babies' smiling is stereotyped, or always the same, and therefore quite predictable. Lower animals that lack a well-developed nervous system rely on innate behaviour. Higher animals, on the other hand, use both innate and learned behaviour. A fish is born knowing how to swim, whereas a human or a giraffe must learn how to walk (Black, 1996).

3.2.3 Reflex Behaviour

An excellent example of an innate animal behaviour, and one in which humans also take part, is the reflex. A reflex is a simple, inborn, automatic response to a stimulus by a part of an organism's body. The simplest model of reflex action involves a receptor and sensory neuron and an effector organ. Such a mechanism is at work, for instance, when certain varieties of coelenterate (a phylum that includes jellyfish) withdraw their tentacles.

More complex reflexes require processing inter-neurons between the sensory and motor neurons as well as specialized receptors. These neurons send signals across the body, or to various parts of the body, as, for example, when food in the mouth stimulates the salivary glands to produce saliva or when a hand is pulled away rapidly from a hot object.

Reflexes help animals respond quickly to a stimulus, thus protecting them from harm. By contrast, learned behaviour results from experience and enables animals to adjust to new situations. If an animal exhibits a behaviour at birth, it is a near certainty that it is innate and not learned. Sometimes later in life, however, a behaviour may appear to be learned when, in fact, it is a form of innate behaviour that has undergone improvement as the organism matures.

For example, chickens become more adept at pecking as they get older, but this does not mean that pecking is a learned behaviour; on the contrary, it is innate. The improvement in pecking aim is not the result of learning and correction of errors but rather is due to a natural

maturing of muscles and eyes and the coordination between them (Nebraska Behavioural Biology Group, 2007)

SELF ASSESSMENT EXERCISE

i. Define Behaviour
ii. Identify the principles of Behaviour

Answer to Exercise

i. The term behaviour generally refers to the actions or reactions of a person or animal or plant in response to external or internal stimuli. Behaviour is also viewed as an external change or activity exhibited by an organism. Behaviour can also be viewed as the way a person, animal, a plant or chemical behaves or functions in a particular situation.

ii. Principles of behaviour are:

1. Stimulus and Response:
2. Innate and Learned Behaviour
3. Reflex Behaviour

I hope you enjoyed this exercise. Please always remember that these guiding principles aid a better understanding of the concept of behaviour. Thus, if you understand them now, you will have little problem conceptualizing human behaviour and more specifically, health and illness behaviour. Now let us turn to the concept of human behaviour.

3.3 Defining Human Behaviour

Now, let us attempt to provide more specific definition of behaviour, i.e., human behaviour. Remember, this course is about human behaviour in health and illness. However, the dimensions of behaviour provided earlier are also very useful for a proper grasp of the term human behaviour.

- Human Behaviour could therefore be broadly defined as manner of acting or controlling oneself
- It could be viewed as an observable demonstration of capability, skill, or characteristics.
- Human behaviour could also be viewed as an especially definitive expression of capability, in that it is a set of actions that presumably, can be observed, taught, learned and measured (Wikipedia- The free Encyclopedia, 2007).

These definitions therefore portray human behaviour as observable demonstration of skills and characteristics as well as definitive expression of such characteristics. This then indicates that human behaviour is not mechanistic but rather definitive, controlled and flexible. What then are the features of human behaviour.

3.4 Features of Human Behaviour

Let us now briefly discuss the features of human behaviour. Human behaviour could therefore present the following features:

Verbal – this means that human behaviour requires a language to express feelings and emotions. Lower animal also use a form of language to express feelings and emotions but human language appears to be more conscious and definitive. Verbal expression also stimulates good doctor/patient relationship and helps in better diagnosis of illnesses.

Nonverbal – this means human behaviour which is independent of a formal language. This type of behaviour can sometimes be observed through body languages and facial gesture.

Conscious – this refers to a state of being aware of a stimulus or event. For example, a hungry or sick person is very likely to be aware of the state, which in turn triggers behaviours necessary for that particular stimulus. It is thus expected that an individual eats when hungry or visits the health professional when sick.

Unconscious – this is an opposite of consciousness. Here a person is unaware of a stimulus or event. Interestingly, certain body languages that people exhibit could be categorized here. For example, an anxious person may be unaware to the fact that he or she is exhibiting certain behaviours like: tapping the foot, biting the fingers, sweating, etc. Also, a complete state of unconsciousness is best described while sleeping, if not rudely woken by a loud sound.

Overt – this form of human behaviour is open, observable and possibly measured. Good examples are a; child crying when in need or a sick person engaging in certain health habits (eating healthy, exercising), to feel better.

Covert – here, behaviour is closed, hidden and not readily observable. Certain cultural practices could trigger this type of behavioural pattern. A very interesting example is the belief that men are generally not supposed to cry because they are the stronger sex. They are expected to be brave and bear grief ‘like men’, though they may cry in the safety of

their homes. Here, behaviour is covert because such emotions are not readily observed.

Voluntary – here, behaviour is performed willingly and controlled, and not forced. The adage that 'you can take a horse to the stream but you cannot force it to drink' also applies to human behaviour. For example, a student must be willing to learn, and when forced could lead to school drop-out or exam malpractices.

Involuntary – this refers to actions or behaviour, performed suddenly without an ability to be controlled. For example, a sudden sharp pain could trigger a corresponding uncontrollable response like jerking or screaming.

Normal – normal behaviour refers to typical, expected or ordinary activities that generally conform to a given norm and dictate of a society. For example, it is normal for a child to wet the bed or generally behave like a child but such behaviour could be frowned at when they are exhibited by an adult.

Abnormal – abnormal behaviour refers to those activities that are different from the usual or expected. Thus, they are seen to be a deviation from the norm.

4.0 CONCLUSION

Now, you all will agree with me that the concept 'Behaviour' is not as easy as it sounds. Perhaps, we have come to appreciate other technical aspects of behaviour and human behaviour, which appear simple and complex at the same time. I hope that the concepts introduced in this unit, such as stimulus and response, innate and learned behaviour etc. are not very difficult to assimilate. Try applying them to everyday activities and you will realize that they are much simpler than they appear.

5.0 SUMMARY

In this unit, you have learnt the definitions as well as the characteristics of behaviour. We also attempted specific conceptualization of human behaviour as well as its associated features. The information provided in this unit should therefore aid an in-depth understanding of the distinction between human and animal behaviours (Lower animals). We hope you enjoyed this unit. Now, let us attempt the questions below.

6.0 TUTOR MARKED ASSIGNMENT

1. Define human behaviour
2. Identify and Discus the features of human behaviour

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UNIT 2 CONCEPTUALIZING HEALTH AND DISEASE

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1.0 INTRODUCTION

Granted that we are all well, we are likely to assume we do not need to take any special actions to keep healthy. We are unlikely to think of ourselves as ill when we have minor discomfort caused by colds or headaches, or when we feel tired or depressed. However, we all, knowingly or unknowingly, have different concepts of health that guide our behaviours. This unit, therefore, seeks to review the WHO definition of health as well as different concepts of health and disease.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Summarize the WHO perspective of health.
- Distinguish between holistic, positive and negative concepts of health
- Define Disease
- Determine Syndrome and Disease
- Determine transmission of Disease
- Ascertain social significance of Disease

3.0 MAIN CONTENT

3.1 What Is Health

The Constitution of WHO, in conformity with the Charter of the United Nations declares that the following principles are basic to the happiness, harmonious relations and security of all people:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic and social isolation.

The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individual states.

The achievement of any State in the protection of health is of value to all.

Unequal development in different countries in promotion of health, control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all people of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.
Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

SELF ASSESSMENT EXERCISE 1

Give a summary of the WHO perspective of Health.

Answer to Exercise

Have you done that? Well done. Now, let us see if it tallies with the answer provided below

The Constitution of WHO, in conformity with the Charter of the United Nations declares that the following principles are basic to the happiness, harmonious relations and security of all people:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political, belief, economic and social isolation. Also, the health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individual states. The achievement of any State in the protection of health is of value to all. Unequal development in different countries in promotion of health, control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development. The extension to all people of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

Now let us take a look at the three components of health known as holistic, positive and negative concepts of health.

3.2 Components of Health

A researcher once asked a sample of participants, 'Is your health good, average or poor?' When a respondent gave the answer 'good', the researcher asked, 'When you say your health is good, what do you mean?' The answers could be extracted from these three dimensions of health. They are:

- A holistic dimension
- A positive dimension
- A negative dimension

You might also be wondering whether there is any advantage or disadvantage in holding one or other of these views. Below are explanations to the three perceptual dimensions of health as well as the advantages and disadvantages.

3.2.1 A Holistic Dimension Of Health

A Holistic Concept of health is the belief that being healthy means being without any physical disorders or diseases and being emotionally comfortable. For example, a person who feels anxious or who has low self-esteem would, according to this concept, may not be well. Likewise, a person with malaria or chickenpox is likely to label himself/herself ill. Generally, People with this view are likely to label themselves as ill when they experience a wide range of unpleasant feelings, not just physical discomfort or pain.

Advantage Of Holistic Dimension Of Health

- One advantage of having the holistic concept is that it tends to make people sensitive about their health. This can be an advantage because it can help them to notice symptoms more quickly than other people. They notice when something does not feel right and pay more attention to their bodies.
- It can spur people to eat healthy and live healthy.

Disadvantage Of Holistic Dimension Of Health

- It can lead to oversensitivity to signs and symptoms of illness. Thus, oversensitivity can lead people to believe that they are ill when they are not.
- It can lead to unnecessary worry and result in people wasting their Doctor's time.

3.2.2 A Positive Dimension Of Health

A **positive dimension** of health is the belief that being healthy is a state achieved only by continuous effort. People with this belief take active steps to maintain their health for example, through their choice of food, by taking exercise and other activities they believe will keep them well. Such people are likely to feel responsible for their own health. They will take credit for the continued absence of disease and blame themselves if they develop symptoms. According to this view, people who do not take action to maintain their own health (for example, by 'healthy eating') cannot be healthy — even if, at any one time, there is nothing wrong with them (Cockerham, 2003).

Advantages Of Positive Dimension Of Health

- One result of having a positive concept of health is that people tend to take plenty of exercise, avoid smoking and excessive

intake of alcohol, and eat a balanced diet. This is likely to be advantageous to them.

- Another advantage is that if such people become ill, they are likely to adopt attitudes and behaviour that contribute to getting better. There is some evidence that the chances of surviving cancer are influenced by the attitude of the patient. People who believe they can recover and avoid feeling defeated by their illness tend to do better than those who believe that they are doomed to die.
- People with positive dimensions to health tend to be active rather than passive in relation to their own health.

Disadvantage Of Positive Dimensions Of Health

- One disadvantage of this concept is that, by taking responsibility for their own health, people might blame themselves for their illnesses and feel guilty when they become ill.

3.2.3 A Negative Dimension Of Health

A **negative dimension** of health is the view that being healthy is the absence of illness — for example, not having any symptoms of disease, pain or distress. People with this view are likely to believe that good health is normal and to take it for granted.

Advantage Of Negative Dimension Of Health

- A person with this perspective may be less anxious about his/health.

Disadvantage Of Negative Dimension Of Health

- A person with negative health concept believes that being healthy is by chance, while those with positive concepts take active steps to stay well.
- He/she may think less of healthy habits as well as measures to live healthy.

- He/she may engage in self medication because good health is taken for granted.

SELF ASSESSMENT EXERCISE 2

Read the following replies from different people on the question ‘Are you healthy’? And decide which dimension of health best fits each answer.

Answer A: 'There's nothing wrong with me, as far as I know.'
Answer B: 'I look after myself, stay fit and that sort of thing.'
Answer C: 'I feel well balanced. My body and my mind are working well together.'

Now try to decide which concept of health is closest to the way you think about your health.

Answer to Exercise

A Negative dimension of health
B Positive dimension of health
C Holistic dimension

3.3 Defining Disease

When we think of physical infirmities that we have had, we most often think in terms of what is wrong with our bodies biologically; for instance, a virus producing disease such as chicken pox or the flu, or a failure of the body to produce needed substances such as insulin in diabetes, or an abnormal growth as in cancer. In other words, we usually think in terms of some type of disease.

Pathology is the study of diseases. The subject of systematic classification of diseases is referred to as *nosology*. The broader body of knowledge about human diseases and their treatments is *medicine*. Many similar (and a few of the same) conditions or processes can affect animals (wild or domestic). The study of diseases affecting animals is veterinary medicine.

Definition 1 A disease is a change away from a normal state of health to an abnormal state in which health is diminished

Definition 2 Disease is also a medical condition. It is an abnormality of the body or mind that causes discomfort, dysfunction, distress, or death to the person afflicted or those in contact with the person. Sometimes the term is used broadly to include injuries, disabilities, disorders, syndromes, infections, symptoms, deviant behaviours, and atypical variations of structure and function, while in other contexts these may be considered distinguishable categories.

Definition 3 Cole (1970), defined disease as specific kinds of biological reactions to some kind of injury or change affecting the internal environment of the body.

Disease thus alters the normal functioning of the body and creates a lot of anxiety for the sick person. It is also a universal phenomenon, constitutes a threat to survival and disrupts socio-economic life of people.

Definition 4 In biology, *disease* refers to any abnormal condition of an organism that impairs function.

The term *disease* is also, often used metaphorically for disordered, dysfunctional, or distressing conditions of other things, as in *disease of society*.

3.4 Syndromes and Disease

Medical usage sometimes distinguishes a *disease*, which has a known specific cause or causes (called its etiology), from a *syndrome*, which is a collection of signs or symptoms that occur together. However, many conditions have been identified, yet continue to be referred to as "syndromes". Furthermore, numerous conditions of unknown etiology are referred to as "diseases" in many contexts (Taylor, 2006).

3.5 Transmission of Disease

Some diseases, such as influenza, are contagious or infectious, and can be transmitted by any of a variety of mechanisms, including aerosols produced by coughs and sneezes, by bites of insects or other carriers of the disease, from contaminated water or food, etc.
Other diseases, such as cancer and heart disease are not considered to be due to infection, although micro-organisms may play a role, and cannot be spread from person to person.

3.6 Social Significance of Disease

The identification of a condition as a disease, rather than as simply a variation of human structure or function, can have significant social or economic implications. The controversial recognitions of diseases of post-traumatic stress disorder, also known as "Soldier's heart," "shell shock," and "combat fatigue"; repetitive motion injury or repetitive stress injury (RSI); and Gulf War syndrome has had a number of positive and negative effects on the financial and other responsibilities of governments, corporations and institutions towards individuals, as well as on the individuals themselves. The social implication of viewing aging as a disease could be profound, though this classification is not yet widespread (Taylor. 2006).

A condition may be considered to be a disease in some cultures or eras but not in others. Oppositional-defiant disorder, attention-deficit hyperactivity disorder, and, increasingly, obesity are conditions considered to be diseases in the United States and Canada today, but were not so-considered decades ago and are not so-considered in some other countries. Also, malaria, HIV/AIDS, childhood diseases like polio etc, seem to be top priority in the sub Saharan African countries. Lepers are also a group of afflicted individuals who were historically shunned and the term "leper" still evokes social stigma. Fear of disease can still be a widespread social phenomenon, though not all diseases evoke extreme social stigma.

4.0 CONCLUSION

When thinking about your own health, you might have realized that you use more than one of the three concepts of health, or perhaps you use all three. Do not be surprised by this. The fact that there are different perceptual dimensions of health does not mean that your attitude to health necessarily belongs to just one of them. You will probably find that you apply one concept in some situations and others on different occasions.

5.0 SUMMARY

We have been able to define health as well as identify different components of health. We have also learnt different definitions of disease, as well as syndromes, transmission and social significance of disease. I hope you find them quite interesting and insightful.

6.0 TUTOR MARKED ASSIGNMENT

1. Define Disease
2. Identify and briefly describe the 3 components of health. Identify the advantages and disadvantages of each component.

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UNIT 3 CONCEPTUALIZING ILLNESS

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1.0 INTRODUCTION

All of us have had experiences of getting sick and feelings of discomfort associated with it. It may be something as mild as cold, headache, fainting spell, or as serious and long lasting as chronic life-threatening disease such as cancer, diabetes, HIV/AIDS, etc. Illness is certainly a universal human experience, irrespective of age, gender, religious belief or socio-cultural differences. What then is illness?
This unit tries to introduce the definition and different dimensions of illness. First we will try to provide several definitions of illness.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Provide an in-dept definition of illness.
- Determine perspectives of illness
- Determine how concepts of illness overlap
- Determine how concepts of illness do not overlap
- Distinguish between disease and illness
- Illustrate components of illness dynamics

3.0 MAIN CONTENT

3.1 Definition of Illness

Illness has several definitions. Two of them are of the way the word was used up to the 18th century—to mean either "wickedness, depravity, immorality", or "unpleasantness, disagreeableness, hurtfulness". These older meanings reflect the fact that the word "ill" is a contracted form of "evil".

Another meaning, dating from the 19th century, is the modern one: "Illness; the state of being ill". The dictionary defines "ill" in this third sense as "a disease, a sickness". Looking up "sickness" we find "The condition of being sick or ill; illness, ill health"; and under "sick" (a Germanic word whose ultimate origin is unknown) we find "affected by illness, unwell, ailing ... not in a healthy state", and, of course, "having an inclination to vomit".

There is a rather unhelpful circularity about these dictionary definitions. But dictionaries of the English language usually only aim to tell us the origins of words and how they have been used historically. They do not aim at the much more contestable goal of conceptual clarity. For that we have to look elsewhere. In this case, let us look at how disease, illness and sickness have been elucidated first by a medical practitioner, who ought to know something about the subject; and then, after noting some popular and literary definitions, by a philosopher, who ought to know something about conceptual clarity.

It might be thought that so fundamental a concept in medical science, ‘illness’ would have been the subject of broad agreement and succinct definition, but this appears to be very far from the truth indeed (Szasz, 1987). Definitions of illness have changed regularly throughout the history of medicine in response to fashion and a variety of other factors. The present situation is in part complicated because many of these historical definitions co-exist with their more recent counterparts (Cockerham, 2003; Taylor, 2006).

For example, the definition of illness as a syndrome, or coherent cluster of symptoms is credited to the seventeenth-century physician Sydenham. His definition, which does not rely on the notion of pathogens or pathological process, is still current, being used alongside the more modern, but logically quite different definition of illness, as that of bacterial infection. There are, of course, still more recent definitions; all are useful and all more or less appropriate according to circumstances.

Definition 1: Bishop (1994) defined Illness as the experience of suffering and discomfort, which may or may not be related to objective physical pathology.

Definition 2: Barondness (1979); Jennings, (1986), defined illness as an experience of discomfort and suffering.

Advances in science and technology have greatly improved our ability to detect disease and, more than any other factor, have influenced the views of both lay people and professionals in their understanding of illness (Kendel, 1975). For this reason, definitions of illness, with the exception of mental illness which is sometimes defined ambiguously, are biased towards a structural or physiological view, making the assumption that the core of illness consists of organic dysfunction or 'disease'.

Definition 3: Illness is also defined as a state or condition of suffering as the result of a disease or sickness.

This definition is thus based on the modern scientific view that an illness is an abnormal biological affliction or mental disorder with a cause, a characteristic train of symptoms, and a method of treatment (Cockerham, 2003).

Definition 4: Illness is also the individual's perception and labeling of a set of physical and emotional experiences.

This definition, therefore, highlights the role of cognition on illness perception (Cockerham, 2003).

Definition 5: Illness, although often used to mean disease, can also refer to a person's *perception* of their health, regardless of whether they in fact have a disease (Weiss and Lonnquist, 2005)

As you will rightly agree the above perspectives to illness leave one in little doubt about the concept. Now let us try our hands on this simple exercise.

SELF ASSESSMENT EXERCISE 1

i. Define Illness
ii. Can the 18^{th} century conception of illness be applicable in contemporary time?

Answer To Exercise

i. Illness is defined as an experience of discomfort and suffering (Barondness, 1979; Jennings, 1986). Illness is also defined as a state or condition of suffering as the result of a disease or sickness (Cockerham, 2003). Illness, although often used to

mean disease, can also refer to person's *perception* of their health, regardless of whether they in fact have a disease (Weiss and Lonnquist, 2005).

ii. Illness has several conceptions. One of them is of the way the word was used up to the 18th century—to mean either "wickedness, depravity, immorality", or "unpleasantness, disagreeableness, hurtfulness". These older meanings reflect the fact that the word "ill" is a contracted form of "evil". Contemporary views of illness are that of scientific and medical approaches, but few observations indicate that illness could be perceived as a state of immorality and wickedness. These views are likely to have spiritual undertones to them.

3.2 Perspectives of Illness

Now let us introduce another aspect of illness experience that could further aid our understanding of the concept. We can call them perspectives of illness. They are:

- Illness as subjective sensation
- Illness as a set of symptoms or disease
- Illness as a disorder or a malfunction of a body tissue, organ or system

3.2.1 Illness as the Subjective Sensation

A subjective sensation of illness means feeling ill. People might feel ill when they have some disease symptoms; they might also feel ill when no symptoms are present. By this definition, illness exists when people decide that they feel ill or describe themselves as being ill. People who are very anxious about, or sensitive towards, their health are likely to think of themselves as ill even when symptoms are very mild or absent. Other people may also refuse to think of themselves as ill even when there are obvious signs that something is wrong (Taylor, 2006).

3.2.2 Illness As Observable Symptoms Of Disease

Disease refers to a diagnosable problem, which might be physiological (a physical disorder) or psychiatric (a mental disorder). This view of illness is objective, i.e. illness is something for which there is likely to be publicly available evidence — for example, two people with medical knowledge agreeing that a patient has a disease. Also, when people become ill they usually develop **symptoms**. A symptom is something that is noticeable to the affected person (e.g. itching or pain). It might be noticeable to other people too (e.g. a rash or a lump). Soon after developing symptoms, people begin to think of themselves as ill and

decide to take some action. This might be to buy some medication or to visit their doctor. The physician might then confirm that the person is ill and diagnose the disease. However, there are sometimes situations in which this pattern is not followed. For example, people might think of themselves as ill but a doctor or a hospital consultant might be unable to detect any disorder. Sometimes, people might have a disease but not notice any symptoms, or might notice symptoms but not think of themselves as ill. For example, a person might catch a cold, but ignore it and carry on as normal. It might surprise you that there are several different opinions about what is meant by being healthy and also a range of views about what is meant by being ill (Bishop, 1994).

3.2.3 Illness As A Disorder Or Malfunction

The term '**disorder**' refers to some malfunction of a body tissue, organ or system. This concept is based on the idea that body systems can go wrong. This definition is the one that the writer of a medical textbook is likely to have in mind (Cockerham, 2003).

