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SCHOOL OF SCIENCE AND TECHNOLOGY

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MODULE 1 DEFINING CONCEPTS: HUMAN BEHAVIOUR AND MODELS

UNIT 1 BEHAVIOUR: BASIC CONCEPTS

CONTENT

1.0 INTRODUCTION

Welcome to HEM 705 (Human Behaviour in 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 behaviour. 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, 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)

3.2.4 Behaviorism and Conditioning

This school of thought had its roots in the late nineteenth century, with the writings of a number of philosophers and psychologists as well as practical scientists, such as the Russian physiologist Ivan Pavlov (1849-1936). Pavlov showed that an animal could be trained to respond to a particular stimulus even when that stimulus is removed, so long as the stimulus has been associated with a secondary one.

Pavlov began his now famous set of experiments by placing powdered meat in a dog's mouth and observing that saliva flowed into the mouth as a reflex reaction to the introduction of the meat. He then began ringing a bell before he gave the dog its food. After doing this several times, he discovered that the dog salivated merely at the sound of the bell. Many experiments of this type demonstrated that an innate behaviour can be modified, and thus was born the scientific concept of conditioning or learning by association with particular stimuli.

The variety of conditioning applied by Pavlov, known as **classical conditioning,** calls for pairing a stimulus that elicits a specific response with one that does not, until the second stimulus elicits a response like the first. Classical conditioning is contrasted with operant conditioning, which involves administering or withholding reinforcements (that is, rewards) based on the performance of a targeted response (Pavlov, 1927)

3.2.5 Operant Conditioning

During operant conditioning, a random behaviour is rewarded and subsequently retained by an animal. According to operant conditioning theory, if we want to train a dog to sit on command, all we have to do is wait until the dog sits and then say, "Sit," and give the dog a biscuit. After a few repetitions, the dog will sit on command because the reward apparently reinforces the behaviour and fosters its repetition.

Human parents apply operant conditioning when they admonish their offspring with such phrase as "You can't watch TV until you've cleaned your room." Likewise, young chimpanzees learn through a form of operant conditioning. By observing their parents, young chimps learn how to strip a twig and then use it to pick up termites (a tasty treat to a chimpanzee) from rotten logs. Their behaviour thus is rewarded, an example of the way that operant conditioning enables animals to add new, non-inherited forms of behaviour to their range of skills.

Though the theory of operant conditioning goes back to the work of the American psychologist Edward L. Thorndike (1874-1949), by far its most famous proponent was another American psychologist, B. F. Skinner (1904-1990). In applying operant conditioning to human beings, Skinner and his followers took the theory to extremes, maintaining that humans have no ideas of their own, only conditioned responses to stimuli. Love, courage, faith, and all the other emotions and attitudes that people hold in high esteem are, according to this school of thought, simply a matter of learned responses, rather like a parrot making human-like sounds to earn treats. This extreme form of behaviourism is no longer held in high regard within the scientific or medical communities.

SELF ASSESSMENT EXERCISE

i. Define Behaviour
ii. Identify the principles of Behaviour

ANSWER TO SELF ASSESSMENT 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:

   a. Stimulus and Response:
   b. Innate and Learned Behaviour
   c. Reflex Behaviour
   d. Behaviourism and Conditioning
   e. Operant Conditioning

We 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, 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 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 as the same time. I hope that the concepts introduced in this unit, such as stimulus and response, innate and learned behaviour, behaviourism and conditioning, 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). I 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

CONTENTS

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

Give a summary of the WHO perspective of Health.

ANSWER TO SELF ASSESSMENT 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, 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.

Advantages 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.

Disadvantages of Holistic Dimension

- 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.
- It can also result in people not leading a lifestyle that is good for their health, such as going to work, taking strenuous exercise and going on holiday.

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

Read the following replies from different people on the question 'Are you healthy'? then 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.

ANSWERS TO SELF ASSESSMENT 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. This unit thus provides different definitions of disease. This will also aid the appreciation of this course. Happy reading!
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 diseases 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 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.

3.5 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

CONTENTS

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 indept 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 b y 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 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

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

ANSWER TO SELF ASSESSMENT 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 a 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, ill health 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 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 ill health is objective, i.e. ill health 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 ill health 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

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 SELF ASSESSMENT EXERCISE

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

We 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, 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 of 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. We hope you found this unit helpful. Now let us try this exercise.