3.3 How Concepts of Illness Overlap

Students can have difficulty in telling the difference between the three concepts of illness. This is partly because they sometimes overlap.

For example, 'illness as subjective sensation' can overlap with 'illness as having symptoms of disease'. This is because some of the symptoms of illness (e.g. pain and tiredness) are themselves subjective sensations. This overlap is most noticeable with mental disorders. Unlike physical illnesses, mental disorders often have no symptoms that are detectable through observation, blood tests, scans, and so on. For example, a person suffering from depression is likely to have no observable symptoms apart from complaining of overwhelming feelings of misery and helplessness. In this case, 'illness as a subjective sensation' is the same as 'illness as disease symptoms'.

In other situations it is easier to tell the difference. For example, a person with a skin rash (observable disease symptom) might not think of himself or herself as ill (subjective sensation), particularly if the rash is not accompanied by pain.

The concept of 'illness as disease symptoms' can also overlap with 'illness as a disorder or malfunction'. This is usually the case when the symptoms correspond very closely to the malfunction. For example, a person with a lung disorder such as pneumonia will experience difficulty in breathing.

3.4 When Concepts of Illness Do Not Overlap

However, in other situations these concepts of illness can be distinct. For example, a person could experience symptoms, such as sneezing and a runny nose that are not caused by malfunction of any body tissue, organ or system. Rather, those symptoms are the result of ineffective functioning of the immune system to overcome a cold virus. In this case, 'illness as disease symptoms' is distinct from 'illness as disorder or malfunction'. A contrasting example is that a person can have a serious malfunction of body tissue (such as a tumour growing on the spleen) but not feel ill. Some symptoms like tumours in some parts of the body, including the abdomen and brain, can grow for many months before they are noticed. This is because there are few sense organs in these parts of the body. Symptoms are unlikely to be felt until the tumour is pressing on surrounding tissue that has more sense organs. So the sufferer might remain healthy with no sign of illness until it gets critical.

Another situation in which 'illness as symptoms of disease' and 'illness as malfunction' do not overlap is when the symptoms could be the result of a range of malfunctions. For example, a person feels constantly tired and out of breath. A blood test reveals that the person is anaemic (has too few red blood cells). The symptoms of tiredness, shortness of breath and anaemia do not arise from any particular disorder or malfunction. The anaemia could be caused in several ways — for example, by a disorder of the bone marrow, by internal bleeding or by a dietary deficiency. Only by further tests and investigations could a specific disorder or malfunction be detected.

However, in most people who are seriously ill, these three aspects of illness occur together. People will think of themselves as ill, they will notice symptoms (e.g. partial paralysis) and they will have an organ malfunction (e.g. a stroke or bleed into the brain).

SELF ASSESSMENT EXERCISE 2

Have you enjoyed your readings? Now let us attempt this.

A researcher asked a sample of people the question, 'What does "illness" mean to you?' Read the following replies from different people and decide which concept of illness best fits each answer. The three concepts of illness you should use are:

- Illness as a subjective sensation of illness
- Illness as disease symptoms
- Illness as disorder or malfunction

Answer A: 'It means having things like heart disease or something blocking your intestines.'

Answer B: 'All sorts of things. You know sickness and diarrhea, unbearable pain, lumps growing on your skin. '

Answer C: 'It's when you don't feel well.

Answer to Exercise

A Illness as a disorder
B Illness as disease symptom
C Illness as subjective sensation

I hope you enjoyed this exercise. Now let us focus on the distinctions between disease and illness.

3.5 Distinction between Illness and Disease

Professor Marshall Marinker, a general practitioner, suggested over twenty years ago a helpful way of distinguishing between disease and illness. He characterizes these "two modes of unhealth as follows.

"**Disease** ... *is a pathological process, most often physical as in throat infection, or cancer of the bronchus, sometimes undetermined in origin, as in some mental illnesses*. Thus, disease can be thought of as the presence of pathology, which can occur with or without subjective feelings of being unwell or social recognition of that state. The quality which identifies disease is some deviation from a biological norm. There is *an objectivity about disease which doctors are able to see, touch, measure, and smell. Diseases are valued as the central facts in the medical view.*

"Illness ... is a feeling, an experience of un-wellness which is entirely personal, interior to the person or the patient. Thus, it is a subjective state of un-wellness, with certain individual differences in coping mechanisms. Often it accompanies disease, but the disease may be undeclared, as in the early stages of cancer or tuberculosis or diabetes. Sometimes illness exists where no disease can be found. A person without any disease may feel unhealthy and believe he/she has an illness. Another person may feel healthy and believe he/she does not have an illness even though he/she may have a disease such as dangerously high blood pressure which may lead to a fatal heart attack or categorized as subjective, with certain individual differences in coping mechanisms. Alternatively, a person may have a disease and not feel ill. For example, Hypertension is called the silent killer because it

can exist for a long time without being detected. Many cancers can also exist and develop for weeks, months or even years without being detected (Weiss and Lonnquist, 2005).

3.6 Illness Dynamics

The relationship among one's biological status (e.g., genetic constitution and physical pathology), emotional makeup, and the supports and stresses of a social matrix (confluence of biologic, psychologic, and social aspects), represents the patient's understanding of a specific disease during a particular period of life. Illness dynamics incline one to assess all illness-related information in light of singular values, wishes, needs, and fears, ultimately causing the patient to perceive, assess, and defend against the loss of health in a highly subjective manner. This may significantly affect the patient's ability to cope with the disease.

3.6.1 Major Components of Illness Dynamics

Biological

- Nature, severity, and time course of disease
- Affected organ, system, body part, or body function
- Baseline physiological functioning and physical resilience
- Genetic endowment

Psychological

- Maturity of ego functioning and object relationships
- Personality type
- Stage in the lifecycle
- Interpersonal aspects of the therapeutic relationship (e.g., countertransferance of healthcare providers)
- Previous psychiatric history
- Effect of past history on attitudes toward treatment (e.g., postoperative complications)

Social

- Dynamics of family relationships
- Family attitudes toward illness
- Level of interpersonal functioning (e.g., educational and occupational achievements; ability to form and maintain friendships)
- Cultural attitudes

4.0 CONCLUSION

Illness definition is indeed not as easy as it appears because of its dynamic nature. As a subjective experience, illness is influenced not only by the person's biological state but also by cultural and social factors, situational variables, stress, personality, and concepts held by the person about the nature of disease. Thus illness represents a true interaction between the physical, social and the psychological.

5.0 SUMMARY

We have systematically defined illness. We also went further to analyze the three perspectives of illness as well as the distinction between illness and disease. Lastly, we looked at the dynamics of illness. I hope you found this unit helpful. Now let us try this exercise.

6.0 TUTOR MARKED ASSIGNMENT

1. Distinguish between illness and disease
2. Identify the major components of illness dynamics.

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MODULE 2 CONCEPTUALIZING HEALTH/ILLNESS DICHOTOMIES AND DETERMINANTS

Unit 1 Health and Illness and the Mind – Body Relationship
Unit 2 Acute Illness versus Chronic Illness
Unit 3 Culture and Socio-Demographic Determinants of Health and Illness

UNIT 1 HEALTH AND ILLNESS AND THE MIND – BODY RELATIONSHIP

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
3.1 Illness and the Mind-Body Relationship: A Brief History
3.1.1 Illness and the Mind-Body Relationship: The Middle Ages
3.1.2 Illness and the Mind-Body Relationship: The Modern Era
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

The relationship between the mind and the body has long been a controversial topic. Are experiences, such as illness experiences purely mental, physical, or an interaction between the mental and physical? This unit therefore seeks to provide answers to these.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Illustrate historical perspective of illness and the mind – body relationship.
- Identify the perspectives of illness and the mind-body relationship in the middle ages.
- Illustrate the conception of illness and the mind-body relationship in the modern era.

3.0 MAIN CONTENT

3.1 Illness and the Mind and Body Relationship: A Brief History

As Gentry and Matarazzo (1981) pointed out, the view that there are delicate interrelationships, such as the dry mouth and racing heart associated with fear and anger, or the headache triggered by emotional stress, can be found in ancient literature documents from Babylonia and Greece.

The Greeks were among the earliest civilizations to identify the role of bodily functioning in health and illness. Rather than ascribing illness to evil spirit, they developed a humoral theory of illness that was first proposed by Hippocrates in 377 B.C., and later expanded by Galen (A.D. 129). According to this view, disease arises when the four circulating fluids of the body – blood, black bile, yellow bile and phlegm – are out of balance. An excess of yellow bile was linked to a choleric temperament. It was assumed that this yellow bile prompted an individual to become chronically angry and irritable, hence the word choleric (angry), which literally means bile. An excess of black bile was considered to cause a person to be chronically sad or melancholic, hence the term melancholy, which literally means black bile. The sanguine or optimistic temperament, characterized by calm, listless personality attributes, was seen as being due to an excess of bodily humor phlegm (Gatchel, et al, 1997).

Of course, this humoral view of personality and illness was long ago abandoned, along with a number of other pre-scientific notions. On a historical level, however, it points out how physical or biological factors have been seen through the ages as significantly interacting with and affecting the personality or psychological characteristics of an individual (Gatchel, et al, 1997).

The function of treatment is to restore the balance among the humors. Specific personality types were thus believed to be associated with bodily temperaments in which one of the four humors predominated. In essence, then, the Greeks ascribed disease states to bodily factors, but also believed that these factors could also have an impact on the mind (Taylor, 2006).

SELF ASSESSMENT EXERCISE

Describe the pre-historic conception of illness and the mind-body relationship

Answer to Exercise

The Greeks were among the earliest civilizations to identify the role of bodily functioning in health and illness. Rather than ascribing illness to evil spirit, they developed a humoral theory of illness that was first proposed by Hippocrates in 377 B.C., and later expanded by Galen (A.D. 129). According to this view, disease arises when the four circulating fluids of the body – blood, black bile, yellow bile and phlegm – are out of balance. For example, an excess of yellow bile was linked to a choleric temperament. Thus, the function of treatment is to restore the balance among the humors. In essence, then, the Greeks ascribed disease states to bodily factors, but also believed that these factors could also have an impact on the mind

3.1.1 Illness and the Mind-Body Relationship - The Middle Ages

Mysticism and demonology dominated concepts of illness in the middle-ages, while afflicted persons were seen as receivers of God's punishment for evil doing. Cure often consisted of driving out evil by tutoring the body. Later, this "therapy" was replaced by penance through prayers and good works. Throughout this time, the church was seen as the guardian of medical knowledge; as a result medical practices took on religious overtones, including religiously based but unscientific generalizations about the body-mind illness relationship.

3.1.2 Illness And The Mind-Body Relationship – The Modern Era

Beginning in the Renaissance and continuing up to the present day, great strides have been made in the technological basis of medical practices. Most notable among these were Anton Vaan Leeuwenhoek's (1632-1723) work in microscopy and Gionanni Morgagni's (1682-1771) contributions to autopsy, both of which laid the groundwork for the rejection of the humoral theory of illness. The humoral approach was finally put to rest by the theory of cellular pathology, which maintains that all disease is disease of the cell rather than a matter of fluid imbalance (Kaplan, 1975).As a result of such advances, medicine looked more and more to the medical laboratory and bodily factors, rather than to the mind, as a basis for medical progress.

This view however began to change with the rise of modern psychology, particularly with Sigmund Freud's (1856-1936) early work on conversion hysteria. According to Freud, specific unconscious conflicts can produce particular physical disturbances that symbolize the repressed psychological conflicts. In conversion hysteria, the patient

converts the conflict into a symptom via the voluntary nervous system; he or she becomes relative free of the anxiety the conflict would otherwise produce.

The conversion hysteria literature is full of intriguing but biologically impossible disturbances, such as glove anaesthesia (in which the hand, but not the other parts of the arm, loses sensation) in response to highly stressful events. Other problems include sudden loss of speech, hearing or sight; tremors; muscular paralysis, etc, have also been interpreted as forms of conversion hysteria. True conversion hysterias are now less frequent than they were in Freud's time (Taylor, 2006)

Nonetheless, the idea that specific illnesses are produced by individual's internal conflicts was perpetuated by the works of Flanders Dunbar (Dunbar, 1943), and Franz Alexander (Alexander, 1950). Unlike Freud, these researchers linked patterns of personality rather than single specific conflict to specific illnesses. For example, Alexander developed a profile of the ulcer prone personality as someone whose disorder was caused primarily by excessive needs for dependency and love. A more important departure from Freud concerned the physiological mechanism postulated to account for the link between conflict and disorder. Whereas, Freud believed that conversion reactions occurred via the voluntary nervous system with no necessary physiological changes, Dunbar and Alexander argued that conflicts produce anxiety that becomes unconscious and takes a physiological toll on the body via the autonomic nervous system. The continuous physiological changes eventually produce an actual organic disturbance. In the case of ulcer patient, for example, repressed emotions resulting from frustration dependency and love-seeking needs were said to increase the secretion of acid in the stomach, eventually eroding the stomach lining and producing ulcer (Alexanader, 1950). Dunbar and Alexander's work however helped shape the emerging field of **psychosomatic medicine** (Taylor, 2006)

4.0 CONCLUSION

There indeed exist a delicate relationship between mind and body on illness experiences. Observations have shown the delicate relationship between stress, personality and physical complaints like headache or even cancer. The Greeks were therefore one of the first civilization to identify the role of bodily functioning to illness. Thus, rather than ascribing illness to evil spirit, as previously thought, or even as currently thought sometimes, illness was ascribed to imbalance in bodily fluids. Also, a further assessment of mind-body relationship gave rise to the psychosomatic movement, which was of course, without its criticism.

5.0 SUMMARY

Wow, I'm sure you find this unit very insightful, like the previous ones. In this unit, we have been able to trace the historical perspective of mind-body relationship as well as different perceptions of illness, pre and post the modern era. Now let us attempt the following exercise.

6.0 TUTOR MARKED ASSIGNMENT

Identify the pre and post historic views of illness and the mind body relationship.

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UNIT 2 ACUTE VERSUS CHRONIC ILLNESS

CONTENTS

1.0 Introduction
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3.0 Main Content
    3.1 Defining Acute Illness
        3.1.1 Types of Acute Illness
    3.2 Defining Chronic Illness
        3.2.2 Types of Chronic Illness
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    3.4 Chronic Illness and Hospitalization
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

As you must have noted, we provided information on illness and the mind-body relationship in the previous unit. Of course, these are very necessary information as they help for better appreciation of this course. However, in this unit, we will analyze acute versus chronic illness. Observations indicate that we cannot understand human behaviour in health and illness without looking at these basic terms. So, we are going to look at acute versus chronic illness as well as the diseases categorized under each. Happy reading!

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Define acute illness
- Enumerate types of acute illness
- Define chronic illness
- Determine types of chronic illness
- Ascertain differences between acute and chronic illness
- Determine the influence of chronic illness on hospitalization

3.0 MAIN CONTENT

3.1 Defining Acute Illness

Acute illness is by definition a self-limiting disease which is mostly characterized by the symptoms having a rapid onset. These symptoms are fairly intense and resolve in short period of time as either cure or death in the patient.

3.1.1 Types of Acute Illness

We commonly know these acute diseases as:

- Colds
- Flu
- Bronchitis
- Malaria
- Childhood illnesses
- Tonsillitis
- Appendicitis
- Ear aches
- Most headaches
- Some infectious diseases, etc.

3.2 Defining Chronic Illness

Chronic diseases are those that occur across the whole spectrum of illnesses, mental health problems and injuries. Chronic diseases tend to be complex conditions in how they are caused, are often long-lasting and persistent in their effects and can produce a range of complications.

Chronic conditions are those which are long-term (lasting more than 6 months) and can have a significant effect on a person's life. Management to reduce the severity of both the symptoms and the impact is possible in many conditions. Management includes medication and/or lifestyle changes such as diet and exercise, and stress management. At the same time, it should be noted that chronic diseases may get worse, lead to death, be cured, remain dormant or require continual monitoring.

3.2.1 Types of Chronic Illness

The following are various types of chronic illness

- **Epilepsy – Neurological Disease**

The condition arises when there is a brief interruption in the normal electrical function of the brain. Epileptic attacks can vary between

momentary withdrawal without loss of consciousness (*petit mal)* and muscular spasms and convulsions *(grand mal)* (Wikipedia – The free Encyclopedia, 2007)

- **Heart Disease**

This is an umbrella term for a number of different diseases which affect the heart. The most common heart diseases are:

Coronary Heart Disease: a disease of the heart itself caused by the accumulation of atheromatous plaques within the walls of the arteries that supply the myocardium.

Ischaemic Heart Disease: another disease of the heart itself, characterized by reduced blood supply to the organ.

Cardiovascular Disease: a sub-umbrella term for a number of diseases that affect the heart itself and/or the blood vessel system, especially the veins and arteries leading to and from the heart. Research on disease dimorphism suggests that women who suffer with cardiovascular disease usually suffer from forms that affect the blood vessels while men usually suffer from forms that affect the heart muscle itself. Known or associated causes of cardiovascular disease include diabetes mellitus, hypertension, hyperhomocysteinemia and hypercholesterolemia.

Cor pulmonale: a failure of the right side of the heart.

Hereditary Heart Disease: heart disease caused by unavoidable genetic factors since birth.

Hypertensive Heart Disease: heart disease caused by high blood pressure, especially localized high blood pressure.

Inflammatory Heart Disease: heart disease that involves inflammation of the heart muscle and/or the tissue surrounding it.

Valvular Heart Disease: heart disease that affects the valves of the heart. (Retrieved from "http://en.wikipedia.org/wiki/Heart_disease")

- **Asthma – Respiratory Disease**

Asthma is characterized by attacks of breathlessness, coughing and wheezing. Attacks vary in severity and duration. Attacks can be triggered by a variety of factors: exposure to allergens, dust, humidity and infection, emotional factors etc.

- **Mental Illness**

A **mental illness** as defined in psychiatry and other mental health professions is abnormal mental condition or disorder expressing symptoms that cause significant distress and/or dysfunction. This can involve cognitive, emotional, behavioural and interpersonal impairments.

Similar but sometimes alternative concepts include: mental disorder, psychological or psychiatric disorder or syndrome, emotional problems, emotional or psychosocial disability. The term insanity, sometimes used colloquially as a synonym for expressing symptoms of a mental health condition or irrationality, is used technically as a legal term.

Specific disorders often described as mental illnesses include clinical depression, generalized anxiety disorder, bipolar disorder, and schizophrenia. Diagnosis is performed by a mental health professional. Mental health conditions have been linked to both biological (e.g. genetics, neurochemistry, brain structure), disease (viruses, bacteria, toxins), drugs (both illegal and over-the-counter medication) and psychosocial (e.g. cognitive biases, emotional problems, trauma, socioeconomic disadvantage) causes. Different schools of thought offer different explanations, although current research employing the term 'mental illness' would most probably originate in a biopsychiatry point of view (Wikipedia – The free Encyclopedia, 2007).

- **Diabetes – Metabolic Disease**

Diabetes is one of the leading causes of death in Africa and the world, and contributes to significant illness disability, and poor quality of life. It shares several of the risk factors with cardiovascular disease and is itself a risk factor. There is a marked difference in the age profile of people with different types of diabetes. There are two types:

- Type 1: Insulin-dependent diabetes – IDD (common among children);
- Type 2: Non-insulin-dependent diabetes – NID (adults over 40).

Type 1 diabetes is the most common form among children and young adults. In these children, the pancreas does not produce sufficient insulin. Type 2 diabetes is predominant among middle-aged and elderly due to its rapid increase in prevalence after age 45. Here, blood sugar is increased and sugar in the urine is increased also (Wikipedia – The free Encyclopedia, 2007).

- **Cancer**

Cancer develops when cells in a part of the body begin to grow out of control. Although there are many kinds of cancer, they all start because of out-of-control growth of abnormal cells. Normal body cells grow, divide, and die in an orderly fashion. During the early years of a person's life, normal cells divide more rapidly until the person becomes an adult. After that, cells in most parts of the body divide only to replace worn-out or dying cells and to repair injuries. Because cancer cells continue to grow and divide, they are different from normal cells. Instead of dying, they outlive normal cells and continue to form new abnormal cells.

Cancer usually forms as tumour. Some cancers, like leukemia, do not form tumours, instead, these cancer cells involve the blood and blood-forming organs and circulate through other tissues where they grow. Often, cancer cells travel to other parts of the body where they begin to grow and replace normal tissue. This process is called *metastasis.* Regardless of where a cancer may spread, however, it is always named for the place it began. For instance, breast cancer that spreads to the liver is still called breast cancer, not liver cancer. Not all tumours are cancerous. Benign (noncancerous) tumours do not spread (metastasize) to other parts of the body and, with very rare exceptions, are not life threatening. Different types of cancer can behave very differently. For example, lung cancer and breast cancer are very different diseases. They grow at different rates and respond to different treatments. That is why people with cancer need treatment that is aimed at their particular kind of cancer.

The overall incidence for cancer is lowest in late childhood. In adult life it increases with age. Death rates from cancer increase with age, from age 15. The older population makes up a higher proportion of those dying from cancer, and this proportion is increasing (wikipedia – The free Encyclopedia, 2007).

- **HIV/AIDS**

HIV/AIDS was to enter the world's consciousness and become part of the vocabulary of the human soul as a result of the dawning awareness of the advent of the strange new disease first reported in California in 1981. With time, the HIV/AIDS pandemic is unfolding and revealing its secrets. (Pratt, 2003). AIDS is therefore a new disease and its full name is Acquired Immune Deficiency Syndrome. As the name implies, it is a disease caused by a deficiency in the body's immune system. It is a syndrome because there is a range of different symptoms which are

always found in each case. It is acquired because HIV/AIDS is an infectious disease caused by a virus which spread from person to person through a variety of routes. This makes it different from immune deficiency from other causes such as treatment with anti-cancer drugs or immune system suppressing drugs given to persons receiving transplant operations. (Hubley, 1995). Thus, with Africa, inclusive Nigeria, bearing about 70%, of HIV infections, there is no gainsaying that the epidemic is one of the new factors responsible for the continued underdevelopment of the continent (Human Development Report, Nigeria, 2004).

SELF ASSESSMENT EXERCISE

i. Define acute and chronic illness
ii. Identify the various types of acute and chronic illnesses

Answer to Exercise

- Acute illness is, by definition, a self-limiting disease which is mostly characterized by the symptoms having a rapid onset. These symptoms are fairly intense and resolve in short period of time as either cure or death in the patient. Chronic conditions are those which are long-term (lasting more than 6 months) and can have a significant effect on a person's life.
- Types of acute illness are flu, malaria, ear aches, tonsillitis, etc.
- Types of chronic illness are diabetes, mental illness, HIV/AIDS, heart diseases cancer, etc.

3.3 Distinction between Acute and Chronic Illness

We have looked at various definitions of acute and chronic illness as well as some various types obtainable, now let us look at the basic distinctions between them.

- Acute diseases have a limited duration, while chronic diseases can remain in the individual for decades.
- Suffice to note that these diseases do not necessarily result in the death of the individual and they may not die directly from the symptoms of this disease. However, the chronic nature of the escalating symptomatology associated with chronic diseases, brings about great hardship to the individual in one way or another and severely undermines the quality of life through a continuum of ongoing fixed symptoms as well as the addition of ancillary sufferings. All this eventually leads to a terminal situation due to a weakening of the vital force.

- A person with chronic illness is more likely to depend longer on healthcare services than those suffering from acute illness. He or she is more likely to be dependent more on family and friends for normal everyday activities, than those with acute symptoms.
- Psychological, social and family stress could be more visible in the case of chronic illness than acute illness. For example, a HIV positive individual grapples daily with the depression, fear, anger, stigma and discrimination associated with the disease and may feel traumatized by such medical state.
- Chronic diseases bring about gradual deterioration of the mental, physical and emotional spheres of a person, while this may not be so for acute disease. Thus, the deterioration observed for acute disease is most times sudden and reduces when the person gets medical attention. For example, a person suffering from terminal cancer, long before it has been diagnosed, may show mental and emotional symptoms years before the overt symptoms manifest. Some people may suggest that this person used to be friendly and out going until a particular tragedy occurred some years earlier. The patient may also complain how their mental clarity used to be clearer before the said event. The patient will be able to relate their loss of mental clarity by stating that they now have a horrible memory for peoples' names, or that now, unlike before, they can't remember anything and always have to make lists of everything. However, this almost imperceptible decline is recognized by the vital force's attempt to call for help, by producing symptoms. It is the accurate reporting and faithful recording of these injured cries that allow the healer to clearly prescribe a therapeutic protocol for the alleviation of the suffering.

3.4 Chronic Illness and Hospitalization

When individuals have a chronic disease, whether from birth or contracted in later life, they are likely to engage with the health system to a greater extent than anyone else. This may begin with visits to a general practitioner, followed by diagnostic tests, pharmaceutical prescriptions, consultations with specialists, visits to hospitals and possibly surgery. This may also take place in the context of a reduced earning capacity.

Put differently, people with chronic diseases require maximum health services and they are least able to afford them. Those within the 60+ population with a sustained chronic disease are likely to have been on welfare benefits, if there is any, before the usual retirement age of 60 to 65 years. People with chronic disease may have also continued to work, though this may have been part time or casually.

An important aspect of living with a chronic disease is that as people become older they may develop other illnesses. Co-morbidities have a number of impacts; these people have even more expenses, they suffer the effects of polypharmacy, and suffer increased effects of the illnesses.

4.0 CONCLUSION

Advances in research and the delivery of health care have reduced mortality from disease and extended life expectancy in developed countries. We are living longer, but are we necessarily living better? Those who would have died from their condition may now survive but there is the emotional cost of long-term treatment and medical surveillance to consider (for example, the patient who has had a liver transplant must then continue immuno suppression treatment). Such patients must cope with a chronic condition and yet the emotional dimensions of these conditions are frequently overlooked when medical care is considered.

5.0 SUMMARY

In this unit, we have briefly defined acute and chronic illnesses. We also enumerated the various types of acute and chronic illnesses. This unit also provided a detailed distinction between acute and chronic illness and also went further to look at chronic illness and hospitalization. Let us now answer the questions stated below.

6.0 TUTOR MARKED ASSIGNMENT

1. Distinguish between acute and chronic illness
2. Identify the influence of chronic illness on hospitalization

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UNIT 3 CULTURE AND SOCIO-DEMOGRAPHIC DETERMINANTS OF HEALTH AND ILLNESS

CONTENTS

1.0 Introduction
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3.0 Main Content
  3.1 Cultural factors of Health and Illness
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    3.2.5 Socioeconomic status, Health and Illness
4.0 Conclusion
5.0 Summary
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1.0 INTRODUCTION

We have looked at several conceptions of illness, disease and health, illness and the mind-body relationship. We also looked at certain dichotomies of illness, such as acute versus chronic illnesses. We presented other contributory factors that accounted for changing patterns of illness. This unit therefore hopes to further identify contributory variables of illness and health. Specifically, this unit looks at cultural, social, demographic and situational perspectives of illness and health. Thus, illness does not occur in isolation, it is such contributory variables that predict various human behaviours in illness and health.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Illustrate cultural factors influencing health and illness behaviour
- Identify the socio-demographic factors of health and illness behaviour

3.0 MAIN CONTENT

3.1 Cultural Factors of Health and Illness

Understanding the nature of health and illness and how people engage in several health behaviour, in a bid to keep healthy or respond to physical distress when ill, as the case may be, requires a consideration of the cultural context in which health and illness behaviours takes place. Although, the biological processes involved in disease are the same across cultural boundaries, but how people understand, experience and respond to illness is often radically different.

Anthropological studies of different illness and health seeking behaviours across culture have shown that health and illness conceptions do not occur in isolation, but are part of the larger cultural belief system. Western technological societies tend to think of illness in terms of germs or specific dysfunctions within the body, while others may have a mystical interpretation to it. In Fabrega (1974) study of illness belief and medical care among the Spanish speaking people, the author described two contrasting approaches to illness. Indians of Mayan descent, regard illness as either a sign of sin or an indication that one's enemies have plotted with devils and witches to cause harm. A return to health requires that the sick person and his family make certain social, moral and religious reparations.

Individuals of direct Spanish descent, however, have different and more individualistic views of illness. They regard the occurrence as evidence that the person's strength has been overcome and depleted. For these individuals, illness can be caused by biological, social and psychological factors, with the principal causes found in the person's emotions and social relationships. Thus, a return to health means a return of a person's strength, positive emotions and good social relationships. These beliefs, in turn, reflect the more differentiated world view that conceives of the individual as a separate person but with strong ties to the social group.

Even within Western technological society, cultural groups differ in their responses to illness. For example, Zola (1964), found a classical difference between Irish American and Italian American. Whereas, patients of Irish descendants tended to describe a relatively small number of localized symptoms and downplay the pain, patients of Italian descent reported more symptoms relating to more areas of the body and were vocal about the pain.

Also, in a comparison of reaction to pain among the Jewish, Italians, Iris and Americans, Zborowski (1952) observed that Italian and Jewish patients tended to be emotional about the pain, often exaggerating their illness experience. Irish tended to deny the pain while the Americans tended to be more stoical and "objective" about their discomfort. The

writer observed that, even though the Jews and Italians tended to be more expressive about their illness experience, they apparently did so for different reasons. He noted that Italians were primarily concerned with pain sensation and were satisfied simply to find relief. Jews, however, were more concerned with the meaning of the pain and with potential consequences. In these studies therefore, the different responses to discomfort reflect overall cultural differences between groups and they also provide basic orientations and categories for interpreting somatic experiences.

SELF ASSESSMENT EXERCISE

How are illness and health perceived in your culture?

Answer to Exercise

Providing answer to this exercise will be highly subjective. Please, find time to attempt this exercise and also discuss with your friends or course mates. I am sure this experience will be a very insightful and interesting one. Ok! Can we move on? Next are the socio-demographic factors of health and illness.

3.2 Social and Demographic Factors of Health and Illness

Although culture provides basic orientations to interpreting health and illness experiences, the experience of such, however, is further shaped by various demographic factors. Such factors therefore include: age, gender, marital status, living arrangement and socioeconomic status.

3.2.1 Age, Health and Illness

Observations indicate that childhood and youthfulness signifies good health and vigour while illness and thus, decline in health increases as one gets older. Thus, older people are likely to report more activity restriction, physician visit and health complications due to chronic diseases and frail immune systems than the younger ones.

Younger people are also more likely to engage in risky health behaviours like unprotected sexual habits, drug abuse or even engage in dangerous physical activities than the older ones because of the assumption that they are younger and full of energy. They are also more likely to be careless with illness experience and might interpret symptoms differently than the older ones. Whereas the older people might view symptom experience seriously and work towards getting well, the younger ones are likely to ignore those symptoms until its late to get medical attention.

3.2.2 Gender, Health and Illness

Studies have shown that women report more illnesses than do men. Also, because of their physical make-up and experiences like child birth and motherhood, women are more likely to engage in health seeking behaviour than men. Although there are some questions as to whether women actually experience more symptoms, one study has found evidence that women have more "diffuse" view of illness, often reporting symptoms that "radiate" throughout the body. In addition, men often appear unaware of serious health problems when reporting symptoms to a doctor (Verbrugge, 1980). It is also known that breast cancer is more common in women than men and only men have prostrate cancer.

3.2.3 Marital Status, Health and Illness

Marital status also seems to have significant effect on illness behaviour. Studies have shown that compared with those who are married, unmarried individuals are likely to report more symptoms and think themselves to be in poorer health than the married ones. This may be due to the poor feeding habit and other associated health risks likely to be observed among the unmarried individuals. For the unmarried females, boredom and an urge for a husband may predispose them to stress, depression and poor immunity to diseases.

Also, child bearing and motherhood may predispose the married ladies to several forms of health complications, stress and loss of energy may sometimes arise when they had to combine motherhood with a formal job. Thus, they are more likely to engage in health seeking behaviours in a bid to function adequately in the home.

Likewise, married men are more likely to engage less in risky health and physical behaviours than the unmarried one, especially when there are children involved.

3.2.4 Living Conditions, Health and Illness

Overall, individuals living with one to three others may report fewest symptoms than those living with four or more others. Also, those living in a crowded and poorly ventilated environment are more vulnerable to diseases than those living in neat and spacious environment. Overall, poor living condition predisposes one to frequent hospital visits and self medications.

3.2.5 Socioeconomic Status, Health and Illness

Social class or socioeconomic status plays an important role in health and illness behaviour. A poor person is more like to have less purchasing power, poor feeding habit, and poor health service, live in poor and indecent environment and die younger due to complications of diseases. In their comparison between the white and blue collar jobs, Rosenblatt and Suchman (1964) observed that the blue-collar workers are less informed about health and illness, more skeptical about medical care, more dependent when ill than their white-collar counterparts.

4.0 CONCLUSION

We have seen that the cultural and socio-demographic factors of illness experience are indeed part of the very many facets of health and illness. Observations indicate that though biological processes involved in illnesses are globally similar, but the perceptions, experiences and responses to illness are often radically dissimilar. Culture described as the way people live, plays a huge role in the understanding and studying of illness behaviour. Also, the influence of certain socio-demographic factors of illness experience cannot be over-emphasized. We have seen that age, gender, marital status, living conditions and socio-economic status exert significant influence on health and illness behaviour.

5.0 SUMMARY

I hope you enjoyed your studies. In this unit, we looked at the roles of culture as well as socio-demographic variables on health and illness experience. Now let us tackle the question stated below.

6.0 TUTOR MARKED ASSIGNMENT

Identify and discuss the Socio-demographic factors of Health and Illness behaviour

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MODULE 3 CONCEPTUALIZING HEALTH BEHAVIOUR

Unit 1 What is Health Behaviour?
Unit 2 Changing Patterns of Health and Illness
Unit 3 Theoretical Approaches to Health and Illness Behaviour

UNIT 1 WHAT IS HEALTH BEHAVIOUR

CONTENTS

1.0 Introduction
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  3.1 Defining Health Behaviour
  3.2 Health Promotion: An Overview
  3.3 Dimensions of Health Behaviour
  3.4 What are Health Habits
  3.5 Complexities of Health Behaviour
4.0 Conclusion
5.0 Summary
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1.0 INTRODUCTION

At the beginning of this course, we started by defining behaviour, and human behaviour. We also looked at diseases, health and illness. We further discussed other health and illness related variables like illness and the mind-body relationship, acute versus chronic illness, and also scrutinized cultural and socio-demographic factors of health and illness.
The fact that social and cultural factors provide the context for the experience of health and illness is well established, but how then do we notice symptoms and perceive ourselves to be ill or healthy. An obvious beginning is providing a clear and in-depth definition of health behaviour as well as illness behaviour. This is because we cannot conceptualize illness behaviour without first looking at health behaviour. It is not an understatement to state that a deviation in health behaviour could lead to illness and thus, illness behaviour. We purposely left this topic till now, to form the beginning of module 3, unit 1 while all the topics discussed in previous units and modules served as basic introductions to health and illness behaviours.

Remember that the term 'health' is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or/and infirmity. However, health is a broad term that includes both health and illness behaviours.

2.0 OBJECTIVES

At the end of this unit, you are expected to:

- Define health behaviour
- Illustrate an overview of health promotion
- Identify dimensions of health behaviour
- Explain and identify health habits
- Describe the complexities of health behaviour

3.0 MAIN CONTENT

3.1 Defining Health Behaviour

Health behaviour is a broad term that includes:

- Health Behaviour
- Illness behaviour

Definition 1: Health behaviours are behaviours considered to be related to primary prevention of disease.

Definition 2: Health behaviour is defined as: any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end.

Definition 3: The combination of knowledge, practices, and attitudes that together contribute to motivate the actions we take regarding health.

Definition 4: Health behaviours are behaviours undertaken by people to enhance or maintain their health (Stone, 1979). Poor health behaviours are thus important not only because they are implicated in illness but also because they may easily become poor health habits.

Definition 5: Health behaviours are behaviours that a person engages in, while still healthy for the purpose of preventing disease (Kasl and Cobb, 1966). These include a wide range of behaviour from stopping smoking, losing weight, exercising regularly and eating right.

Definition 6: Health behaviour is an activity undertaken by a person believing himself/herself to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic stage (for example, following a healthy diet). This is regarded as *primary prevention of disease.*

Secondary prevention of disease is more closely related to the control of a disease that an individual has or that is incipient in the individual. This type of prevention is most closely tied to illness behavior. Illness behaviour – Any activity undertaken by a person, who feels ill to define the state of his or her health and to discover a suitable remedy (for example, going to the doctor).

Tertiary prevention is generally seen as directed towards reducing the impact and progression of symptomatic disease in the individual. This type of prevention is highly related to the concept of sick-role behaviour. Sick role behaviour – Any activity undertaken for the purpose of getting well, by those who consider themselves ill (for example, taking prescribed medication or resting). It generally includes receiving treatment from appropriate therapists, involves a whole range of dependent behaviours, and leads to some degree of neglect of the person's usual duties.

3.2 Health Promotion: An Overview

Health promotion is a general philosophy that has at its core the idea that good health, or wellness, is a personal and collective achievement.

- For the individual, it involves developing a programme of good health habits early in life and carrying them through adulthood and old age.
- For the medical practitioner, health promotion involves teaching people how best to achieve this healthy lifestyle and helping people at risk for particular health problems learn behaviours to offset or monitor those risks (Maddux, et al, 1988).
- For the psychologist, health promotion involves the development of interventions to help people practice good health habits and change poor ones.
- For the community and the nation, health promotion involves a general emphasis on good health, the availability of information to help people develop and maintain healthy life styles, and the availability of resources and facilities that can help people change poor health habits.
- The mass media can contribute to health promotion by educating people about health risks posed by certain behaviours such as smoking, excessive alcohol consumption, unprotected sexual habits and sharing of sharp objects.

- The legislation can also contribute to health promotion by mandating certain activities that may reduce risk, such as the use of seat belts when driving, prohibition of drunk driving, mandatory immunization of children etc (Taylor, 2006)

3.3 Dimensions of Health Behaviour

However, there is no consensus about the traits that constitute a genuinely healthy body and researchers operationalize the concept of health behaviour in many ways. Ware (1986), in his review of literature identified the following 6 primary dimensions of health behaviours used by many researchers:

Physical Functioning: focuses on physical limitations regarding ability to take care of self, being mobile and participating in physical activities, ability to perform everyday activity; and number of days confined in bed.

Mental Health: focuses on feelings of anxiety and depression, psychological well-being and control of emotions and behaviour.

Social Well being: focuses on visiting with or speaking on the telephone with friends and family and the number of close friends and acquaintances.

Role Functioning: focuses on freedom and limitations in discharging usual role activities such as work or school

General Health Perception: focuses on self-assessment of current health status and amount of pain being experienced.

Symptoms: focuses on reports of physical and psychophysiological symptoms. (Weiss and Lonnquist, 2005).

Now, we know that we cannot talk about illness behaviour without first touching on the concept of health behaviour. This is a broad concept that deals with illness, health and sick role behaviour. Let us now, attempt this interesting exercise.

SELF ASSESSMENT EXERCISE

i. Define health behaviour
ii. Identify the 6 primary dimensions of health behaviour

Have you done that? Now let us compare what you have with the answers provided below. If they are similar, then you are looking good.

Answer to Exercise

i. Health behaviour is a broad term that includes: health behaviour and Illness behaviour. Health behaviour is any activity undertaken by a person believing himself/herself to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic stage. For example, following a healthy diet (primary prevention). It also involves measures aimed at controlling disease (secondary prevention) and controlling the impact and progression of symptoms (tertiary prevention).

ii. Six primary dimensions of health behaviours are:
   a. Physical Functioning
   b. Mental health
   c. Social well-being
   d. Role functioning
   e. General health perception
   f. Symptoms

3.4 What Are Health Habits?

Health habits are health-related behaviour that are firmly established and often performed automatically, without awareness. These habits usually develop in childhood and begin to stabilize around age 11 or 12 (Cohen, Brownell and Felix, 1990). Wearing a seat belt, brushing one's teeth, and eating a healthy diet are examples of these kinds of behaviours. Although, a health habit may have developed initially because it was reinforced by positive outcomes, such as parental approval, it eventually becomes independent of the reinforced process and is maintained by the environmental factors with which it is customarily associated. As such, it can be highly resistance to change. Consequently, it is important to establish good health habits and eliminate poor ones (Taylor, 2006).

A dramatic illustration of the importance of good health habits in maintaining good health is provided by a classic study of people living in California, conducted by Belloc and Beslow (1972). These scientists began by defining seven important good health habit: sleeping 7 to 8 hours at night, not smoking, eating breakfast each day, having not more that one to two alcohol drinks each day, getting regular exercise, not eating between meals, and being not more that 10% overweight. They then asked each of nearly 7,000 country residents to indicate which of these behaviours they practiced. Residents were also asked to indicate how many illnesses they had had, which illnesses they had, how much energy they had and how disabled they had been (for example, how

many days of work they had missed on the previous six to twelve months period). The researchers found that the more good health habit people practiced, the fewer illnesses they had, the better they felt, and the less disabled they had been. A follow-up of these individuals nine and half years later found that mortality rate were dramatically lower for both men and women practising the seven health habits. Specifically, men following these health habits had a mortality rate only 28%, than that of men following zero to three of the health habits (78%), and women following the seven health habits had a mortality rate of 43% than that of women following zero to three of the health habits, (57%) (Breslow and Enstrom, 1980)

3.5 Complexities of Health Behaviour

Although, healthy and unhealthy lifestyles are commonly discussed as if a person either does or does not practice good health behaviour, research on health behaviours has shown that the practice of one health behaviour is often only weakly related to the practice of others (Kirscht, 1983, Mechanic, 1979). Why is this?

- The major reasons seem to be that health behaviours differ on a number of dimensions and may be influenced by different factors. For one thing, some health habits require that a person actively engage in positive activities, whereas others require the avoidance of harmful ones. Thus, a person may initiate good habits like exercising and eating right, the same person may have difficulty in avoiding the temptation involved in smoking and excessive use of alcohol.
- In addition, some health habits such as brushing ones teeth, eating right and exercising, can be performed by the individual without professional assistance, whereas others, such as receiving regular check-ups or immunization, require medical supervision.
- Health behaviours also differ considerably in their complexity. Some, like immunization or check-ups, are relatively simple and are performed only occasionally, many health behaviours, however, are repeated and are embedded in important habit patterns. For example, obtaining health benefits from exercise requires that the person exercise on a regular basis. Positive habits like brushing one's teeth, and negative habits such as smoking and overeating, are closely related to the person's daily routines and general habits patterns. Beyond this, complex, long-term habits may become integrated together as a part of the person's overall life-style (Kirscht, 1983).

4.0 CONCLUSION

This unit provided an in-depth definition of health behaviour, of which most tended to perceive health behaviour as any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health. This unit also presented an overview of health promotion as well as complexities of health behaviours. It further analyzed dimensions of health behaviour and identified several health habits that could aid healthy living.

5.0 SUMMARY

I hope you enjoyed reading through this unit. In this unit, we define health behaviour in an unambiguous manner to aid proper assimilation. It is very important to have a firm grasp of what health behaviour is all about as these also influences conception of illness behaviour. Now let us attempt the following questions.

6.0 TUTOR MARKED ASSIGNMENT

1. Illustrate an overview of health promotion
2. Explain the complexities of health behaviour

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UNIT 2 CHANGING PATTERNS OF HEALTH AND ILLNESS

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    3.2 Environment, Health and Diseases
    3.3 Lifestyle, Health and Diseases
    3.4 Health/Illness and the Advent of New Technology
    3.5 Health/Illness and Health Research
    3.6 Changing patterns of Health/Illness and Epidemiology
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

One may ask, why bother with changing patterns of illness since illness and health experience seems obvious and also cuts across age, social, race, etc. However, by focusing our lenses on the changing pattern of health/illness, we are able to appreciate the great metamorphosis that has been experienced in illness causation and origins, as well as in different health seeking habits. Do not forget that before now, the human race reported less complicated illnesses, which are also mainly acute in nature and thus less complicated treatment regimes. But now, the table is turning the other way. Most illnesses reported now are chronic and oftentimes very complicated. One is thus wont to ask, what triggered these changes in illness patterns. Thus, changes in technology and lifestyle reflect directly to these observations. This unit seeks to further shed more light on the aforementioned topic.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Analyze the changing patterns of illness and metamorphosis of disease
- Discuss the influence of lifestyle on the changing patterns of health/illness
- Identify environmental influences on health/illness
- Identify the role of technological advancement on disease detection

- Explain changing patterns of illness and health research
- Scrutinize the role of epidemiology on changing patterns of health/illness

3.0 MAIN CONTENT

3.1 Changing Patterns of Illness and Disease Metamorphosis

In the past 100 years of so, it was observed that patterns of disease have changed substantially. Observations have shown that until the 20th Century, the major causes of illness and death were acute disorders, especially tuberculosis, influenza, pneumonia, cholera, etc. Presently, it could be observed that chronic diseases like cancer, diabetes, HIV/AIDS, heart diseases, etc. are major causes of illness. Simultaneously, there has been an increase in what have been called the 'preventable' disorders, including the lung cancer, cardiovascular diseases, alcohol, drug abuse and vehicular accidents (Matarazzo, 1985). Also, since 1900, life expectancy for both men and women has greatly improved in the western world and more recently in the developing world. This change is made possible by, in part, breakthroughs in treating and preventing infectious diseases such as polio, influenza, smallpox, rubella (Matarazzo, 1985). With the elimination of these diseases through vaccination, 'new' diseases become more prominent and now account for more deaths. Cancer deaths, for example, have tripled, even among children, presently, heart diseases, cancer and HIV/AIDS have become major killers. Thus, because people may live with such chronic diseases, presently obtainable across the globe for so many years, such illness behaviours such as health seeking habits and decisions for treatment are thus on the rise in connection to these.