6.0 TUTOR MARKED ASSIGNMENT

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

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UNIT 4 MODELS OF ILLNESS

CONTENTS

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 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.
- Describe the views of Naturalistic Model of illness perception and causation.

3.0 MAIN CONTENT

3.1 Expectancy-Value Model

Many models of 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 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' (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.

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 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 two 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 variables 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 SELF ASSESSMENT EXERCISE

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

ii. a. 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'.

b. 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.

c. 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.

We 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 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 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 illness behaviour. Thus, the Social Learning perspective is of the notion that the potential for an illness 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 – 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, 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.

5.0 SUMMARY

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

- The Naturalistic model of Illness
- The Health Perception model
- Attribution model

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UNIT 5 ILLNESS: THE MIND – BODY RELATIONSHIP

CONTENTS

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
- Illustrate illness and the mind body relationship.

3.0 MAIN CONTENT

3.1 Illness and the Mind/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), while 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

ANSWERS TO SELF ASSESSMENT 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. An excess of yellow bile was linked to a choleric temperament. Thus, 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

3.1.1 lllness 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 b y 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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MODULE 2 CONCEPTUALIZING ILLNESS DICHOTOMIES AND SOCIO DEMOGRAPHIC FACTORS

UNIT 1 MENTAL AND PHYSICAL ILLNESS IN CONTEMPORARY MEDICINE

CONTENTS

1.0 INTRODUCTION

In this unit, we will look at mental and physical illness in contemporary medicine. As you would recall, unit 5, module 1, looked at the mind-body phenomenon and its influence on illness experience. This unit is therefore a continuation of the terms tackled in the previous unit. Specifically, unit 1 of module 2 will look at the origin and distinction between mental and physical illness. It will also assess public opinion about mental illness. You might ponder, why all these terms since this course: Human Behaviour in Illness should deal directly with illness beahviour issues. Of course, we cannot appreciate illness behaviour without a broad overview of related terms. Happy reading!

2.0 OBJECTIVES

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

- Determine the origin of the distinction between mental and physical illness
- Describe the distinctions between mental and physical illness
- Ascertain public opinion about mental illness.

3.0 MAIN CONTENT

3.1 Distinguishing Between Mental and Physical Illness:

3.1.1 Origin of the Distinction

The idea that insanity was fundamentally different from other illnesses, that it was a disease of the mind rather than the body, only developed towards the end of the 18th century. The scene was set by Cartesian dualism, the dominant philosophical influence of the time, but medical opinion also played crucial roles.

The development, first of private mad-houses and later of large, purpose-built lunatic asylums took the management of the insane out of the hands of the general run of physicians; and because the managers of these new institutions were concerned only with insanity it was relatively easy for them to regard it as different from other illnesses that did not concern them.
At the same time it was becoming clear that insanity was not accompanied by the obvious pathological changes that post-mortem examination was revealing in other diseases. It was increasingly apparent also that although the armamentarium of 18th century medicine — special diets, bleeding, purging and blistering — was as effective in the management of hysteria as it was in other disorders, it had little effect on madness itself. In England the success of the clergyman Francis Willis in curing the King (George III) of his madness after the conspicuous failure of his physicians to do so, and the remarkable success of the York Retreat (opened by the Quaker William Tuke in 1796) in calming and curing its inmates despite using few medicaments or restraints, both had a considerable influence on public opinion. It was in this climate that the terms "disease of the mind", "disorder of the mind" and "mental illness" first began to be widely used. Indeed, the York Retreat was explicitly for "persons afflicted with disorders of the mind" (Hunter & Macalpine, 1963).

The implication of these new terms was that madness was a disease of the mind, not of the body, and there was some debate whether diseased minds might not be better treated by philosophers than by physicians. ‘Moral treatment’ — a benevolent, ordered regime based on moderation and religious observance rather than medication — became the mainstay of the new asylums that were built in the early years of the 19th century,

and initially several of them had no physician. It was not long, though, before the medical profession reasserted itself. In Philadelphia, Benjamin Rush (1812) insisted that the fundamental pathology of what he himself referred to as "disease of the mind" was somatic (he suggested that it lays "primarily in the blood vessels of the brain") and in 1845 Wilhelm Griesinger, the first professor of psychiatry, convinced most of his German contemporaries when he argued in his influential textbook that "Psychische Krankheiten sind Erkrankungen des Gehirns" (mental illnesses are diseases of the brain). By the middle of the 19th century it was also generally accepted that the superintendent of an y properly run lunatic asylum should be a physician. But the terms mental illness and mental disease survived, partly because they clearly implied that what had previously been called madness or insanity was medical territory. The doubts about causation also survived, even within the medical profession itself. Indeed, the school of psychoanalysis that emerged at the end of the 19th century regarded all mental illnesses as entirely psychogenic disorders to be treated by psychotherapy; and until the 1930s mental disease remained largely uninfluenced by the physician.