SELF ASSESSMENT EXERCISE

i. Identify the diseases that were recorded prior to 20th century as well as contemporary diseases.
ii. What do you think is the reasons for such disease metamorphosis?

Answer to Exercise

i. Pre 20th Century: Influenza, Cholera, Tuberculosis, Leprosy, etc.
ii. Contemporary diseases are: HIV/AIDS, Cancer, Diabetes, Heart Diseases, etc.
iii. Reasons for disease metamorphosis are: Change in health behaviours, change in eating habits, water and air pollution, increase of processed food, use of chemicals in agricultural produce, etc.

Did my answers tally with yours? Remember, these are basically common sense answers. However, this exercise helps to increase awareness on these obvious but often neglected observations. Ok, let us continue with the rest of the topic for this unit.

3.2 Environment, Health and Disease

Added to the effect of individual behaviour on health are the effects of our collective actions as a society. Health hazzards in the environment, such as polluted water, air, toxic chemicals, refuse dumps, etc. have the potential to kill, injure and sicken individuals, and significantly influence the entire communities. Air pollution contributes substantially to respiratory ailments; toxic compounds have been shown to lead to cancer, chronic degenerative diseases, reproductory and developmental impairment, neurological problems and diseases of immune system (Bishop, 1994).

3.3 Lifestyle, Health and Disease

Suffice to note that such chronic diseases like cancer, diabetes, HIV/AIDS, etc. that formed major causes of death and illness nowadays, have no 'magic bullet' cure or vaccine but are, in some respect, diseases caused by lifestyle and behaviour. Diet, smoking, stress, substance use and abuse are all behavioural factors that are associated with development of today's feared illnesses. Califona (1989), for example, observed that at the turn of the century, 580 deaths out of every 100,000 U.S. citizens were due to influenza, pneumonia, diptheria, tuberculosis, and gastro-intestinal infections. Today, these diseases account for only 30 deaths per 100,000 citizens. This rapid decline in deaths from infectious agents, he argues, has been accompanied by increased numbers of deaths from diseases caused or facilitated by preventable behavioural factors such as smoking.

3.4 Health/Illness and Advent of New Technology

Worthy of note is the fact that new technologies now make it possible to detect, prevent, and even identify genes that contribute to, many disorders. Just in the past years, genes contributing to many disorders including breast cancer, diabetes, etc. have been uncovered. Equipment for proper diagnosis of diseases like HIV/AIDS have improved the life-span of individuals. Such complex and innovative technologies have also aided the production of drugs needed to tackle several delibitating diseases. Thus, we could assert that the advent of new technologies have really paved way for more informed health seeking behaviour.

3.5 Health/Illness and Health Research

Helping people to make informed and appropriate decisions appears to be at the forefront of health research. For example, the answers to the following question: "my mother had a heart attack, should I be making changes in my diet?" could be identified through research in the risk factor for diseases such as high fat diet and genetic predisposition. Thus, people could learn to change their diet and stick to their resolution. Research has indeed given us feedback on healthy living.

3.6 Changing Patterns of Health/Illness and Epidemiology

Changing pattern of illness could also be analyzed from the point of view of epidemiology. Epidemiology is the study of frequency, distribution and causes of infectious and noninfectious diseases in a population, based on an investigation of the physical and social environment. For example, epidemiologists not only study who has what kind of cancer, but address questions such as why some cancers are more prevalent in certain areas than others, likewise HIV/AIDS and other communicable and non-communicable diseases. Thus, such findings help form certain illness and health seeking behaviour, like safe sex and sex education in areas where HIV/AIDS prevalence is seen to be very high.

4.0 CONCLUSION

It is indeed very obvious that there are many variables associated with changing patterns of health and illness. Suffice to note that variables such as lifestyle, health researches, new technology, disease metamorphosis, epidemiological variables all combine to form coherent understanding in this regard. Please note that the variables presented here are just few of the many factors that influence such observable changing patterns of health and illness. Please, feel free to come up with more.

5.0 SUMMARY

In this unit, we look at certain variables associated with changing patterns of health and illness. Such variables include: lifestyles changes, the advent of new technology, disease metamorphosis, epidemiological issues and health research that sought to provide empirical findings to these variables.

6.0 TUTOR MARKED ASSIGNMENT

Identify the roles of lifestyle, health research and advent of new technology on changing patterns of health and illness.

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UNIT 3 THEORETICAL APPROACHES TO HEALTH AND ILLNESS BEHAVIOUR

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1.0 Introduction
2.0 Objectives
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        3.1.1 Social Learning Model
        3.1.2 Fishbein's Theory of Reasoned Action
        3.1.3 The Health Belief Model
    3.2 Attribution Model
    3.3 The Health Perception Approach
    3.4 Social Network/Social Support Theories
    3.5 Naturalistic Viewpoint
4.0 Conclusion
5.0 Summary
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1.0 INTRODUCTION

All theories of health and illness serve to create a context of meaning within which the patient can make sense of his or her bodily experience. A meaningful context for illness usually reflects core perceptual, social, and expectancy values, and allows the patient to bring order to the chaotic world of serious illness and to regain some sense of control in a frightening situation. The following are models that would broaden our conception of health and illness behaviour.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Describe Expectancy-Value Model as well as its 3 main approaches
- Discuss the role of Attribution Model of health and illness perception
- Determine the influence of Health Perception Model on illness and health seeking behaviours.
- Discuss the social network/social support theory
- Describe the views of Naturalistic Model of illness perception and causation.

3.0 MAIN CONTENT

3.1 Expectancy-Value Model

Many models of health and illness behaviour are based upon an expectance-value approach to motivation. This asserts that individuals are motivated to maximize gains and minimize losses. Behavioural choice and persistence are a function of the expected success of the behaviour in attaining a goal and the value of the goal. Below are three models based on this approach:

3.1.1 Social Learning Theory

Rotters's Social Learning Theory posits that: 'the potential for behaviour to occur in any specific situation is a function of the expectancy that the behaviour will lead to a particular reinforcement in that situation and the value of that outcome' (Rotter, 1954). Thus, a sick person is likely to take a day or two off from work if he or she expects to be pampered by worried relatives and vice versa. One generalized expectancy in particular – locus of control – has been the focus of much work. Locus of control is the generalized expectancy that whether one's own behaviour or forces external to oneself controls reinforcement. Starting with Rotter's Scale, measuring generalized expectancies on one dimension (Rotter, 1966), locus of control has been expanded to include three orthogonal dimensions (internal; powerful and chance: (Levenson, 1973).

Locus of control can be measured as a general expectancy or an expectancy specific to a particular situation. Strickland (1978) therefore suggests that in a novel or ambiguous situation an individual's behaviour is predictable from generalized expectancies.

Also, the concept of health as a value has been neglected in health research. It is frequently assumed that the value placed on health is uniformly high. The most common method of measuring health is based on Rockeach's terminal value ranking test (1973), for which respondents are asked to assess the value of health relative to such items as: a comfortable life, world peace, happiness and health.

3.1.2 Fishbein's Theory of Reasoned Action

This theory is based on the assumption that most human behaviour is under voluntary control and hence is largely guided by intention. Intention is determined by both the individual's attitude towards performing the behaviour and their subjective norms, i.e. their

perception of the degree to which significant others think performing the behaviour is important (Fishbein and Ajzen, 1975).

The attitude component is the product of the beliefs (expectations) that performing a specific behaviour will lead to a certain consequence, and the individual's valuation of that consequence (i.e., how good or bad such an outcome would be). The subjective normative component of the model also incorporates an expectancy and value component. It is the product of the expectation that important others will consider the performance of the behaviour important and the value of that person's approval. This theory thus considers both the individual's attitude towards a behaviour as well as the influence of social environment as important predictors of behavioural intention. The relative contribution of the two components of the model will in part depend on the behaviour in question. For example, a pregnant woman is likely to go through the pain and rigors of pregnancy because of the value and the joy that a new baby brings.

3.1.3 The Health Belief Model

The Health Belief Model (HBM), unlike the previous theories was developed to explain and predict behaviour in health context (Becker, 1974). While originally developed to predict preventive health behaviours, the model has also been used to predict behaviour of both acute and chronically ill patients. The likelihood of an individual undertaking a particular action is seen as a function of the individual's perception of:

- Their susceptibility to the illness
- The seriousness of the illness
- The potential benefit and costs involved in undertaking the particular action.

Cues to action, which may be internal (such as the perception of a symptom) or external (such as health education message) will determine whether behaviour is performed. However, the precise way in which the variable combine to predict behaviour is unclear. Stone (1990) suggests that the HBM makes relative rather than quantitative predictions.

SELF ASSESSMENT EXERCISE

i. Identify the three models categorized under the expectancy value principles.
ii. Give a brief description of each.

Answer to Exercise

i. The Social Learning theory, Fishbein's Theory of Reasoned Action and The Health Belief Model.

- Rotters's Social Learning Theory posits that: 'the potential for a behaviour to occur in any specific situation is a function of the expectancy that the behaviour will lead to a particular reinforcement in that situation and the value of that outcome'.

- Fishbein's Theory of Reasoned Action is based on the assumption that most human behaviour is under voluntary control and hence is largely guided by intention. Intention is determined by both the individual's attitude towards performing the behaviour and their subjective norms, i.e. their perception of the degree to which significant others think performing the behaviour is important.

- The Health Belief Model (HBM), unlike the two previous theories was developed to explain and predict behaviour in health context. The likelihood of an individual undertaking a particular action is seen as a function of the individual's perception of: their susceptibility to the illness, the seriousness of the illness and the potential benefit and costs involved in undertaking the particular action.

I hope you enjoyed these exercises. Now let us focus on other models that could also broaden our understanding of illness and health.

3.2 Attribution Model

Attribution Model is concerned with the way people explain events (Kelly and Michela, 1980). It deals with causes that individuals infer from outcomes that have occurred in the past. By contrast, Social Learning Theory deals with expectancies about the future. However, the distinction between attribution of causes of past events and perceived control over a future situation has been made by Brickman et al. (1983). They treat judgement about the cause of a problem as separate from judgement about solutions to the problem. Hence in a health-related

context, attributions concerning the origin of an illness will not necessarily be the same as attributions concerning its treatment or course.

3.3 The Health Perception Approach

This view is based on the notion that illness related to behaviours result from a series of decisions based on how patients view their current health situations (Garrity and Lawson, 1989). Therefore, a patient's understanding of his or her clinical status is seen as equally important as actual physical status in determining behavioural health outcomes such as return to work and resumption of activities. Patient's mood and behaviour concerning their illness are seen as resulting from what they believe about how severe their disorder is, and, within the limits of the patient's actual physical disability, recovery is bound to health perceptions.

3.4 Social Networks/Social Support Theories

Most health educators today recognize the critical importance of the social environment and advocate changes in the social ecology which is supportive of individual change leading to better health and a higher quality of life. However, within the community, long-term behavior change depends on the level of participation and ownership felt by those being served. In order to see how Social Networks and Social Support Theories might impact on health needs, it is thus necessary to define what is meant by certain concepts.

Social networks can be kin (extended family) or non-kin (church or work groups, friends or neighbours who regularly socialize in clubs and sporting teams). Social networks have certain types of characteristics:

(1) *Structural*, such as size (number of people) and *density* (extent to which members really know one another);
(2) *Interactional*, which include reciprocity (mutual sharing), *durability* (length of time in relationship), intensity (frequency of interactions between members), and dispersion (ease with which members can contact each other); and
(3) *Functional*, such as providing social support, connections to social contacts and resources, and maintenance of social identity.

Social support refers to the varying types of aid that are given to members of a social network. Research indicates that there are four kinds of supportive behaviors or acts:

(1) Emotional support - listening, showing trust and concern;

(2) Instrumental support - offering real aid in the form of labor, money, time;
(3) Informational support - providing advice, suggestions, directives, referrals; and
(4) Appraisal support -affirming each other and giving feedback. This social support is given and received through the individual's social network. However, it is important to remember that "some or all network ties may or may not be supportive."

3.5 Naturalistic Model

In naturalistic causation, illness is explained in impersonal terms. When the body is in balance with the natural environment, a state of health prevails. However, when that balance is disturbed, illness results. Often, people invoke both types of causation in explaining an episode of illness, and treatment may entail two corresponding types of therapy.
Naturalistic theories of disease causation tend to view health as a state of harmony between a human being and his or her environment; when this balance is upset, illness will result.

4.0 CONCLUSION

As we have seen, theories about health and illness deal with ideas people use to maintain a healthy state.

Such ideas spanned from perceptual, social and expectancy values. Expectancy-Value Approach looked at motivation and health/illness behaviour. Thus, the Social Learning perspective is of the notion that the potential for an illness or health beahviour is a function of expectancy that the behaviour will lead to a particular reinforcement. The Feinbein's Theory of Reason Action is also based on the assumption that most human behaviour – health/illness behaviour is under voluntary control and hence largely guided by intentions. For the Health Belief Model, its approaches and principles are based on how individuals predict and behave in health context. Also, attribution theory is concerned with how individuals explain events. To Health Perception Approach, health/illness related behaviour results from a series of decisions based on how patients view their current health status, while the naturalistic model saw illness as resulting from imbalance between the nature and the body. Lastly, the social support view, looked at the varying types of aid that are given to members of a social network.

5.0 SUMMARY

This unit highlighted different theoretical perspectives to health/illness and thus provided insights and understanding of health/illness

behaviour. It first looked at the Expectancy-Value Models of illness; secondly, it looked at the role of attribution and health perception on illness perceptions. Finally, it analyzed the naturalistic viewpoints to illness causation. I hope you found this unit interesting. Now let us do some exercises.

6.0 TUTOR MARKED ASSIGNMENT

Identify the views of the following models of health/illness

- The Naturalistic model of Illness
- The Health Perception model
- Attribution model
- The Social support theory 

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MODULE 4 ATTITUDE CHANGE AND SPECIFIC HEALTH BEHAVIOUR PROBLEMS

Unit 1 Preventive Health Behaviour
Unit 2 Attitude Change and Health Promotion
Unit 3 Addressing Specific Health Behaviour Problems

UNIT 1 PREVENTIVE HEALTH BEHAVIOUR

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
  3.1 Understanding Preventive Health Behaviour
  3.2 Determinants of Preventive Health Behaviour
  3.3 Major Trends in Preventive Health Behaviour
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

In the developed and other developing countries, premature death and disability results mainly from chronic diseases such as heart disease, stroke, cancer, injury, chronic obstructive pulmonary disease, arthritis, e.t.c. Many of these illnesses have been characterized as resulting largely from "accumulated, multiple indiscretions" (Westberg and Jason 1996, p. 145) and linked to habitual, and sometimes harmful, ways of living. It follows that considerable morbidity and premature mortality could be reduced if individuals practiced certain preventive health behaviors. Such preventive health behaviours will be discussed in this unit

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Describe preventive health behaviour
- Identify the determinants of preventive health behaviour
- Illustrate the major trends in preventive health behaviours

3.0 MAIN CONTENT

3.1 Understanding Preventive Health Behaviour

There is no one theory or concept that explains why people perform certain behaviors. Many theories have been developed to describe, understand, explain, and influence health-related behavior. Although these theories contribute substantially to our understanding of individual behavior, they are often limited because the broader social and environmental context in which an individual lives is not taken into account. It is becoming increasingly recognized that individual unhealthful behaviors reflect the social, cultural, and environmental contexts within which they occur.

Theories, that assist our understanding of preventive health behaviors, can be divided into three categories:

1. Theories that describe the health behavior and behavior change of individuals. Commonly used theories include the health belief model; the theory of reasoned action; the trans-theoretical (or stages of change) model; and social cognitive theory (Pronchaska and DiClemente, 1984; Strecher and Rosenstock, 1997; Rogers, 1983; Bandura, 1986).

2. Theories that describe the behavior of communities and environmental changes, such as the diffusion of innovation theory and the communication-behavior change model (McGuire, 1989).

3. Theories that help people understand different approaches to societal change, such as community organization theories (Ajzen and Fishbein, 1980).

These and other theories help to explain "why we do what we do when we do it." Their common thread is the belief that if a person performs a health-related behavior, the chances of acquiring a disease or an illness will decrease.

Preventive health behavior generally follows from a belief that such behavior will benefit health. An obvious example is quitting smoking to reduce the chances of early morbidity and mortality. It does not follow, of course, that all beliefs on which preventive behaviors are based are well founded, nor that the resulting behaviors will have the desired outcomes. Many preventive behaviors have never been demonstrated to be effective, such as megadoses of vitamin C to prevent the common cold.

Preventive actions can reduce, but not eliminate, the chances of acquiring a disease or illness. The strength of the cause and effect relationship between a certain behavior and the health problem one is trying to prevent will determine the impact performing the behavior will have on reducing the risk. This impact is measured in terms of attributable risk. Attributable risk is a measure of the chance of acquiring a disease if the risk factors for it are eliminated or preventive health behavior is engaged in. The chances are influenced by the relationship of the preventive behavior to the etiology of the disease. Most people are aware that if you smoke you have an increased risk of getting lung cancer. Data indicate that almost 90 percent of lung cancer cases in males and 79 percent in females can be attributed to smoking, according to the Office on Smoking and Health. Some people who do not smoke get lung cancer, of course, but the numbers are small. Similarly, wearing a seat belt reduces the chance of dying in an automobile crash, yet it does not guarantee that the individual involved will not be seriously hurt.

SELF ASSESSMENT EXERCISE

What do you understand by preventive health behaviour?

Answer to Exercise

Preventive health behavior generally follows from a belief that certain health behavior will benefit health. An obvious example is quitting smoking to reduce the chances of early morbidity and mortality or exercising for stronger cadiovascular muscles and good health. There is no one theory or concept that explains why people perform certain behaviors. Many theories have been developed to describe, understand, explain, and influence health-related behavior. Although these theories contribute substantially to our understanding of individual behavior, they are often limited because the broader social and environmental context in which an individual lives is not taken into account. It is becoming increasingly recognized that individual unhealthful behaviors reflect the social, cultural, and environmental contexts within which they occur.

3.2 Determinants of Preventive Health Behaviour

Although individual actions contribute to a person's health behavior, preventive health behavior is not totally volitional. Socio-cultural and environmental aspects of a person's life influence preventive health behavior, and these factors can have minimal to great effect in determining whether a preventive health behavior is performed.

- Some preventive health-related behaviors occur for reasons unrelated to health. Cultural traditions, attitudes, and beliefs can play an important role in the ways in which people behave. In Mediterranean countries, the traditional diet has been found to be an important preventive diet. The traditional meal is often cooked in olive oil, which may help in preventing heart disease.

- Social, economic, and cultural determinants of behaviors are closely linked. For many years it was unfashionable for women to smoke cigarettes. In the decades since this taboo was removed, there have been substantial gender-related changes in the overall burden of smoking-related diseases. Between 1981 and 1996 the per-person mortality burden of smoking-related diseases such as lung cancer and chronic obstructive pulmonary disease decreased by 15 percent and 16 percent, respectively, for males, but increased by 62 percent and 70 percent for females. Currently, 24.2 percent of adult men and 20.9 percent of adult women smoke cigarettes, according to the Centers for Disease Control and Prevention (CDC).

- Preventive health-related behaviors are also undertaken specifically to improve or enhance health. These types of behavior include both primary prevention and early detection. Primary prevention behaviors aim to prevent the incidence of disease (the number of new cases occurring within a given time frame). Exercise to improve aerobic fitness and prevent cardiovascular disease is an example of a primary preventive behavior. People who increase their levels of physical activity have been found to have reduced levels of risk factors such as high blood pressure, high blood cholesterol, and excess body fat. Early detection (or secondary prevention) behaviors aim to prevent early forms of disease from progressing. This involves people who have already developed preclinical disease or risk factors for disease but in whom the disease has not yet become clinically apparent. Behaviors such as having a breast screen (mammogram) or a pap test for cervical cancer are intended to detect disease early so it can be treated promptly (Westbeng and Janson, 1996).

- Some preventive health-related behaviors may, or may not, improve health outcomes. It is becoming increasingly common for people to use a range of complementary and alternative medicines to improve their health. The 1995 Australian National Health Survey estimated that almost 26 percent of the population used vitamin or mineral supplements, and over 9 percent used herbal or natural medications. Females used these therapies more

than males. These behaviors are undertaken with the hope of improving health without clear evidence that the practice has beneficial effects for individuals or populations.

3.3 Major Trends in Preventive Health Behaviour

Despite the general good health of people in developed and developing countries, there is still considerable scope for improvement in preventive health behaviors. Unfortunately, the last years of the twentieth century and early twenty first century saw only modest improvements in this area.

The number of people using seat belts has improved due to several sensitization programmes. This period also saw a reduction in the number of people reporting driving while over the blood alcohol limit and a reduction in alcohol-related motor vehicle deaths. Also, economic hardship in some countries may have stopped many from drinking excessively.

In African countries, society frowns at women that smokes so cases of lung cancer is not very common among this group, though, the younger generation appears to be smoking more than the older ones.

Although there is a strong association between dietary behavior and many chronic illnesses, there has been little change in terms of people following dietary guidelines or eating fresh fruits and vegetables. Obesity has continued to increase, with no real change in physical activity.

4.0 CONCLUSION

It is clear that individual preventive behaviors such as eating healthy, exercising regularly, moderation in the use of alcohol and the avoidance of tobacco and tobacco products can contribute greatly to a person's health. However, preventive health behavior is but one element within a complex range of influences on health. Biological, social, environmental, and economic factors also play a role. Together these influence the health outcomes for individuals as well as for populations.