SELF ASSESSMENT EXERCISE

Identify major events that triggered origin of the distinctions between mental and physical illness.

Note: For better learning experience, cover your study material when attempting this exercise. You can compare the answers afterwards.

ANSWERS TO SELF ASSESSMENT EXERCISE

- In the 18th century, Cartesian dualism, the dominant philosophical influence of the time, triggered the development of private mad-houses and later of large, purpose-built lunatic asylums. This took the management of the insane out of the hands of the general run of physicians; and because the managers of these new institutions were concerned only with insanity it was relatively easy for them to regard it as different from other illnesses that did not concern them.
- At the same time it was becoming clear that insanity was not accompanied by the obvious pathological changes that post-mortem examination was revealing in other diseases.
- In England the success of the clergyman Francis Willis in curing the King (George III) of his madness after the conspicuous failure of his physicians to do so, and the remarkable success of the York Retreat (opened by the Quaker William Tuke in 1796) in calming and curing its inmates despite using few medicaments or

restraints, both had a considerable influence on public opinion. It was in this climate that the terms "disease of the mind", "disorder of the mind" and "mental illness" first began to be widely used. Indeed, the York Retreat was explicitly for "persons afflicted with disorders of the mind"

- The implication of these new terms was that madness was a disease of the mind, not of the body, and there was some debate whether diseased minds might not be better treated by philosophers than by physicians.
- 'Moral treatment' — a benevolent, ordered regime based on moderation and religious observance rather than medication — became the mainstay of the new asylums that were built in the early years of the 19th century, and initially several of them had no physician.

3.1.2 Are there Distinctions between Mental and Physical Illness?

The assumption that there are distinctions between mental and physical illness is still made, both by the lay public and by many doctors, and the terms 'mental disorder' and 'mental and behavioural disorder' are still used in the two most widely used official nomenclatures, the World Health Organization's *International Classification of Diseases* (ICD) and the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM).

In reality, neither minds nor bodies develop illnesses. Only people (or, in a wider context, organisms) do so, and when they do, both mind and body, psyche and soma, are usually involved.

Pain, the most characteristic feature of so-called bodily illness, is a purely psychological phenomenon, and the first manifestation of most infections, from influenza to plague, is also a subjective change — a vague general malaise (Canter, 1972).

Fear and other emotions play an important role in the genesis of hypertension, asthma and other bodily illnesses, and bodily changes such as fatigue, anorexia and weight loss are commonplace in psychiatric disorders. That most characteristic of all psychiatric disorders, depressive illness illustrates the impossibility of distinguishing between physical and mental illnesses.

The fact is, it is not possible to identify any characteristic features of either the symptomatology or the etiology of so-called mental illnesses that consistently distinguish them from physical illnesses. Nor do so-called physical illnesses have any characteristics that distinguish them

reliably from mental illnesses. If pathological changes and dysfunctions are restricted to organs other than the brain, as is often the case, effects on mentation and behaviour are relatively restricted, but this is an inconstant and purely quantitative difference, and in any case does not apply to diseases of the brain or situations in which there is a secondary disturbance of cerebral function.

There are many differences between 'mental' and 'physical' disorders, of course. Hallucinations, delusions and grossly irrational behaviour, for example, are a conspicuous feature of the former. But they occur only in a small proportion of mental disorders, and also feature in the confusional states that may complicate many physical disorders.

In reality, the differences between mental and physical illnesses, striking though some of them are, are quantitative rather than qualitative, differences of emphasis rather than fundamental differences, and no more profound than the differences between diseases of the circulatory system and those of the digestive system, or between kidney diseases and skin diseases.
Why then do we still talk of 'mental' illnesses, or indeed of 'physical' illnesses? However, compelling literature documents that there is indeed much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders.

3.2 Public Misconceptions of Mental versus Physical Illness

Unfortunately, the linguistic distinction between mental and physical illnesses, and the mind/body distinction from which this was originally derived, still encourages many lay people, and some doctors and other health professionals, to assume that the two are fundamentally different. Both are apt to assume that developing a 'mental illness' is an evidence of a certain lack of moral fiber and that, if they really tried, people with illnesses of this kind ought to be able to control their anxieties, their despondency and their strange preoccupations and 'snap out of it'. It is true, of course, that most of us believe in 'free will'; we believe that we ourselves and other people can exercise a certain amount of control over our feelings and behaviour. But there is no reason, justified either by logic or by medical understanding, why people suffering from, say, phobic anxiety or depression should be able to exert more control over their symptoms than those suffering from cough or migraine.

There is a further and equally damaging assumption that the symptoms of mental disorders are in some sense less 'real' than those of physical disorders with a tangible local pathology. As a result, people experiencing intense fatigue, or pain that is not accompanied by any obvious local lesion, are often dismayed or affronted by being told that

they are suffering from neurasthenia, the chronic fatigue syndrome or 'psychogenic' pain, and interpret such diagnoses as implying that their doctor does not believe that they are really in pain or exhausted by the slightest effort, and is dismissing their complaints as 'all in the mind'.

4.0 CONCLUSION

Misunderstandings of this kind are important and frequent. They undermine the relationship between doctor and patient and often result in a refusal to consult a psychiatrist or clinical psychologist, or to countenance a potentially effective treatment. The answer to such problems lies in painstaking explanation and gentle persuasion, and in the longer run in better education of both the general public and doctors themselves, not in conniving with patients' convictions that their symptoms are caused by 'real' or 'physical' illnesses. It may be sensible sometimes to do this as a holding tactic in an individual patient. It is never appropriate in other contexts. Not only is the distinction between mental and physical illness ill-founded and incompatible with contemporary understanding of disease, it is also damaging to the long-term interests of patients themselves. It invites both patients and their doctors to ignore what may be important causal factors and potentially effective therapies; and by implying that illnesses so described are fundamentally different from all other types of ill-health; it helps to perpetuate the stigma associated with 'mental' illness. We should talk of psychiatric illnesses or disorders rather than of mental illnesses; and if we do continue to refer to 'mental' and 'physical' illnesses we should preface both with 'so-called', to remind ourselves and our audience that these are archaic and deeply misleading terms.

5.0 SUMMARY

We have also looked at the concepts of mental and physical illnesses and its classifications. Also, public attitudes towards mental and physical illness formed an interesting part of this unit. I hope you enjoyed your studies. Let us attempt this exercise.

6.0 TUTOR MARKED ASSIGNMENT

There is much 'physical' in mental illness and much 'mental' in physical illness – Discuss.

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UNIT 2 ACUTE ILLNESS VS CHRONIC ILLNESS

CONTENTS

1.0 INTRODUCTION

As we must have noted, we provided information on mental and physical illness in unit 1 of module 2. Of course, these are very necessary information as they helped for better appreciation of this course. However, in unit 2, we will analyze acute versus chronic illness. Observations indicate that we cannot understand human behaviour in 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
- Most infectious disease, etc.

3.2 Defining Chronic Illness

Chronic diseases are those that occur across the whole spectrum of illness, 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 (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 a 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

ANSWERS TO SELF ASSESSMENT EXERCISE

i. 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.

ii. a. Types of acute illness are flu, malaria, ear aches, tonsillitis, etc.
   b. 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 upon the vital force, 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 is not 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 same 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 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 themselves. While it is true that people with a chronic disease are more at risk of adverse events than are well people simply because they are in more constant contact with the health system, those elderly people with co-morbidities are at even greater risk because of the complexity of their illnesses and their care.

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 CHANGING PATTERNS OF ILLNESS

CONTENTS

1.0 INTRODUCTION

One may ask, why bother with changing patterns of illness since illness experience seems obvious and also cuts across age, social, race, etc. However, by focusing our lenses on the changing pattern of illness, we are able to appreciate the great metamorphosis that has been experienced in illness causation and origins. 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 illness
- Identify the role of technological advancement of disease detection
- Explain changing patterns of illness and health research

- Scrutinize the role of epidemiology on changing patterns of illness

3.0 MAIN CONTENT

3.1 Changing Patterns of Illness and Disease Metamorphosis

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.

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.

ANSWERS TO SELF ASSESSMENT EXERCISE

i.
- Pre 20th Century: Influenza, Cholera, Tuberculosis, Leprosy, etc.
- Contemporary diseases are: HIV/AIDS, Cancer, Diabetes, Heart Diseases, etc.

ii. 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 Changing Patterns of Illness and Lifestyle

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.