5.0 SUMMARY

I hope you enjoyed reading through this unit. In this unit, we looked at the concept of preventive health behaviour, its determinants as well as major trends in preventive health behaviours. Now let us attempt the following questions presented below.

6.0 TUTOR MARKED ASSIGNMENT

Describe the determinants of preventive health behaviour

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UNIT 2 ATTITUDE CHANGE AND HEALTH PROMOTION

CONTENTS

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    3.1.1 Information Appeals
    3.1.2 Persuasion
      3.1.2.1 Key factors in Persuasion
    3.1.3 Fear Appeal
    3.1.4 Mass Media Appeal
    3.1.5 Self help Groups
  3.2 Health Promotion in the schools
  3.3 Health Promotion in the work place
  3.4 Health Promotion in the communities
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
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1.0 INTRODUCTION

How can we encourage healthy living? One way is through changing people's attitudes and beliefs. As noted earlier, two of the major Theoretical approaches to healthy behaviour: the health belief model and the theory of reasoned action emphasize belief and attitude as determinants of people's health practices. Both theories also argued for changes in attitude and belief as prerequisites for changes in health behaviour. Thus, according to HBM, promoting positive health behaviours requires that we persuade people that they are susceptible to given diseases such as AIDS, Cancer or heart disease and there are effective ways of preventing these illnesses. Alternatively, the TRA argues that attempts to change health behaviours need to produce change in people's attitudes towards behaviours such as smoking cessation and exercise, as well as convince people that such behavioural changes will be viewed positively by others.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Identify and discuss the principles used to promote attitude change and positive health behaviour.
- Discuss the goals of health promotion in schools, workplaces and communities.

3.0 MAIN CONTENT

3.1 Principles Used to Promote Attitude Change and Positive Health Behaviour

How can we go about promoting these attitude changes? This question has been the focus of great deal of research among health professionals. Beginning in the 1950's, many studies have examined in great detail how people respond to persuation attempts and the process involved. From these researches have come principles that can be used to promote attitudes and beliefs conducive to good health behaviour (Bishop, 1994). The following are some of the principles identified:

3.1.1 Information Appeals

Promoting good health behaviour requires that people be aware of the connections between behaviour and health and know what is involved in healthy behaviour. For example, motivating people to eat a balanced and healthy diet or engage in more physical exercise demands that they be aware of the role of diet and exercise in health and realize their importance. So, a necessary step in changing health behaviour is providing people with information to guide their actions.

This is a simple enough proposition, but there is more to information appeal than simply providing the information. Bringing about changes in behaviour through information appeals involves at least five different processes. (McGiure, 1969). They are:

We need to *get the audience attention*: This is no mean feat, considering the amount of information that people are constantly bombarded with. Once a message is received, the next step is *comprehension*. For a message to be comprehensive, it must be presented in terms that are understandable to the audience and that fit their conceptions of health and illness. Assuming the message is understood by the audience, the third step in persuasion is *yielding*, that is, accepting the position advocated by the message. For information to have a long-term effect there must also be message *retention*, and finally, *action* in which the person's behaviour changes to become healthier.

3.1.2 Persuasion

How can we facilitate these processes and increase the likelihood that health information will be effective in changing health behaviour? Studies of persuasion have identified key factors in persuasion. They are:

3.1.2.1 Key Factors in Persuasion

- First, the effectiveness of a message often depends on who presents it. It is clearly advantageous for a message to be delivered by a communicator who is perceived as an expert or trustworthy. For health messages, physicians and other health professionals are ideal communicators, especially when they are well known and prestigious. Also, traditional rulers, religious heads, non-governmental organizations, parents, etc. could also act as communicators of health messages, especially in the area of HIV/AIDS and safe sex.
- Secondly, messages are more likely to be accepted when they are presented by communicators who are attractive (Chaiken, 1979), confident in their delivery and perceived as similar to the audience. For example, information on female genital mutilation or Vesco Vaginal Fistula is more likely to be accepted when presented by a female health worker or the head of an NGO working in that area than the opposite.

3.1.3 Fear Appeal

One of the more common approaches to attitude change is to try to motivate change in behaviour through the use of fear. The idea is that people will be more likely to accept a message and change their behaviours if their fears and apprehension are appealed to. Such an approach is particularly relevant to health behaviour since the objective of changing health behaviour is to avoid future disease and disability. Thus the message often has a built-in component of fear (Bishop, 1994). For example, recent efforts aimed at encouraging ‘safe sex’ are designed to convince people to change their sexual behaviour so as to avoid the threat of AIDS. Given the fear of AIDS, such messages are implicitly, if not explicitly, designed to motivate behaviour change through arousing fear. Similarly, efforts to persuade people to stop smoking are often based on appealing to their fear of cancer and heart diseases.

3.1.4 Mass Media Appeal

Another means of influencing people's attitudes and health behaviour that would seem promising is through the mass media. In modern technological societies, there are few people who are not touched in one way or another by television, radio, newspaper and other mass media. Overall, the primary value of mass media appeals lies in their cumulative effects. Although, individual media messages and campaigns may have relatively weak effects, the summation of multiple messages over time can be quite impressive. A good example is the daily and consistent campaign against HIV/AIDS infection, thus reducing the statistics of HIV/AIDS in most countries.

3.1.5 Self-Help Groups

The discussion above considers programmes that rely on professionals to assist in bringing about behaviour change. What about programmes in which people with problem health behaviours help themselves and others with similar problems. Interest in self-help groups for a variety of problems, including chronic ailments like HIV/AIDS, Cancer, Alcoholism, weight problems, physical deformities, etc, have dramatically increased in recent years. All these groups are based on the idea that no one is better able to help another with a problem than someone who has experienced or is experiencing the problem first hand. Further, by helping others, the helper is also helped. This is what Alan Gartner and Frank Riessman (1984), called the 'helper therapy principle'. Groups play a critical role of providing its members with support, reinforcement, sanction and feedback. Thus, it enhances the power of the individual members to deal with the problem.

SELF ASSESSMENT EXERCISE

Identify the principles used to promote attitude change and positive health behaviour

Answer to Exercise

- Fear Appeal
- Persuasion
- Information Appeal
- The Mass Media
- Self Help Group

3.2 Health Promotion in the Schools

By their nature, schools provide an ideal setting for promoting positive health behaviour. Childhood is the time when many lifelong behaviour patterns are being formed, and the amount of time children spend in the classroom makes school settings attractive as an intervention site. Thus many have called for comprehensive health education in schools because it is believed that such programmes would help children understand personal and societal health issues. It will also increase their competency to make informed decisions about health behaviours that effect health.

3.3 Health Promotion in the Work Place

Whereas schools provide a seemingly ideal location for promoting health in children, the work place has considerable potentials for encouraging good health habits in adults. Working adults spend a great deal of time at their places of work. Thus, the work place has a large captive audience that can potentially be influenced to adopt positive health habits. From an employee's point of view, there are some economic and humanitarian reasons for promoting healthy living. It is evident that the annual cost of treating preventable diseases runs into millions of Naira or Dollars, including the direct cost of disease treatment and indirect costs from lost productivity, absenteeism, and employee turnover.

Recent years have witnessed a veritable explosion of health promotion programmes in the work place. Programmes range in size from few lectures on health topics such as stress management, nutrition, exercise, to extensive programmes involving large, well-staffed exercise and health facilities.

3.4 Health Promotion in the Communities

Several of the approaches already described have been aimed at specific segments of the population such as school children and adult employees, what about health promotion programmes that target entire communities? Might there be advantages to developing programmes that can be applied across the board to everyone living in a particular area? The answer is clearly yes. Stephen Weiss (1984) points out several advantages for community-based prevention programmes.

Such programmes use prevention methods that apply to the environments in which people live. One problem with programmes limited to the clinic, schools or work place is that person's behaviour might be effectively changed in that setting, but the change may not

generalize to other environments. Because members of the target population all live in the same community, community-based programmes enhance opportunities for information exchange and social support among programme participants. Further, because of their scale, community-based programmes can minimize the per capital cost.

By their nature, community based interventions are complex undertakings. To be comprehensive and effective, such programme typically involves multi channels such as mass media campaigns, work place programmes, health education programmes in the schools, physician appeals and face-to-face counseling (Puska, 1984)

4.0 CONCLUSION

Does changing attitudes change health behaviour? Studies of persuasion demonstrate convincingly that people's attitudes can be changed through information and fear appeals. Although this is encouraging and provides us with an important first step, it is only a first step. For attitude change to promote good health, the changes must not be only in attitude, but in behaviour also. Thus, our interest in attitude change is predicated on the assumption that changes in attitudes will be reflected in people's behaviour.

5.0 SUMMARY

In this unit, we looked at basic principles employed to promote attitude change and positive health behaviour. We further discussed issues of health promotion in schools, work place and the communities. We hope you enjoyed this unit. Now let us attempt the questions below.

6.0 TUTOR MARKED ASSIGNMENT

1. Discuss the principles used to promote attitude change and positive health behaviour
2. Briefly discuss health promotions in school, workplace and communities.

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UNIT 3 ADDRESSING SPECIFIC HEALTH BEHAVIOUR PROBLEMS

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1.0 INTRODUCTION

So far, we have considered the processes that determine people's health behaviour and some of the basic techniques available for influencing those behaviours. We are now ready to take up applications of these principles to specific health problems. The unit thus considers alcohol abuse, obesity, and HIV/AIDS which forms one of the main products of risky sexual behaviours. These 3 specific health problems form just a small sample of the very many health behaviour problems.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Describe alcohol abuse and its health implications
- Identify causes of alcohol abuse
- Describe obesity and its causes
- Discuss in detail, the symptoms and causes of HIV/AIDS

3.0 MAIN CONTENT

3.1 Alcohol Abuse

Data on consumption of alcoholic beverages indicate that the use and abuse of alcohol is widespread throughout the world. Alcohol consumption differs significantly between countries, but all countries have at least some individuals who drink to excess. Along with tobacco, alcohol consumption is a major source of disease and death. Although some evidence indicates that the consumption of moderate amounts of alcohol may, in fact, be beneficial to one's health, the extended heavy drinking of alcohol and the consumption of alcohol under certain circumstances can produce serious health effects, including cirrhosis of the liver, gastrointestinal problems, lung disease, and neurological problems. Among the latter is the Wermick-Korsakoff Syndrome, a psychotic condition characterized by severe memory deficits and confusion, as well as visual and movement difficulties. One of the most heart wrenching effects of alcohol use is the Fetal Alcohol Symdrome (FAS), in which the consumption of alcohol by a woman during pregnancy can lead to serious health problems of the child, including growth deficiencies, central nervous system difficulties, facial abnormalities and mental retardation (Benzer, 1987).

In addition to the direct medical complications of alcohol use, the consumption of alcohol also has many indirect effects. For example, a good number of traffic accidents, suicides and homicides could be attributed to alcohol related habits. Also, the abuse of alcohol could cost a country a huge amount of money, as indirect cost of treatment, crime and vehicular accidents.

3.1.1 What causes Alcoholism?

Alcoholism generally refers to alcohol consumption that is compulsive, addictive or habitual and results in serious threat to a person's health and well-being.

What is it that leads to alcoholism and why are some people able to consume alcohol in moderate quantities while others become alcoholics?

The causes of alcoholism have been widely debated for a long time. Probably the most popular theory is that alcoholism is a disease (Gitlow, 1973, Jellinek, 1960). According to this model, the alcoholic sometimes differ from others who consume alcohol. Although most people can control their drinking, the alcoholic cannot. After a drink or two, an alcoholic experiences a physiological addictive response triggered by the alcohol consumed, which leads to an irresistible craving for more alcohol. The person is then unable to stop drinking until intoxication occurs or the person runs out of alcohol drinks.

Despite its popularity, the disease model was seriously criticized by several alcoholism researchers (Marlatt, 1979, Peele, 1984). Among the criticisms are that the disease model does not address why people drink or adequately describe the process by which a person becomes an alcoholic. Further, it does not explain how it is that many problem drinkers cease their problem drinking without treatment or account for alcoholics who learn to drink in a controlled manner (Peele, 1984).

Whereas the disease model seeks the causes of alcoholism in the biological makeup of the person, the social learning model looks to the social environment. According to this model, alcoholism is a learned addictive behaviour that can be unlearned. Several studies have also provided evidence that drinking patterns are related to the person's social environment. For example, parent drinking and drinking by peers are significantly related to onset of drinking habit in adolescents (Monti, Abrams, Kadden and Cooney, 1989). In addition, the amount that a person drinks in a particular situation can be significantly influenced by the drinking behaviour of a model (parents, friends). Beyond this, there is also evidence that the likelihood of becoming an alcoholic is increased if the person has a history of deviant behaviour and lacks the social skills for dealing with distressed situation (Zucker and Golberg, 1986).

SELF ASSESSMENT EXERCISE

i. What is Alcoholism?
ii. What are the direct and indirect effects of alcohol abuse?

Answer to Exercise

i. Alcoholism generally refers to alcohol consumption that is compulsive, addictive or habitual and results in serious threat to a person's health and well-being.
ii. The direct causes of alcohol abuse include cirrhosis of the liver, gastrointestinal problems, lung disease, and neurological problems. Among the latter is the Wermick-Korsakoff Syndrome, a psychotic condition characterized by severe memory deficits and confusion, as well as visual and movement difficulties. One of the most heart wrenching effects of alcohol use is the Fetal Alcohol Symdrome (FAS), in which the consumption of alcohol by a woman during pregnancy can lead to serious health problems of the child, including growth deficiencies, central nervous system difficulties, facial abnormalities and mental retardation
    - Indirect causes of alcohol abuse are traffic accidents, homicides, child or marital abuse, suicide, absenteeism, etc.

I hope you found this exercise helpful. Now let us continue with the rest of the unit.

3.2 Obesity

Obesity is a condition in which the natural energy reserve, stored in the fatty tissue of humans and other mammals, is increased to a point where it is associated with certain health conditions or increased mortality. Obesity is both an individual and clinical condition and is increasingly viewed as a serious public health problem. Excessive body weight has been shown to predispose to various diseases, particularly cardiovascular diseases, diabetes mellitus type 2, sleep apnea, and osteoarthritis

Obesity, especially central obesity (male-type or waist-predominant obesity), is an important risk factor for the "metabolic syndrome" ("syndrome X"), the clustering of a number of diseases and risk factors that heavily predispose for cardiovascular disease. These are diabetes mellitus type 2, high blood pressure, high blood cholesterol, and triglyceride levels (combined hyperlipidemia). An inflammatory state is present, which — together with the above — has been implicated in the high prevalence of atherosclerosis (fatty lumps in the arterial wall), and a prothrombotic state may further worsen cardiovascular risk (Powdemaker, 1997).

Apart from the metabolic syndrome, obesity is also correlated (in population studies) with a variety of other complications. For many of these complaints, it has not been clearly established to what extent they are caused directly by obesity itself, or have some other cause (such as limited exercise) that causes obesity as well. Most confidence in a direct cause is given to the mechanical complications in the following list:

- *Cardiovascular*: congestive heart failure, enlarged heart and its associated arrhythmias and dizziness, cor pulmonale, varicose veins, and pulmonary embolism.
- *Endocrine*: polycystic ovarian syndrome (PCOS), menstrual disorders, and infertility.
- *Gastrointestinal*: gastroesophageal reflux disease (GERD), fatty liver disease, cholelithiasis (gallstones), hernia, and colorectal cancer.
- *Renal and genitourinary*: erectile dysfunction, (Esposito et al, 2004), urinary incontinence, chronic renal failure, (Ejerblad, et al, 2006), hypogonadism (male), breast cancer (female), uterine cancer (female), stillbirth.
- *Integument* (skin and appendages): stretch marks, acanthosis nigricans, lymphedema, cellulitis, carbuncles, intertrigo

- *Musculoskeletal*: hyperuricemia (which predisposes to gout), immobility, osteoarthritis, low back pain
- *Neurologic*: stroke, meralgia paresthetica, headache, carpal tunnel syndrome, dementia (Whitmer et al, 2005).
- *Respiratory*: dyspnea, obstructive sleep apnea, hypoventilation syndrome, pickwickian syndrome, asthma
- *Psychological*: Depression, low self esteem, body dysmorphic disorder, social stigmatization

While being severely obese has many health ramifications, those who are somewhat overweight face little increased mortality or morbidity. Some studies suggest that the somewhat "overweight" tend to live longer than those at their "ideal" weight (Giugliano, Di Palo, Giugliano, Marfella, D'Andrea, D'Armiento and Giugliano, 2004). This may in part be attributable to lower mortality rates in diseases where death is either caused or contributed to by significant weight loss due to the greater risk of being underweight experienced by those in the ideal category. Another factor which may confound mortality data is smoking, since obese individuals are less likely to smoke (Giugliano, Di Palo, Giugliano, Marfella, D'Andrea, D'Armiento and Giugliano, 2004).

3.2.1 Causes of Obesity

Overeating

In its simplest conception, obesity is only made possible when the lifetime energy intake exceeds lifetime energy expenditure by more than it does for individuals of "normal weight". When food energy intake exceeds energy expenditure, fat cells (and to a lesser extent muscle and liver cells) throughout the body take in the energy and store it as fat.

Additional factors

Factors that have been suggested to contribute to the development of obesity include:

- Genetic factors and some genetic disorders (e.g., Prader-Willi syndrome)
- Underlying illness (e.g., hypothyroidism)
- Eating disorders (e.g., binge eating disorder)
- Certain medications (e.g., atypical antipsychotics, some fertility medication)
- Sedentary lifestyle
- A high glycemic diet (i.e., a diet that consists of meals that give high postprandial blood sugar)

- Weight cycling, caused by repeated attempts to lose weight by dieting.

As with many medical conditions, the caloric imbalance that results in obesity often develops from a combination of genetic and environmental factors. Various genetic abnormalities that predispose to obesity have been identified (such as Prader-willi syndrome and leptin receptor mutations), but known single-locus mutations have been found in only about 5% of obese individuals. While it is thought that a large proportion of the causative genes are still to be identified, much obesity is likely the result of interactions between multiple genes, and non-genetic factors are likely also important (Giugliano, et al, 2004).

3.3 HIV/AIDS

Acquired immune deficiency syndrome or acquired immunodeficiency syndrome (AIDS) is a collection of symptoms and infections resulting from the specific damage to the immune system caused by the human immunodeficiency virus (HIV) (Marx (1982). The late stage of the condition leaves individuals prone to opportunistic infections and tumors. Although treatments for AIDS and HIV exist to slow the virus's progression, there is no known cure. HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid, preseminal fluid, and breast milk (Divisions of HIV/AIDS Prevention, 2003). This transmission can come in the form of anal, vaginal or oral sex, blood transfusion, contaminated hypodermic needles, exchange between mother and baby during pregnancy, childbirth, or breastfeeding, or other exposure to one of the above bodily fluids.

Most researchers believe that HIV originated in sub-Saharan Africa during the twentieth century (Gao, Bailes, Robertson, Chen, Rodenburg, Michael, Cummins, Arthur, Peeters, Shaw, Sharp, and Hahn, (1999). It is now a pandemic, with an estimated 38.6 million people now living with the disease worldwide (UNAIDS, 2006). As of January 2006, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimate that AIDS has killed more than 25 million people since it was first recognized on June 5, 1981, making it one of the most destructive epidemics in recorded history. In 2005 alone, AIDS claimed an estimated 2.4 to 3.3 million lives, of which more than 570,000 were children (UNAIDS, 2006). A third of these deaths are occurring in sub-Saharan Africa, retarding economic growth and destroying human capital. Antiretroviral treatment reduces both the mortality and the morbidity of HIV infection, but routine access to antiretroviral medication is not available in all countries (Palella, Delaney, Moorman, Loveless, Fuhrer, Satten, Aschman and Holmberg,

1998). HIV/AIDS stigma is more severe than that associated with other life-threatening conditions and extends beyond the disease itself to providers and even volunteers involved with the care of people living with HIV.

3.3.1 Causes of HIV/AIDS

The three main transmission routes of HIV are sexual contact, exposure to infected body fluids or tissues, and from mother to fetus or child during perinatal period. It is possible to find HIV in the saliva, tears, and urine of infected individuals, but there are no recorded cases of infection by these secretions, and the risk of infection is negligible.

3.3.1.1 Sexual contact

The majority of HIV infections are acquired through unprotected sexual relations between partners, one of whom has HIV. Sexual transmission occurs with the contact between sexual secretions of one partner with the rectal, genital or oral mucous membranes of another. Oral sex is not without its risks as HIV is transmissible through both insertive and receptive oral sex (Rothenberg, Scarlett, del Rio, Reznik, and O'Daniels (1998). The risk of HIV transmission from exposure to saliva is considerably smaller than the risk from exposure to semen; contrary to popular belief, one would have to swallow gallons of saliva from a carrier to run a significant risk of becoming infected (UNAIDS, 2001).

Sexually transmitted infections (STIs) increase the risk of HIV transmission and infection because they cause the disruption of the normal epithelial barrier by genital ulceration and/or microulceration; and by accumulation of pools of HIV-susceptible or HIV-infected cells (lymphocytes and macrophages) in semen and vaginal secretions. Epidemiological studies from sub-Saharan Africa, Europe and North America have suggested that there is approximately a four times greater risk of becoming infected with HIV in the presence of a genital ulcer such as those caused by syphilis and/or chancroid. There is also a significant increased risk in the presence of STIs such as gonorrhea, Chlamydial infection and trichomoniasis which cause local accumulations of lymphocytes and macrophages (Mastro, de Vincenzi 1996).

During a sexual act, only male or female condoms can reduce the chances of infection with HIV and other STDs and the chances of becoming pregnant. The best evidence to date indicates that typical condom use reduces the risk of heterosexual HIV transmission by approximately 80% over the long-term, though the benefit is likely to be higher if condoms are used correctly on every occasion (Mastro, de

Vincenzi 1996). The effective use of condoms and screening of blood transfusion in Africa and other countries, is credited with contributing to the lower rates of AIDS in these regions. Promoting condom use, however, has often proved controversial and difficult.

Many religious groups, most noticeably the Roman Catholic Church, have opposed the use of condoms on religious grounds, and have sometimes seen condom promotion as an affront to the promotion of marriage, monogamy and sexual morality. Defenders of the Catholic Church's role in AIDS and general STD prevention state that, while they may be against the use of contraception, they are strong advocates of abstinence outside marriage. This attitude is also found among some health care providers and policy makers in sub-Saharan African nations, where HIV and AIDS prevalence is extremely high. They also believe that the distribution and promotion of condoms is tantamount to promoting sex amongst the youth and sending the wrong message to uninfected individuals. However, no evidence has been produced that promotion of condom use increases sexual promiscuity, and abstinence-only programs have been unsuccessful both in changing sexual behavior and in reducing HIV transmission (UNAIDS, 2006).

The United States government and health organizations both endorse the *ABC Approach* to lower the risk of acquiring AIDS during sex:

> **Abstinence** or delay of sexual activity, especially for youth,
> **Being faithful**, especially for those in committed relationships,
> **Condom use**, for those who engage in risky behavior.

This approach has been very successful in Uganda, where HIV prevalence has decreased from 15% to 5%. However, more has been done than just this. As Edward Green, a Harvard medical anthropologist, put it:

> "*Uganda has pioneered approaches towards reducing stigma, bringing discussion of sexual behavior out into the open, involving HIV-infected people in public education, persuading individuals and couples to be tested and counseled, improving the status of women, involving religious organizations, enlisting traditional healers, and much more.*"

However, criticism of the ABC approach is widespread because a faithful partner of an unfaithful partner is at risk of contracting HIV and that discrimination against women and girls is so great that they are without voice in almost every area of their lives. Other programs and initiatives promote condom use more heavily. Condom use is an integral part of the *CNN Approach*. This is:

Condom use, for those who engage in risky behavior,
Needles, use clean ones,
Negotiating skills; negotiating safer sex with a partner and empowering women to make smart choices.

3.3.1.2 Exposure to infected body fluids

This transmission route is particularly relevant to intravenous drug users, hemophiliacs and recipients of blood transfusions and blood products. Sharing and reusing syringes contaminated with HIV-infected blood represents a major risk for infection with not only HIV, but also hepatitis B and hepatitis C. Needle sharing is the cause of one third of all new HIV-infections and 50% of hepatitis C infections in North America, China, and Eastern Europe. The risk of being infected with HIV from a single prick with a needle that has been used on an HIV-infected person is thought to be about 1 in 150. Post-exposure prophylaxis with anti-HIV drugs can further reduce that small risk (Gao, Bailes, Robertson, Chen, Rodenburg, Michael, Cummins, Arthur, Peeters, Shaw, Sharp, and Hahn, 1999). Health care workers (nurses, laboratory workers, doctors etc) are also concerned, although more rarely. This route can affect people who give and receive tattoos and piercings. Universal precautions are frequently not followed in both sub-Saharan Africa and much of Asia because of both a shortage of supplies and inadequate training. The WHO estimates that approximately 2.5% of all HIV infections in sub-Saharan Africa are transmitted through unsafe healthcare injections. Because of this, the United Nations General Assembly, supported by universal medical opinion on the matter, has urged the nations of the world to implement universal precautions to prevent HIV transmission in health care settings (UNAID, 2006)

The risk of transmitting HIV to blood transfusion recipients is extremely low in developed countries where improved donor selection and HIV screening is performed. However, according to the WHO, the overwhelming majority of the world's population does not have access to safe blood and "between 5% and 10% of HIV infections worldwide are transmitted through the transfusion of infected blood and blood products".

Medical workers who follow universal precautions or body-substance isolation, such as wearing latex gloves when giving injections and washing the hands frequently, can help prevent infection by HIV.

All AIDS-prevention organizations advise drug-users not to share needles and other material required to prepare and take drugs (including syringes, cotton balls, the spoons, water for diluting the drug, straws, crack pipes, etc). It is important that people use new or properly

sterilized needles for each injection. Information on cleaning needles using bleach is available from health care and addiction professionals and from needle exchanges. In some developed countries, clean needles are available free in some cities, at needle exchanges or safe injection sites. Additionally, many nations have decriminalized needle possession and made it possible to buy injection equipment from pharmacists without a prescription.

3.3.1.3 Mother-to-child transmission (MTCT)

The transmission of the virus from the mother to the child can occur *in utero* during the last weeks of pregnancy and at childbirth. In the absence of treatment, the transmission rate between the mother to the child during pregnancy, labor and delivery is 25%. However, when the mother has access to antiretroviral therapy and gives birth by caesarean section, the rate of transmission is just 1%. (Coovadia, 2004). A number of factors influence the risk of infection, particularly the viral load of the mother at birth (the higher the load, the higher the risk). Breastfeeding increases the risk of transmission by 10–15%. This risk depends on clinical factors and may vary according to the pattern and duration of breast-feeding.

Studies have shown that antiretroviral drugs, caesarean delivery and formula feeding reduce the chance of transmission of HIV from mother to child. Current recommendations state that when replacement feeding is acceptable, feasible, affordable, sustainable and safe, HIV-infected mothers should avoid breast-feeding their infant. However, if this is not the case, exclusive breast-feeding is recommended during the first months of life and discontinued as soon as possible (UNAIDS, 2006). In 2005, around 700,000 children under 15 contracted HIV, mainly through MTCT, with 630,000 of these infections occurring in Africa. Of the estimated 2.3 million [1.7–3.5 million] children currently living with HIV, 2 million (almost 90%) live in sub-Saharan Africa (UNAIDS, 2006).

Prevention strategies are well known in developed countries, however, recent epidemiological and behavioral studies in Europe and North America have suggested that a substantial minority of young people continue to engage in high-risk practices and that despite HIV/AIDS knowledge young people underestimate their own risk of becoming infected with HIV. However, transmission of HIV between intravenous drug users has clearly decreased, and HIV transmission by blood transfusion has become quite rare in developed countries.

4.0 CONCLUSION

This unit looked at 3 specific health problems – Alcohol abuse, obesity and HIV/AIDS. The health problems addressed here of course formed just a small sample of the very many health behaviour problems. This unit highlighted the meaning and causes of the alcohol abuse, obesity and HIV/AIDS as well its effects on health and well-being. For example, Acquired immune deficiency syndrome, (AIDS) was viewed as a collection of symptoms and infections resulting from the specific damage to the immune system caused by the human immunodeficiency virus (HIV). The late stage of the condition leaves individuals prone to opportunistic infections and tumors. Obesity was also seen as a condition in which the natural energy reserve, stored in the fatty tissue of humans and other mammals, is increased to a point where it is associated with certain health conditions or increased mortality. In this unit, alcoholism was conceptualized as alcohol consumption that is compulsive, addictive or habitual and results in serious threat to a person's health and well-being.

5.0 SUMMARY

I hope you enjoyed reading through this unit and also found the self assessment exercise very helpful. Now let us attempt the question below.

6.0 TUTOR MARKED ASSIGNMENT

1. Briefly discuss HIV/AIDS and its origin
2. Describe the modes of transmission of HIV/AIDS

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MODULE 5 CONCEPTUALIZING ILLNESS BEHAVIOUR

Unit 1 Defining Illness Behaviour
Unit 2 Symptom Experience
Unit 3 The Sick Role

UNIT 1 DEFINING ILLNESS BEHAVIOUR

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1.0 INTRODUCTION

So far, we have looked at health behaviours, its definitions, models, health habits, as well as some specific health problems. Health behaviour is a broad term that includes health behaviour and illness behaviour so we cannot conceptualize illness behaviour without having a broad view of health behaviour. By definition, health behaviour is viewed as any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end. Now, it is time to focus specifically on the term ‘illness behaviour’

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Define illness behaviour
- Identify variations of illness behaviour
- Illustrate stages of illness behaviour

3.0 MAIN CONTENT

3.1 Defining Illness Behaviour

The concept of illness behaviour was largely defined and adopted during the second half of the twentieth century. The notion of "illness behaviour" was advanced in 1960 to explain the process by which patients seek medical help or advice.

Definition 1: The concept 'illness behaviour' refers to the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes such pain, discomfort or other signs of organic malfunctioning. (Mechanic and Volkart, 1961).

On the surface, it may seem that the nature and severity of illness would be the sole determinant of an individual's response, and for very severe illnesses, this often is true. But many people fail to see the physician or go very late in the disease process despite the presence of serious symptoms, while many others see the physician routinely for trivial or minor complaints. Thus, these patterns suggest that illness behaviour is influenced by social and cultural factors in addition to physiological conditions.

Definition 2: The concept of illness behaviour is also concerned with the widely different ways that individuals behave in response to disease.

Definition 3: Broadly speaking, illness behaviour is any behaviour undertaken by an individual who feels ill to relieve that experience or to define the meaning of the illness experience.

Definition 4: The Sociologist, David Mechanic, also defined illness behaviour as 'the ways in which given symptoms may be differently perceived, evaluated and acted (or not acted) upon by different kinds of persons (Mechanic, 1962).

Definition 5: Illness behaviour includes all forms of reactions resulting from signs and symptoms of a disease. Examples include conscious inactivity, self-treatment, and seeking help from health professionals as well as from friends and family (Cockerham, 2003)

However, it is important to note that the study of illness behaviour is therefore the study of behaviour in its social context (which describes how people respond to their symptoms), rather than in relation to a physiological or pathological condition. Taking a Paracetamol, staying in bed, and visiting a doctor are all examples of illness behaviours which may be associated with malaria, and constitute the kinds of responses

which show large variations from individual to individual. The concept includes variations in the use of language as well as in motor and non-verbal behaviour and thus encompasses individual differences in the way people described and experience symptoms. We will look at different variations of illness behaviour, after attempting the following self assessment exercises.

Self Assessment Exercise

Define Illness Behaviour

Answer to Exercise

The concept 'illness behaviour' refers to the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes such pain, discomfort or other signs of organic malfunctioning. (Mechanic and Volkart, 1961).

The concept of illness behaviour is also concerned with the widely different ways that individuals behave in response to disease.

Broadly speaking, illness behaviour is any behaviour undertaken by an individual who feels ill to relieve that experience or to define the meaning of the illness experience.

The Sociologist, David Mechanic, also defined illness behaviour as 'the ways in which given symptoms may be differently perceived, evaluated and acted (or not acted) upon by different kinds of persons (Mechanic, 1962).

Illness behaviour includes all forms of reactions resulting from signs and symptoms of a disease. Examples include conscious inactivity, self-treatment, and seeking help from health professionals as well as from friends and family (Cockerham, 2003)

3.2 Variations of Illness Behaviour

Many studies (Cockerham, 2003; Weiss et al, 2005; Taylor, 2006; Suchman, 1965, etc.) have linked illness behaviour variation to:

- Ethnicity
- Education
- Family structure
- Social networks

Illness behaviour has also been shown to differ in terms of:

- Individual differences such as personality, age and sex
  Illness behaviour is also shown to be linked with:
- Health care coverage and insurance.
  However, much of the early work on illness behaviour was seen in the context of:
- Understanding patient help-seeking behaviour
  Also other research literature on illness behaviour has gone well beyond this more narrow medicalized view. Many studies have considered the different perspectives of illness behaviour held by individuals and health care practitioners.
- The differing worldviews of patients and practitioners are now seen as highly relevant to illness behaviour. The medical practitioner and the individual experiencing symptoms go through very different appraisals of the meaning of the symptoms.
  Increasingly in the literature there is the recognition of:
- The strong relationship between the physical and mental experience of symptoms and the meaning of that experience for illness behaviour.
  Similarly, it is also of the opinion that:
- Aspects of individual learning history have a marked influence on illness behaviour. This is because, different style of modeling and reinforcing illness behaviour such as avoiding work and chores produce differing responses to illness both in individuals who are normally well, and in those who are chronically ill.

From a review of the variations of illness behaviour provided above, you would realize that the study of illness behaviour is thus multifaceted. Though, we seem to have touched a good number of the variables identified earlier in previous units, and they also served the very important function of precursors to the study of illness behaviour. Now we are going to focus on more specific variables of illness behaviour. Let us look at the stages of illness behaviour.

3.3 Stages of Illness Behaviour

One approach that provides insight into the sequence of events that take place when a person is not healthy is Suchman (1965) description of the stages of illness experience. According to Suchman, when an individual perceives himself/herself to be sick, he or she can pass through as many as five different response stages, depending on their interpretation of the particular illness experience. The precise starting and ending point of each stage, however, is not always easy to determine since the different stages often overlap significantly. Furthermore, although illness behaviour may not involve all of the stages described by Suchman and can be terminated at any particular stage through denial, the significance

of this model is that each stage requires the sick person to take different kinds of decisions and actions. In evaluating the experience of illness, the sick person must therefore interpret not only his or her symptoms, but also what is necessary in terms of available resources, alternative behaviours and the probability of success.

In order to really have a very detailed overview of illness behaviour, Suchman (1965) devised an orderly approach for studying illness behaviour with his five key stages of illness experience. They are

1. Symptom Experience
2. Assumption of Sick Role
3. Medical Care Contact
4. Dependent Patient Role
5. Recovery and Rehabilitation Stage

Each stage involves major decisions that must be taken by the individual to determine whether the sequence of stages continues or the process is discontinued. Below is a diagrammatic representation of Suchman's stages of illness experience.

Table 1 : Suchman's Stages Of Illness Experience[4,5]

	I Symptom experience	II Assumption of the sick role	III Medical care contact	IV Dependent-patient role	V Recovery and rehabilitation
Decision	Something is wrong	Relinquish normal roles	Seek professional advice	Accept professional treatment	Relinquish sick role
Behaviours	Application of folk medicine, self-medication	Request professional validation for sick role from members of lay referral system –continue lay remedies	Seek authoritative legitimation for sick role – negotiate treatment procedures	Undergo treatment procedures for illness – follow regimen	Resume normal roles
Outcomes	Denial (flight into health) → Delay → Acceptance	Denial → Acceptance	Denial → Shopping → Confirmation	Rejection → Secondary gain → Acceptance	Refusal (chronic sick role) → Malingerer → Acceptance

Note: These stages of illness behaviour/experience will be comprehensively elaborated in the subsequent units and modules.

4.0 CONCLUSION

Suchman's stages of illness experience have indeed given us an orderly approach to the study of illness behaviour. We will try to elaborate more on them.

5.0 SUMMARY

In this unit, we looked at different perspectives of illness behaviour. Using Suchman's stages of illness experience, we were able to articulate better the pattern the study of illness behaviour should fall in. So in the subsequent units, we will take a thorough look at each stage of illness experience

6.0 TUTOR MARKED ASSIGNMENT

1. Define illness behaviour
2. Illustrate the stages of illness experience/behaviour

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UNIT 2 SYMPTOM EXPERIENCE

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1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Defining Symptom
    3.2 Importance of Symptoms
    3.3 Symptom Interrogation
    3.4 List of Symptoms
4.0 Conclusion
5.0 Summary
6.0 Tutor marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

When we perceive ourselves to be ill, this assessment is often based on the perception of certain symptoms. For example, a person feeling the onset of malaria might note the occurrence of headache, feverish feelings and body ache. Likewise, a person feeling the onset of cold might notice the occurrence of cough, nasal congestion and body weakness. By perceiving such symptoms, especially if one had previously experienced such similar occurrence, one may be accurate in relating such symptoms to the health practitioner. Suffice to observe that such assumptions may be accurate in many cases, but symptom perception may represent far more than this. So this unit hopes to shed more light on the aforementioned variable: symptom experience.

Due to the intricacy of symptoms, it is difficult to construct a simple definition. Illness symptoms are "differently labeled by individuals in dissimilar social situations" (Browner 1983: 494). Certain aetiologies such as those found in biomedicine maintain that disease occurs when an external pathogen enters the body and disrupts physiological homeostasis. Therefore, symptoms are not believed to be part of the "patient's concept of his intact body" (Casell 1976: 145).

2.0 Objectives

- Define Symptom
- Illustrate importance of Symptoms
- Describe symptom Interrogation
- Make a list of Symptoms

3.0 Main Content

3.1 Defining Symptoms

Definition 1

However, symptoms are viewed as the manifestation of bodily malfunction.

Definition 2

In non-traditional health care systems, symptoms are believed to be manifestations of the intrusion of the supernatural. On the other hand, non-western ideologies explain disease causation as an object intrusion, spirit intrusion, an act of witchcraft, or the result of soul loss or neglected/transgressed social taboos (Low 1985).

Although it may seem logical that different civilizations with diverse illness ideologies would have different definitions for symptoms, certain commonalities regarding the definition of symptoms exist among these civilizations. For instance, some cultures do support the belief that symptoms are the manifestation of illness, whether it is the cause of a pathogen or a spirit invasion.

Definition 3

Symptoms enable a person to report self-experiences of health on a day-to-day basis. These self-reported experiences can be used to "establish relationships between physical symptoms, psychological factors, and health actions" (Brown et al. 1994: 378).

3.2 Importance of Symptoms

Having a clear definition of the symptom is necessary, but just as vital is having an understanding of why symptoms are important.

- Symptoms are used by the sick to gain legitimization of the sick role from society.
- Just as culture is integrated in the beliefs and behaviours of every society, symptoms are deeply embedded in the concept of sickness and healing.
- Symptoms add clarity to the complex ideas of sickness and healing in such a way that it is difficult to discuss either process without touching on these symbols.
- The symptom is regarded as a vital part of the illness experience because it offers insight into the physiological and psychological aspects of the patient's body. In this way, the symptom

symbolizes the roots of a tree, anchoring a societal understanding of medical knowledge and healing aetiologies.

- The symptom is of great significance because "everywhere, sickness and healing are primal human concerns" (Telles and Pollack 1981).

- The concept of feelings, in the form of symptoms, also becomes important because they often act as threads that bind the aspect of health to the personal concept of human emotion. In this rite, feelings are important in the definition of health and illness. The way an individual feels is a "prime criterion of health, illness, and recovery" (Telles and Pollack 1981).

- The symptom is of great social significance in the way it "reflects both the individual's relations in the social system and represents cultural participation; it is a help-seeking behaviour of individuals or families attempting to re-establish a balanced sociocultural state" (Low 1985:190). These statements are important because they shed light on the social and cultural component of the symptom.

SELF ASSESSMENT EXERCISE

i. What do you understand by symptoms?
ii. Identify the importance of symptom experience

Answer to Exercise

i. Symptoms are viewed as the manifestation of bodily malfunction. Symptoms enable a person to report self-experiences of health on a day-to-day basis. These self-reported experiences can be used to "establish relationships between physical symptoms, psychological factors, and health actions".

ii. Importance of Symptom Experience

- The symptom is regarded as a vital part of the illness experience because it offers insight into the physiological and psychological aspects of the patient's body. In this way, the symptom symbolizes the roots of a tree, anchoring a societal understanding of medical knowledge and healing aetiologies.
- The symptom is of great significance because "everywhere, sickness and healing are primal human concerns" (Telles and Pollack 1981).

- The concept of feelings, in the form of symptoms, also becomes important because they often act as threads that bind the aspect of health to the personal concept of human emotion. In this rite, feelings are important in the definition of health and illness. The way an individual feels is a "prime criterion of health, illness, and recovery" (Telles and Pollack 1981).

3.3 Symptom Interrogation

Most health care practitioners are likely to follow the following history taking steps in symptoms interrogation. They are:

Onset: When did it start?

Palliative: What relieves your symptom?

Provocative: What provokes your symptom?

Quality: How would you describe the symptom? Sharp? Stabbing? Sore? Uncomfortable? Throbbing? Ripping?

Radiating: Do the symptom or pain radiate to another area of your body?

Note: These could be represented as OPPQR

3.4 List of Symptoms

Here are just a few things that will automatically pop into a doctor's head when you give the following symptoms. The doctor will then perform various orthopaedic, laboratory or imaging tests on you to confirm or deny his or her suspicions:

Please keep in mind there are many other conditions, diseases, syndromes and illnesses that your doctor may be thinking depending on what you stated in your patient history. The following are list of symptoms and associated manifestations:

- **Abdominal Pain**: - may be indicative of appendicitis, food allergies, food poisoning, gastro-intestinal disorders, hernia or pre-menstrual syndrome.
- **Abnormal vaginal discharge:** - may be indicative of yeast infection (candidaisis), genital herpes, gonorrhea or trichomoniasis.

- **Backache:** - may be indicative of back strain, DDD (degenerative disc disease), lack of exercise, obesity, female disorders, spinal injury or pancreatic disorders.
- **Blood in the urine, stool, vomit, vagina or penis**: - may be indicative of haemorrhoids, infections, polyps, bowel tumours, ulcers, cancer of the kidneys, colon or bladder.
- **Difficulty in swallowing:** - may be indicative of emotional stress, hernia, cancer of the oesophagus.
- **Excessive sweating:** - may be indicative of thyroid disorder, menopause, stress, food allergies, fever, infection or Hodgkin's disease.
- **Frequent urination**: - may be indicative of bladder infection, a diuretic effect, excessively taking of liquid, not emptying the bladder in a timely fashion or cancer.
- **Indigestion**: - may be indicative of poor diet, lack of enzymes such as HCL (hydrochloric acid), gallbladder dysfunction, heart disease, acidosis, alkalosis, allergies, stress, adrenal liver or pancreatic disorders.
- **Persistent cough**: - may be indicative of lung disorders, pneumonia, emphysema, bronchitis, influenza, food allergies or cancer.
- **Persistent fever**: - may be indicative of influenza, mononucleosis, rheumatic disorders, bronchitis, colds, meningitis, diabetes or chronic infection.
- **Persistent headache**: - may be indicative of migraines, eyestrain, need for glasses, allergies, asthma, drugs, glaucoma, high blood pressure, brain tumour, vitamin deficiencies, sinusitis or stress due to personal life experiences.
- **Rash with blisters:** - may be indicative of Herpes Zoster or Shingles.
- **Sudden weight gain**: - may be indicative of over-eating, lack of exercise, thyroid condition (under-activity) or oedema.
- **Sudden weight loss (unexplained**): - may be indicative of cancer, diabetes, thyroid condition (overactive), hepatitis, parasites, infection or mal-absorption syndrome.
- **Swelling in the appendages or abdomen:** - may be indicative of oedema, heart condition, kidney dysfunction, medication, food allergies, oral contraceptives or steroids.
- **Swollen lymph nodes:** - may be indicative of chronic infection, lymphoma, various cancers, toxic metals, toxic build-up or Hodgkin's disease.
- **Thirsting excessively**: - may be indicative of diabetes, infection, excessive exercise or fever (Standley, 2007)

4.0 CONCLUSION

The symptom may initially seem to merely "play a simple role, primary in nature," (Foucault 1973:91) but without this vital actor, the cast of the healing process would be incomplete. The presence of the symptom not only indicates to the patient that illness is present, but it also initiates the process of healing when presented to the practitioner. The healing process is thus considered complete when the symptoms and the illness disappear. While some may argue that symptoms are merely somatic complaints, these people are blind to the intricate details that assemble the process of healing.

5.0 SUMMARY

We have seen that symptoms are an integral part of the healing process in numerous ways. I hope you enjoyed reading this unit. I'm sure you will agree with me that information encountered in this unit is quite novel and insightful. Now let us try the assignment presented below.

6.0 TUTOR MARKED ASSIGNMENT

1. Identify stages of symptom interrogation
2. Identify list of symptoms for: persistent headache, sudden weight loss, frequent urination, abdominal pain and backache.

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UNIT 3 THE SICK ROLE

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    3.2 Parsons Sick Role Theory
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    3.3 Underlying Values of the Sick Role
        3.3.1 Vulnerability
        3.3.2 Deviance
    3.4 The Sick Role Theory: Ideas from Freud and Max Weber
    3.5 Some Criticism of the Parsons Sick Role Theory
        3.5.1 Rejecting the Sick Role
        3.5.2 Doctor-Patient Relationship
        3.5.3 Blaming the Sick
        3.5.4 Sick Role and Chronic Illness
    3.6 Strengths of Parsons Sick Role Theory
4.0 Conclusion
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1.0 INTRODUCTION

Suffice to note, just as we stated earlier, that if the individual accepts that the symptoms are a sign of illness, and are sufficiently worrisome, then transition is made to the sick role, at which time the individual begins to relinquish some or all normal social roles.

The sick role is therefore a social role characterized by certain exemptions, rights and obligations, and shaped by the society, groups and the cultural tradition to which the sick person belongs.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Describe background of Parsons sick role concept
- Describe Parsons sick role theory
- Identify the rights and obligations of the sick role
- Describe the underlying values of Parsons sick role theory
- Draw ideas from Sigmund Freud and Max Weber in the illustration of Parsons sick role theory

- Determine the strengths and weaknesses of Parsons sick role theory

3.0 MAIN CONTENT

3.1 Background of the Sick Role Concept

The sick-role is a concept arising from the work of an American Sociologist, Talcott-Parsons (1902-1979). Parsons was a structural-functionalist who argued that, social practices should be seen in terms of their function in maintaining order to structure in society. Thus Parsons was concerned with understanding how the sick person relates to the whole social system, and what the person's function is in that system.

Specifically, the sick role concept was first introduced by Talcott Parsons in a 1948 journal article but was elaborated upon in his 1951 book titled 'The Social System'. Parsons emphasized that illness is not simply a biological or psychological condition, and it is not simply an unstructured state free of social norms and regulations. When one is ill, one does not simply exit normal social roles to enter a type of social vacuum; rather, one substitutes a new role – the sick role – for the relinquished, normal roles.

Ultimately, the sick role and sick-role behaviour could be seen as the logical extension of illness behaviour to complete integration into the medical care system. Parsons' argument is that sick-role behaviour accepts the symptomatology and diagnosis of the established medical care system, and thus allows the individual to take on behaviours compliant with the expectations of the medical system.

3.2 Parsons Sick Role Theory

One of the most widely-accepted attempts to define the place of the patient in modern health care was that of Talcott Parsons, the prominent American scholar who was a champion of the Structural Functionalist approach to social analysis. For Parsons, individuals played set roles within particular institutional settings, such as the family, the workplace, the legal apparatus, the medical system, and so on. Parsons argued that the ill take on a sick role, which (like all roles) provides them with a set of responsibilities and privileges. As he wrote, "illness is not merely a state of the organism and/or personality, but comes to be an institutionalized role". Illness represented a legitimate withdrawal into a dependent relationship -- a sick role.

One of the prominent characteristics of Parsons' theory is an asymmetry between the roles of patients and healers. Their rights and obligations

are not equal, with the more institutionalized and legitimized functions of doctors taking precedence over the role of the patients. Indeed, from a phenomenological standpoint, a doctor and a patient may define the illness in different ways. For example, in a study of elderly patients who were recovering from strokes, Becker and Kaufman (1995) noted that the experience of "living" a disease means that one will construct a different idea of the illness trajectory (the narrative, often quite personal, of the progress and development of a disease) and the expected outcomes of that disease. The acceptance of the sick role implies that the patient takes on some responsibility for getting well, and some patients may be actively advised to take over even greater responsibility (diabetics represent a prime example here). Indeed, much healthcare-related intervention relies on the passive co-operation (usually referred to as "compliance") of the patient. Patient compliance has been a standard feature of medical journals in the last couple of decades. Trostle (1988), who interpreted patient compliance as a euphemism for "physician control," claimed that it was an ideology which reaffirmed and legitimized the unequal doctor/patient relationship. The fascination with patient compliance indicates a particular conception of the patient as an "opponent" of the doctor. This interest in patient compliance was ascending in Parsons' time, and came to full bloom in the 1970s and 1980s (based on the importance of the topic in the medical literature; see Trostle, (1988). In some ways, the concern over patient compliance could also be read as a reaction to the rise of self-help movements, the increasing competition from non-traditional medicine, and the emergence of patient activists of various sorts. These developments represent threats to the established institutions of medicine.

Parsons thus, outlined four aspects related to this role, two rights and two obligations (Parsons, 1951: 436-437; Parsons (1978). These are thus presented below.

3.2.1 Rights and Obligations of the Sick Role

Sociologists conceptualize social roles as the expected behaviours (including rights and obligations) of someone with a given position (status) in society. Generally, people hold a status (position) and perform a role (behaviour). Parsons (1951) utilized these concepts to construct a theoretical view of individuals who are sick, hence the “sick role.” This theory outlines two rights and two obligations of individuals who become sick in our society (Cockerham, 2001; 2003).

Rights

i. **The sick person is exempt from “normal” social roles.** An individual’s illness is grounds for his or her exemption from

normal role performance and social responsibilities. This exemption, however, is relative to the nature and severity of the illness. The more severe the illness, the greater the exemption. Exemption requires legitimation by the physician as the authority on what constitutes sickness. Legitimation serves the social function of protecting society against malingering (attempting to remain in the sick role longer than social expectations allow – usually done to acquire secondary gains or additional privileges afforded to ill persons).

ii. **The sick person is not responsible for his or her condition.** An individual's illness is usually thought to be beyond his or her own control. A morbid condition of the body needs to be changed and some curative process apart from person will-power or motivation is needed to get well.

Obligations

(1) **The sick person should try to get well.** The first two aspects of the sick role are conditional upon the third aspect, which is recognition by the sick person that being sick is undesirable. Exemption from normal responsibilities is temporary and conditional upon the desire to regain normal health. Thus, the sick person has an obligation to get well.

(2) **The sick person should seek technically competent help and cooperate with the physician.** The obligation to get well involves a further obligation on the part of the sick person to seek technically competent help, usually from a physician. The sick person is also expected to cooperate with the physician in the process of trying to get well.

SELF ASSESSMENT EXERCISE

Describe Parsons Sick Role Theory

Answer to Exercise

Specifically, the sick role concept was first introduced by Talcott Parsons in a 1948 journal article but was elaborated upon in his 1951 book titled 'The Social System'. Parsons emphasized that illness is not simply a biological or psychological condition, and it is not simply an unstructured state free of social norms and regulations. When one is ill, one does not simply exit normal social roles to enter a type of social vacuum; rather, one substitutes a new role – the sick role – for the relinquished, normal roles. For Parsons, individuals played set roles within particular institutional settings, such as the family, the workplace, the legal apparatus, the medical system, and so on. Parsons argued that

the ill take on a sick role, which (like all roles) provides them with a set of responsibilities and privileges. As he wrote, "illness is not merely a state of the organism and/or personality, but comes to be an institutionalized role". Illness represented a legitimate withdrawal into a dependent relationship -- a sick role.

3.3 Underlying Values of Parsons Sick Role

It is important to note that these rights and obligations of Parsons sick role depend upon each other. If the sick person does not fulfill their obligations or duties their immunity from blame will be withheld and they may lose their other 'rights'. The following are two underlying values of Parsons sick role.

3.3.1 Vulnerability

- Because of threatening symptoms.
- Because they are passive, trusting and prepared to wait for medical help they are vulnerable and open to exploitation by others.
- Patient must submit to bodily inspection, high potential for intimacy, breaches social taboos.
- Patient/ doctor relationship are sometimes unequal and requires higher levels of trust.

3.3.2 Deviance

- The sick can be viewed as a social threat. Because they are relieved of social obligations.
- The more they feel sick the greater the threat to the social system.
- Sickness may be used to evade responsibility.
- Society may be exploited.
  The medical profession acts as 'gate-keeper against this form of deviance. They provide a form of social regulation to protect society.

3.4 The Sick Role Theory: Ideas from Freud and Max Weber's Theories

Parsons used ideas from Freud's psychoanalytic theories as well as from functionalism and from Max Weber's work on authority to create an 'ideal type' that could be used to shed light on the social forces involved in episodes of sickness.

Freud's concepts of transference and counter-transference led Parsons to see the doctor/patient relationship as analogous to that of the parent and child. The idea that a sick person has conflicting drives both to recover from the illness and to continue to enjoy the 'secondary gains' of attention and exemption from normal duties also stems from a Freudian model of the structure of the personality. The **functionalist** perspective was used by Parsons to explain the social role of sickness by examining the use of the sick role mechanism. In order to be excused from their usual duties and to be considered not to be responsible for their condition, the sick person is expected to seek professional advice and to adhere to treatments in order to get well. Medical practitioners are empowered to sanction their temporary absence from the workforce and family duties as well as to absolve them of blame.

Weber identified three types of authority: *charismatic;* using the force of personality, *traditional*; how it has always been, and *rational/legal authority*, which relies on a framework of rules and specialist knowledge. While individual doctors may have any or all of these types of authority in some situations, it is assumed that their credibility as a profession is based on their patients accepting their rational/legal authority in making diagnoses, prescribing treatment and writing sick-notes. (Macguire, 2002)

3.5 Some Criticism of Parsons Sick Role Theory

3.5.1 Rejecting the Sick Role

- This model assumes that the individual voluntarily accepts the sick role.
- Individual may not comply with expectations of the sick role, may not give up social obligations, may resist dependency, may avoid public sick role if their illness is stigmatized.
- Individual may not accept 'passive patient' role.

3.5.2 Doctor-Patient Relationship.

- Going to see a doctor may be the end of a process of help-seeking behaviour, (Cokerham, 2003) discusses importance of 'lay referral system'- lay person consults significant lay groups first.
- This model assumes 'ideal' patient and 'ideal' doctor's roles.
- Differential treatment of patient, and differential doctor-patient relationship- variations depend on social class, gender and ethnicity.

3.5.3 Blaming the Sick

- 'Rights' do not always apply.
- Sometimes individuals are held responsible for their illness, i.e. illness associated with sufferer's lifestyle, e.g., alcoholic lifestyle.
- In stigmatized illness sufferer is often not accepted as legitimately sick.

3.5.4 Chronic Illness.

- Model fits acute illness (measles, appendicitis, relatively short term conditions).
- Does not fit Chronic/ long-term/permanent illness as easily, getting well not an expectation with chronic conditions such as blindness, diabetes.
- In chronic illness acting the sick role is less appropriate and less functional for both individual and social system.
- Chronically ill patients are often encouraged to be independent.

3.6 Strengths

In spite of its shortcomings the idea of the sick role has generated a lot of useful far-reaching research. Arguably, it still has a role in the cross-cultural comparison of ways in which 'time-out' from normal duties can be achieved or in which deviant behaviour may be explained and excused.

The sick role theory is also a valuable contribution to understanding illness behaviours and social perceptions of sickness. (It is perhaps best considered an *ideal type* – a general statement about social phenomena that highlight patterns of "typical.") We discussed a number of criticisms of Sick Role theory, including: a violation in the "ability to get well" for a number of conditions (particularly chronic illnesses); but individuals or groups may sometimes not possess the resources to "seek technically competent help" or to "cooperate with the physician" based upon health insurance, income, role conflicts to compliance, etc.; certain illnesses may reflect an element of personal "blame" due to unhealthy lifestyle choices (i.e. smoking leads to lung cancer); the potential inability to be "exempt from normal social roles" due to issues of status (i.e. parent), income (need to work), gender, age, etc as exist.

4.0 CONCLUSION

The sick-role is thus perceived as a concept arising from the work of American Sociologist, Talcott-Parsons (1902-1979). Parsons was a structural-functionalist who argued that social practices should be seen

in terms of their function in maintaining order to structure in society. In his theory, Parsons argued that the ill take on a sick role, which (like all roles) provides them with a set of responsibilities and privileges. Parsons thus identified two rights and privileges of the sick role. Also, vulnerability and deviance concepts were identified as two underlying values of the theory. Further ideas from related theories, like Freud psychoanalytic theory and that of Max Weber, were drawn to further buttress the efficacy of the Parsons Sick Role theory. However, the assumption that the individual voluntarily accepts the sick role was highlighted as one of the drawbacks of the theory. In-spite of the numerous criticisms, the sick role theory is regarded as a valuable contribution to understanding illness behaviours and social perceptions of sickness

5.0 SUMMARY

In this unit, we looked at Parsons sick role theory, drawing insightful concepts on the rights and obligations of the theory. We further drew ideas from theories of Sigmund Freud and Max Weber, to further assess Parsons sick role theory. The strengths and weaknesses of the theory were also analyzed. Hope you had fun reading this unit. Let us now try the following exercises.

6.0 TUTOR MARKED ASSIGNMENT

1. Identify and describe the rights and obligations of the sick role.
2. Identify the strengths and weaknesses of Parsons sick role theory.

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MODULE 6 DEPENDENT PATIENT ROLE/ RECOVERY AND REHABILITATION

Unit 1 Healing Options
Unit 2 Doctor/Patient Interaction
Unit 3 Delay or Overuse of Medical Care
Unit 4 Recovery – Rehabilitation

UNIT 1 HEALING OPTIONS

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4.0 Conclusion
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1.0 INTRODUCTION

In the previous unit, we reviewed the sick role as well as choices patients need to make to get well. For the patient to make such critical choices he or she needs to identify the healing options available, therefore this unit seeks to identify several options available for medical care/healing. Basically, such healing options are usually categorized under two broad parts: The modern health care and complementary or alternative health care. We will elaborate more on them.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Determine the healing options available in the modern medical care
- Determine the healing options available in the complementary or alternative medicine

3.0 MAIN CONTENT

3.1 The Modern Health Care

3.1.1 Primary Care Provider

A primary care provider (PCP) is the person a patient sees first for checkups and health problems. The following is a review of practitioners that can serve as PCP.

- The term "generalist" often refers to medical doctors (MDs) and doctors of osteopathic medicine (DOs) who specialize in internal medicine, family practice, or pediatrics.
- OB/GYNs are doctors who specialise in obstetrics and gynaecology, including women's health care, wellness, and prenatal care. Many women use an OB/GYN as their primary care provider.
- Nurse practitioners (NPs) are nurses with graduate training. They can serve as a primary care provider in family medicine (FNP), pediatrics (PNP), adult care (ANP), or geriatrics (GNP). Others are trained to address women's health care (common concerns and routine screenings) and family planning. In some countries, NPs can prescribe medications.
- A physician assistant (PA) can provide a wide range of services in collaboration with a Doctor of Medicine (MD) or Osteopathy (DO), (Medical Encyclopedia).

3.1.2 Nursing Care

- Registered nurses (RNs) have graduated from a nursing programme, have passed a state board examination, and are licensed by the state.
- Advanced practice nurses have education and experience beyond the basic training and licensing required of all RNs. This includes nurse practitioners (NPs) and the following:
- Clinical nurse specialists (CNSs) have training in a field such as cardiac, psychiatric, or community health.

- Certified nurse midwives (CNMs) have training in women's health care needs, including prenatal care, labour and delivery, and care of a woman who has given birth.
- Certified registered nurse anaesthetists (CRNAs) have training in the field of anaesthesia. Anaesthesia is the process of putting a patient into a painless sleep, and keeping the patient's body working, so surgeries or special tests can be done (Medical Encyclopedia)

3.1.3 Drug Therapy

Licensed pharmacists have graduate training from a college of pharmacy.

Your pharmacist prepares and processes drug prescriptions that were written by your primary or specialty care provider. Pharmacists provide information to patients about medications, while also consulting with health care providers about dosages, interactions, and side effects of medicines.

Your pharmacist may also follow your progress to check the safe and effective use of your medication (Medical Encyclopedia).

3.1.4 Specialty Care

Your primary care provider may refer you to professionals in various specialties when necessary, such as:

- Allergy and asthma
- Anesthesiology -- general anaesthesia or spinal block for surgeries and some forms of pain control
- Cardiology -- heart disorders
- Dermatology -- skin disorders
- Endocrinology -- hormonal and metabolic disorders, including diabetes
- Gastroenterology -- digestive system disorders
- General surgery -- common surgeries involving any part of the body
- Haematology -- blood disorders
- Immunology -- disorders of the immune system
- Infectious disease -- infections affecting the tissues of any part of the body
- Nephrology -- kidney disorders
- Neurology -- nervous system disorders

- Obstetrics/gynaecology -- pregnancy and women's reproductive disorders
- Oncology – cancer treatment
- Ophthalmology -- eye disorders and surgery
- Orthopaedics -- bone and connective tissue disorders
- Otorhinolaryngology -- ear, nose, and throat (ENT) disorders
- Physical therapy and rehabilitative medicine -- for disorders such as low back injury, spinal cord injuries, and stroke
- Psychiatry -- emotional or mental disorders
- Pulmonary (lung) -- respiratory tract disorders
- Radiology -- X-rays and related procedures (such as ultrasound, CT, and MRI)
- Rheumatology -- pain and other symptoms related to joints and other parts of the musculoskeletal system
- Urology -- disorders of the male reproductive and urinary tracts and the female urinary tract (Medical Encyclopedia)

SELF ASSESSMENT EXERCISE

Identify some healing options and specializations available in the modern health care.

Answer to Exercise

Some healing options and specializations available in modern health care are:

- Cardiology -- heart disorders
- Dermatology -- skin disorders
- Endocrinology -- hormonal and metabolic disorders, including diabetes
- Gastroenterology -- digestive system disorders
- General surgery -- common surgeries involving any part of the body
- Haematology -- blood disorders
- Immunology -- disorders of the immune system
- Infectious disease -- infections affecting the tissues of any part of the body
- Nephrology -- kidney disorders
- Neurology -- nervous system disorders
- Obstetrics/gynaecology -- pregnancy and women's reproductive disorders
- Oncology – cancer treatment

We hope you found this exercise useful and interesting. Now let us look at healing options available in complementary or alternative medicine.

3.2 Complementary and Alternative Medicine

Complementary and Alternative Medicine (CAM) is the use of treatments that are not commonly practiced by the medical profession. CAM includes visits to:

3.2.1 Faith Healing

This is the use of suggestions, power and faith in God to achieve healing. According to Denton (1978), two basic beliefs are prevalent in religious healing. They are:

1. The idea that healing occurs through psychological processes and is effective only with psychophysiological disorders.
2. The other idea is that healing is accomplished only through the intervention of God. This thus constitutes the present day miracle. Denton (1978) also offers 5 general categories of faith healing. They are:

- Self-treatment through prayer.
- Treatment by a lay person thought to be able to communicate with God.
- Treatment by an official church leader for whom healing is only one of many tasks.
- Healing obtained from a person or group of persons who practice healing fulltime without affiliation with a major religious organization.
- Healing obtained from religious leaders who practice full time and are affiliated with a major religious group.

A common theme running through each of these categories is an appeal to God to change a person's physical and mental conditions for the better (Denton, 1978).

3.2.2 Folk Healing

Folk medicine is often regarded as a residue of health measures leftover from pre-scientific historical periods (Bakx,1991). Yet, folk healing has persisted in modern scientific society, and major reasons appear to be dissatisfaction with professional medicine and a cultural gap between biomedical practitioners and particular patients (Bear, 2001, Bakx, 1991, Madsen, 1973). These patients, typically low income persons may view folk medicine as a resource because it represents a body of knowledge about how to treat illness that has grown out of historical experiences of the family and ethnic group (Thorogood, 1990). Common ingredients in

folk remedies are such substances as ginger tea, honey, whisky, lemon juice, garlic, pepper, salt, etc.

3.2.3 Aromatherapy

Aromatherapy is the use of aromatic oils for relaxation.

3.2.4 Acupuncture

Acupuncture is an ancient Chinese technique of inserting fine needles into specific points in the body to ease pain and stimulate bodily functions.

3.2.5 Homeopathy

Homeopathy is the use of micro doses of natural substances to boost immunity.

3.2.6 Naturopathy

Naturopathy is based on the idea that diseases arise from blockages in a person's life force in the body and treatments like acupuncture and homeopathy are needed to restore the energy flow.

3.2.7 Aryuveda

This is an Indian technique of using oil and massage to treat sleeplessness, hypertension and indigestion.

3.2.8 Shiatsu

Japanese therapeutic massage

3.2.9 Crystal Healing

This is based on the idea that healing energy can be obtained from quartz and other minerals.

3.2.10 Biofeedback

This is the use of machines to train people to control involuntary bodily functions.

3.2.11 Use of Dietary Supplements

Like garlic to prevent blood clot, ginger, fish oil capsules to reduce the threat of heart attack

4.0 CONCLUSION

As you can see, there are quite a huge number of options available for medical care/self care. The usage of one or more available options depends on one's orientation, experience and socialization. The list of healing options provided in this unit is of course not exhaustive.

5.0 SUMMARY

In this unit, we looked at several healing options available in modern health care and complementary or alternative health care. These observations also form part of medical care/contact stage of illness behaviour. New let us attempt this exercise.

6.0 TUTOR MARKED ASSIGNMENT

Identify and discuss at least 8 healing options obtainable in the complementary/ alternative medicine.

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UNIT 2 DOCTOR/PATIENT INTERACTION

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        3.2.7 The Dying Patient
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

Talcott Parsons (1951) concept of the sick role provided some basic guidelines for understanding doctor-patient interaction. Parsons explains that the relationship between a physician and his or her patient is one that is oriented towards the doctor helping the patient to deal effectively with a health problem. The physician has the dominant role because he or she is the one invested with medical knowledge and expertise, while the patient holds a subordinate position oriented towards accepting, rejecting or negotiating the recommendation for treatment being offered. In the case of a medical emergency, however, the option of rejection or negotiation on the part of the patient may be quickly discarded as the patient's medical needs require prompt and decisive actions from the doctor (Cockerham, 2003). This unit therefore hopes to elaborate more of these observations.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Explain models of doctor-patient interaction
- Identify and describe determinants of doctor-patient interaction

3.0 MAIN CONTENT

3.1 Models of Doctor/Patient Interaction

Since Parsons formulated his concept of the sick role, two additional perspectives of physician-patient interaction have added to our understanding of the experience. These are the view of Szasz and Hollender of Hayes-Bautista.

Thomas Szasz and Marc Hollender (1956), both physicians, take the position that the seriousness of the patient's symptoms is the determining factor in doctor-patient interaction. Depending on the severity of the symptoms, Szasz and Hollender argued that physician-patient interaction falls into one or three possible models:

- Active-passivity: This applies when the patient is seriously ill or being treated on an emergency basis in a state of relative helplessness because of a severe injury or lack of consciousness. Typically, the situation is desperate as the physician works in a state of high activity to stabilize the patient's condition.

- Guidance-cooperation: This arises most often when the patient has an acute, often more infectious illness like measles or flu. The patient knows what is going on and can cooperate with the physician.

- Mutual participation: This applies when the physician and the patient participate actively to achieve treatment. Strict adherence to medication and related health activities could be obtainable here.

SELF ASSESSMENT EXERCISE

Explain the models of doctor-patient interaction

Answer to Exercise

Depending on the severity of symptoms or illness, Szasz and Hollender argued that physician-patient interaction falls into one or three possible models:

- Active-passivity, guidance-cooperation and mutual participation.

- Active-passivity applies when the patient is seriously ill or being treated on an emergency basis in a state of relative helplessness because of a severe injury or lack of consciousness.

Guidance-cooperation arises most often when the patient has an acute, often more infectious illness like measles or flu. The patient knows what is going on and can cooperate with the physician. Mutual participation applies when the physician and the patient participate actively to achieve treatment. Strict adherence to medication and related health activities could be obtainable here.

3.2 Determinants of Doctor-Patients Interaction

The following are some determinants of Doctor-patient interaction

3.2.1 Communication

The interaction that takes place between a physician and a patient is an exercise in communication. Medical treatment usually begins with a dialogue. Thus, the effectiveness of doctor-patient interaction depends on the ability of both to understand each other. However, a major barrier to effective communication usually lies in the difference between physicians and the patients with respect to:

- Status
- Education
- Professional Training
- Authority

Several sources (Waitzkin, 2000; Clair, 1993), report that a failure to explain a patient's condition to the patient in terms easily understood is a serious problem in medical encounters. Physicians in turn state that an inability to understand or the potentially negative effects of threatening information are the two most common reasons for not communicating effectively with their patients (Davis, 1972).

However, some doctors are very effective communicators, and as Eric 1985 in (Cockerham, 2003) explains, information can be an important therapeutic tool in medical situations if it meets three tests:

- Reduces uncertainty
- Provides a basis for action
- Strengthens the physician-patient relationship

3.2.2 Cultural Differences in Communication

Physician-patient interaction can also be influenced by cultural differences in communication. A major study in this area is that of Zola (1966), comprising Irish and Italian American patients in the presentation of symptoms of an eye, ear, nose and throat clinic. Zola

found that Irish patients tended to understate their symptoms while Italian patients tended to overstate them. Zola observed that the Irish made short concise statements like (I can't see across the street), while Italians provided far greater details (my eyes seem very burny….especially the right eye….Two or three months ago, I woke with my eyes swollen, I bathed it and it did go away, but there was still the burny sensation) – for the same eye problem. The doctors were required to sort the differences in communication styles in order to help them arrive at the appropriate diagnosis.

3.2.3 Women Physicians

Sometimes for women doctors in a work situation, being a woman is a more meaningful status than being a physician. West (1984), reports that some patients may perceive women physicians as less an authority figure than the male physician. In one instance, West (1984) noted that male hospital patients were asked by a woman physician if he was having difficulty passing urine and the patient replies 'You know, the doctor asked me that' In this case, indicates West, it was difficult to tell who 'the doctor' was because 'the doctor' was evidently the female physician who was treating him. Hammond (1980) also suggests that female medical students deliberately develop personal biographies about themselves that show them as being no different from any other medical student. They do so in order to gain acceptance as colleagues from male students who question their motivation, skill and potential for medicine.

3.2.4 Personality of the Patient

3.2.4.1 The Seductive Patient

- Patient idealizes the doctor, taking form in erotic or sexualized transference
- Can be both flattering and disturbing to the physician
- Can evoke [sexual] feelings in the doctor
- Essentially, a doctor cannot stop these feelings. However, it's unethical to act on them and thus, it's not the feelings themselves but what you do with them that may or may not cause trouble

Example

An attractive woman, experiencing difficulty in her marriage, becomes infatuated with her doctor or psychotherapist/counselor, and expresses a desire to see him outside of the office.

3.2.4.2 The Hateful Patient

- This patient is demanding and dissatisfied with their treatment
- Tends to blame physician and others for their illness
- Have unrealistic expectations
- Dumps their inner turmoil into the world around them

Example

Female on male in-patient is uncooperative, demanding and childlike. She assigns staff to being either in the "good" staff or the "bad" staff. This causes the staff to bicker among themselves.

3.2.5 Patient with 1000 Symptoms

- These are somatizing patients
- Appear to be invested in remaining ill
- Doctors get frustrated and angry and often order unnecessary procedures/tests.
- These patients show up frequently in general practice; account for 5-10% of patients seen.
- The need to be ill is unconscious and patients believe the symptoms are real.

Example

A female or male patient fears she may have a tumour. First, she thinks eye pain=tumour, she is given referral to opthalmologist. Second, she thinks elbow pain=tumour, given referral to orthopaedics. Even after seeing a therapist, and making connections between and increase in frequency of symptoms with an increase in stress, she still continue to develop new symptoms and have recurrent fears related to health.

3.2.6 Mentally Disturbed Patient

- False assumption that psychotic individuals cannot deal rationally with illness
- Doctors, as well as staff, may feel frightened of these patients

Example

A 50 year old man with paranoid psychosis is diagnosed with colon cancer. He is admitted to the ward and the staff becomes upset because they are fearful of their safety and feel he should be on the psych floor. They end up avoiding the patient all together. A psychiatrist was called

in and found the patient able to understand his illness and able to make decisions regarding his treatment. Therefore, the patient was concerned about why no one was telling him what was going on.

4.0 CONCLUSION

We have seen that the relationship between a physician and his or her patient is one that is oriented towards the doctor helping the patient to deal effectively with a health problem. While the doctor is perceived to have the dominant role, the patient is expected to hold a subordinate position oriented towards accepting, rejecting or negotiating the recommendation for treatment being offered. Szasz and Hollender (1956) also argued that physician-patient interaction falls into one or three possible models: Active-passivity, guidance-cooperation, mutual participation. This unit also identified several determinants of doctor-patient interaction which include: poor communication, personality of patients, cultural differences in communication, the mentally retarded patient, patient with 1000 symptoms etc. All these influence illness, and illness behaviour.

5.0 SUMMARY

In this unit, we looked at models of doctor-patient interaction as well as several determinants of doctor-patient interaction. I hope you found the unit interesting. Now let us attempt the following questions.

6.0 TUTOR MARKED ASSIGNMENT

Identify and describe determinants of Doctor-Patient Interaction

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UNIT 3 DELAY OR OVERUSE OF MEDICAL CARE

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        3.2.2 Learned Social Response
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    3.3 Self Medication
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
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1.0 INTRODUCTION

For certain illnesses, prompt medical attention is needed in order to survive. For example, the case of sudden heart attack should be taken as an emergency because getting immediate medical attention can literally make the difference between life and death. However, despite the obvious need for prompt and timely treatment, many still have the habit of delaying or overusing medical care. The reason for such unhealthy illness beahviour will be the focus of this unit.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Determine factors influencing delayed medical care
- Determine factors influencing overuse of medical care
- Illustrate the effects of self medication

3.0 MAIN CONTENT

3.1 Delayed Medical Care

What causes people to delay seeking medical attention for serious conditions? Addressing this question is assisted by conceptualizing the

process of seeking medical help in term of stages. In their analysis of the determinants of delay behaviour, Safer, et al., (1979), outline three basic issues:

3.1.1 Appraisal Delay

First, the person must decide if he or she is ill. However, the time involved in this decision is termed appraisal delay. Put differently, appraisal delay is the amount of time it takes a person after experiencing symptoms to decide that he or she is actually ill. As discussed in the previous unit, certain needs, like the need to go to work and earn a living, may trigger such appraisal delay. Thus, an individual may wish away a symptom hoping that he or she would get better with time, while continuing to carry out work activities.

What then determines the amount of delay at this stage? Interviews with patients seeking care at the hospital reveals that, appraisal delay was related to the sensory aspect of the person's symptoms, as well as whether the person had read about the symptoms. It was observed that patients showed less appraisal delay when they are in pain or bleeding, or have a sudden heart attack, but showed more delay when they took time to read about their symptoms. In order words, they are not in so much pain so the probability of taking time to read up about symptoms of a particular illness is very likely.

3.1.2 Illness Delay

However, when a person finally recognizes that a particular symptom is actually as a result of a certain illness or disease, it is then time for such a person to decide whether medical help is needed. This can result in illness delay. Thus illness delay is referred as the time required for a person to decide that professional help is required after deciding that he or she is ill.

To ascertain what actually determines the amount of delay in illness delay, Bishop (1994), observed that illness delay showed a somewhat different pattern. The sensory aspects of the symptoms were still important, but other factors also came into play. At this stage, longer delay was associated with having symptoms that the person had had before. Apparently, because of the previous experience with the symptoms, patients experiencing old symptom may not feel the same urgency to seek help, as did those experiencing such for the first time. Observations also indicate that certain negative images and thoughts associated with medical care could also influence illness delay. Patients who imagine being on the operating table or seeing plenty of blood may tend to delay longer than others.

3.1.3 Utilization Delay

Finally, a sick person must decide to actually be in need of help. Thus, the time required to take this decision is referred to as utilization delay. This is described as the time it takes a person to decide to seek professional help after deciding that such help is needed.

What then triggers delay at this phase? It seems that, whereas appraisal and illness delay depended on sensory aspects of the symptom, utilization delay was mostly related to practical concerns. Bishop (1994) observed that the strongest predictor of utilization delay was concern over the cost of treatment. Not surprisingly, those very concerned about the cost of medical care delay longer than other who, were less concerned. Here, socio-economic status of an individual can greatly influence illness behaviour. In addition, patients with painful symptoms, who felt that their symptoms could be cured, showed less delay than others.

SELF ASSESSMENT EXERCISE

Examine the factors that trigger delay of medical care

Answer to Exercise

The factors are: appraisal delay, illness delay and utilization delay. Appraisal delay is the amount of time it takes a person after experiencing symptoms to decide that he or she is actually ill. Illness delay is referred to as the time required for a person to decide that professional help is required after deciding that he or she is ill. Utilization delay is described as the time it takes a person to decide to seek professional help after deciding that such help is needed.

3.2 Overuse of Medical Care

The opposite of delay is the seeking of medical care without good reason. Observations indicate that many patients seeking medical care from family practitioners have no diagnosable disease. The ‘worried well’, those who are not sick but believe that they might be, are estimated to be responsible for about 50% of the cost of adult ambulatory health care. In addition, patients who seek medical care needlessly may be subjected to unnecessary medical tests, given unnecessary medications and put through needless surgeries. An example of this, as described by Quill (1985), is a 74 year old woman, who over the course of a single year had been evaluated by a cardiologist for chest pain, gastroenterologist for abdominal pain, a pulmonologist for shortness of breath, and was currently being referred

for severe headache and weakness. Beginning when she was 24, she had had over 30 operations for vague problems and was currently taking six different prescription medicines. Yet physical examination showed her to be in remarkably good health.

What leads to this overuse of medical services? Such overuse could be attributed largely to the following factors:

3.2.1 Emotional Reasons

Some of these patients suffer from psychiatric disorders, while others use symptoms and help seeking as a way of getting attention or manipulating others. Overuse of medical care could also be as a result of hypochondriasis - a false belief in having a disease or exaggerated fear of contracting one, could persist despite medical reassurance that nothing is in fact wrong (Kellner, 1987).

3.2.2 Learned Social Response

Overuse of medical care may also be a learned response, in which a person attempts to attract attention and manipulate others. Thus, the person complains of symptoms so as to obtain sympathy or encouragement, and use sick role to avoid responsibilities or challenges. Visiting the doctor is a way to gain sympathy and to have one's entry into the sick role validated (Bishop, 1994).

3.2.3 Self-Handicapping Strategy

Physical complaints also seem to serve as a means by which people can protect their self esteem. Along this line, individuals may use physical symptoms as a self-handicapping strategy. Self handicapping strategy provides people with ready excuses for failure by placing impediments in their own paths. Thus should they perform poorly, they can save face and preserve their self esteem by attributing their failure to the impediment, rather than their own lack of ability (Bishop, 1994).

3.3 Self Medication

Another factor that could influence overuse of medical care is self-medication. Self-medication can be defined as the use of drugs to treat self-diagnosed disorders or symptoms, or the intermittent or continued use of a prescribed drug for chronic or recurrent disease or symptoms. It is usually selected by consumers for symptoms that they regard as troublesome to require drug therapy but not to justify the consultation of a prescriber. In developing countries, most illnesses are treated by self-medication. A major shortfall of self-medication is the lack of clinical

evaluation of the condition by a trained medical professional, which could result in missed diagnosis and delays in appropriate treatments. Self-medication may be a matter of concern for several reasons:

- First, there is a lack of objectivity, and professional distance.
- Self-medication can lead to delayed diagnosis and treatment and worsening of the illness.
- Many diseases need follow-up apart from medication, particularly for mental illness and chronic diseases and this is not usually achieved by self treatment.

4.0 CONCLUSION

In a bid to identify the determinants of delay and overuse of medical care, we observed different illness behaviour. For delay of medical care, the sick person first forms an appraisal of the illness, and if not objectively done could result in illness delay. Thus illness delay is referred as the time required for a person to decide that professional help is needed after deciding that he or she is ill. Finally, a sick person must decide to actually be in need of help. Thus, the time required to take this decision is referred to as utilization delay. This is described as the time it takes a person to decide to seek professional help after deciding that such help is needed.

Overuse of medical care could also be a response to emotional difficulties. Some of these patients suffer from psychiatric disorders, while others use symptoms and help seeking as a way of getting attention. Overuse of medical care may also be a learned response, in which a person attempts to attract attention and manipulate others. Along this line, individuals may use physical symptoms as a self-handicapping strategy-a situation where illness provides ready excuses for personal failures. The issues of self medication, was briefly discussed to broaden our understanding of illness behaviours obtainable in overuse or delay in medical care.

5.0 SUMMARY

This unit looked at issues of delay and overuse of medical care. Several determining factors were identified. I'm sure you must have others in mind. Well done for reading this far. Now let us attempt the following tutor marked assignments.

6.0 TUTOR MARKED ASSIGNMENT

Examine the factors that trigger overuse of medical care.

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UNIT 4 RECOVERY – REHABILITATION

CONTENTS

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1.0 INTRODUCTION

The final stage of Suchman's stage of illness experience (Suchman, 1965), is recovery and rehabilitation. At this stage, the acute patient is expected to relinquish the sick role and move back to normal activities. For the chronic patient, the extent to which prior role obligations may be resumed ranges from those who forsake the sick role, to those who will never be able to leave it (Weiss and Lonnquist, 2005).

Chronic illness raises a number of highly specific problem-solving tasks that a patient encounters on the road to recovery. These tasks include physical problem associated with illness, vocational problems, problems with social relationships, and personal issues concerned with chronic illness (Taylor, 2006). This unit therefore seeks to elaborate more on the aforementioned issues.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Identify and discuss the physical problems associated with chronic illness
- Identify goals of physical rehabilitation of the chronically ill
- Discuss vocational issues of chronic illness
- Discuss problems of social interaction associated with chronic illness

- Discuss personal issues of chronic illness

3.0 MAIN CONTENT

3.1 Physical Problems Associated With Chronic Illness

Physical problems associated with chronic illness may be divided into those that arise as a result of illness itself, and those that emerge as a consequence of the treatment.

3.1.1 Physical Problems as a Result of the Illness

Physical problems that are produced by the illness itself range widely. They may include physical pain such as chest pain experienced by heart patients, headaches which are a presenting discomfort for a wide range of illnesses, or the chronic pain associated with Arthritis. Breathlessness associated with respiratory disorders, and motor difficulties produced by spinal cord injuries also represent important physical problems (Taylor, 2006). Cognitive impairment may also occur, such as language, memory, and learning deficits associated with stroke. In many cases, then, the physical consequences of chronic illness place severe restrictions on the individual's life.

3.1.2 Physical Problems as a Result of Treatment

Treatment of primary symptoms and the underlying disease also produce difficulties in physical functioning. Cancer patients receiving chemotherapy sometimes face nausea, vomiting, hair loss, skin discoloration and other unattractive and uncomfortable bodily changes. Those cancer patients who receive radiation therapy must cope with the burning of the skin, gastrointestinal problems and other temporary disturbances (Nail et al, 1986). Medication of hypertension can produce a variety of side effects including drowsiness, weight gain and impotence. Sexual dysfunction as a result of illness and/or treatment may occur in patients with hypertension and cancer (Anderson, Anderson and daProsse 1989a). Restrictions on the activities of patients, who have a heart attack-including, elimination of smoking, dietary changes and exercise requirements, etc, may pervade their entire way of life. In many cases, patients may feel that, in terms of discomfort and restrictions they impose, the treatments are as bad as the disease.

3.1.3 Goals of Physical Rehabilitation of the Chronically Ill Patient

Physical rehabilitation is an important aspect of chronic illness. This is because, chronic disability leads to higher levels of anxiety, distress and even suicide ideations. Physical rehabilitation of the chronically ill patient therefore involves several goals:

- To learn how to use one's body as much as possible
- To learn how to sense changes in the environment in order to make appropriate physical accommodations
- To learn new physical management skills
- To learn a necessary treatment regime
- To learn how to control expenditure of energy (Gartner and Reissman, 1976).

SELF ASSESSMENT EXERCISE

i. Identify the physical problems that occur as a result of illness
ii. Identify the goals of physical rehabilitation of the chronically ill

Answer to Exercise

Physical problems that are produced by the illness itself range widely. They may include physical pain such as chest pain experienced by heart patients, headaches which are a presenting discomfort for a wide range of illnesses, or the chronic pain associated with Arthritis. Others include amputation due to diabetes or overall weakness also experienced for a wide range of diseases.

The goals are:

- To learn how to use one's body as much as possible
- To learn how to sense changes in the environment in order to make appropriate physical accommodations
- To learn new physical management skills
- To learn a necessary treatment regime
- To learn how to control expenditure of energy

3.2 Vocational Issues in Chronic Illness

Many chronic illnesses create problems for patients' vocational activities and work status. Thus, some patients may need to restrict or change their work activities. For example, a salesman who previously conducted his work from his car, motorcycle or simply by walking

around door to door, but is now diagnosed with stroke, may need to switch to a job in which he/she can do less walking about and use the telephone instead. Also, patients with spinal cord injuries, who previously held positions that require physical activities, will need to acquire skill that will enable them work from a seated position.

Important to note that many chronically ill patients, especially the mentally ill and HIV/AIDS patients face job discrimination. Such patients are likely to be fired, more than other and if tolerated, may be moved to less demanding and obscure positions. They may also be promoted less because the organization believes that they have a poor prognosis and are not worth the investment of time and resources required for training.

Because of these potential problems, any job difficulties that the patient may encounter should be assessed early in the recovery process. Job counseling, retraining programmes and advice on how to combat discrimination can then be initiated promptly (Taylor, 2006).

3.3 Social Interaction Problems in Chronic Illness

The development of chronic illness can create problems of social interaction for the patient. After diagnosis, patients may have problems re-establishing normal social relations. They may complain of others pity or rejection, but unconsciously behave in ways that inadvertently elicit these behaviours. They may withdraw from other people altogether; shy away from social functions or may thrust themselves into social activities before they are ready.

Patients could solely be responsible for whatever difficulties and awkwardness that arise in interaction with others. Acquaintances, friends and relatives may have problems of their own adjusting to patients altered conditions. Many people hold pejorative stereotypes about certain chronically ill patients, including those with AIDS, particularly when individuals are seen as having brought on a disease or problem through their own negligence or seen as not attempting to cope with the disorder. Thus, reactions experienced here may be highly negative. (Schwarzer and Leppin, 1991).

There is however the need for patients to think through whether they want to disclose the fact of their illness to those outside their immediate family. If they decide to do so, they may need to consider the best approach, because certain illnesses, particularly HIV/AIDS, mental illness, may elicit negative reactions from people.

There is some evidence that chronically ill women may experience more deficits in social support than do chronically ill men. One study found that disabled women receive less social support because they are less likely to get married, than disabled men (Kutner, 1987).

3.4 Personal Issues in Chronic Illness

It seems that throughout this unit, we focused more on the adverse changes that chronic illness create and what can be done to ameliorate them. This focus tends to obscure an important point namely, that chronic illness can confer positive outcomes as well as negative ones. In one study of cancer patients, (Collins et al, 1990), observed that more that 90% of the respondents at least reported some beneficial changes in their lives, an a result of the cancer, including an increased ability to appreciate each other and inspiration to do things new in life rather than postponing them. The patients reported that they were putting more effort into their relationships and believed that they had acquired more awareness of others' feelings and more sympathy and compassion for people. They reported feeling stronger, more self-assured and more compassionate toward the unfortunate.

How do patients suffering from chronic illness with its often severe consequences and emotional trauma, nonetheless, manage to achieve such high quality of survival? When people experience an adverse condition like a chronic illness, they strive to minimize its negative impact (Taylor, 2006). When they encounter damaging information and circumstances, they try to reduce the negative implications for themselves or think of it in as much unthreatening a manner as possible. When negative consequences are difficult to deny, a person may attempt to offset them with perceived gains incurred from the event, such as finding meaning through the experience or believing that the self is a better person for having withstood the event.

4.0 CONCLUSION

This unit highlighted dimensions of the final stage of Suchman's, stage of illness experience: recovery and rehabilitation. Here, the acute patient is expected to relinquish the sick role and move back to normal activities while the chronically ill patient may need to grapple with highly specific problem-solving tasks encountered on the road to recovery. These tasks include physical problem associated with illness, vocational problems, problems with social relationships, and personal issues concerned with chronic illness.

5.0 SUMMARY

In this unit, we discussed the physical problems associated with chronic illness, as well as related vocational, social interaction and personal issues. I hope they were helpful. Now let us attempt the following questions.

6.0 TUTOR MARKED ASSIGNMENT

Discuss the vocational, social interaction and personal issues associated with chronic illness

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