3.3 Changing Patterns of 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 has 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.

3.4 Changing Patterns of 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.

3.5 Changing Patterns of 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 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 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 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 new technology on changing patterns of illness.

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UNIT 4 CULTURAL AND DEMOGRAPHIC PERSPECTIVES OF ILLNESS

CONTENTS

1.0 INTRODUCTION

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

2.0 OBJECTIVES

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

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

3.0 MAIN CONTENT

3.1 Cultural Factors of Illness

Understanding the nature of illness and how people respond to physical distress requires a consideration of the cultural context in which illness 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 across culture have shown that 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. 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 is Illness perceived in your culture?

ANSWERS TO SELF ASSESSMENT 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. We are sure this experience will be a very insightful and interesting one. Ok! Can we move on? Next is the socio-demographic factors of illness.

3.2 Social and Demographic Factors of Illness

Although culture provides basic orientations to interpreting illness experiences, the experience of illness, 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 and Illness

Observations indicate that illness increases as one gets older, with older people reporting more activity restriction, physician visit and health complications due to chronic diseases and frail immune systems. Observations also indicate that older people tend to interpret symptoms differently than their younger counterparts. For example, as people age, they tend to attribute relative mild symptoms to aging rather than illness.

3.2.2 Gender and Illness

Studies have shown that women report more illnesses than do 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 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 males. For the unmarried females, boredom and an urge for a husband may predispose them to stress and poor immunity to diseases.

3.2.4 Living Conditions 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 and Illness

Social class or socioeconomic status plays an important role in diseases 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 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 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 illness 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 illness experience. Now let us tackle the question stated below.

6.0 TUTOR MARKED ASSIGNMENT

Identify and discuss the Socio-demographic factors of illness

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UNIT 5 DEFINING HEALTH BEHAVIOUR AND ILLNESS BEHAVIOUR

CONTENTS

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. Also, we looked at several theoretical underpinnings that shed more light on illness and illness experience. We further discussed other illness related variables like the distinctions between mental and physical illness. We also looked at acute versus chronic illness, then further scrutinized cultural and socio-demographic factors of illness.

The fact that social and cultural factors provide the context for the experience of illness is well established, but how then do we notice symptoms and perceive ourselves to be ill. An obvious beginning is providing a clear and in-depth definition of illness behaviour. However, 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 illness behaviour. We purposely left this topic till now, to form the end of unit 5, module 2. This is because the subsequent units will deal directly with the more specific variables of illness behaviour, like symptom experience, the sick role and so on.

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 behaviour is a broad term that includes both health and illness behaviours.

2.0 OBJECTIVES

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

- Define health behaviour
- Identify dimensions of health behaviour
- Define illness behaviour
- Identify the variations of illness behaviour
- Classify stages of illness behaviour
- Describe abnormal illness behaviour

3.0 Main Content

3.1 Defining Health Behaviour

Health behaviour is a broad term that includes:

- Health Behaviour
- Illness behaviour

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

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 health y 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.

In general, illness and sick-role behaviours are viewed as characteristics of individuals and as concepts derived from sociological and sociopsychological theories. (Encyclopedia of Public Health, 2002).

3.2 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:

1. **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.
2. **Mental Health**: focuses on feelings of anxiety and depression, psychological well-being and control of emotions and behaviour.
3. **Social Well being**: focuses on visiting with or speaking on the telephone with friends and family and the number of close friends and acquaintances.
4. **Role Functioning**: focuses on freedom and limitations in discharging usual role activities such as work or school
5. **General Health Perception**: focuses on self-assessment of current health status and amount of pain being experienced.
6. **Symptoms**: focuses on reports of physical and psychophysiologic 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. Alright, let us focus more on illness behaviour since this course is particularly interested in this area. But before then, let us 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.

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Health behaviour is a broad term that includes: health behaviour and Illness behaviour 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 (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

3.3 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. Let us look at different variations of illness behaviour.

3.4 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.

3.5 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 man y 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.

3.6 Abnormal Illness Behaviour

Before we round up this unit, let us look at another dimension of illness behaviour known as 'abnormal illness behaviour'.
The concept of abnormal illness behaviour' was introduced in 1969 in an attempt to provide a framework for more constructive study of

conditions such as hysteria, hypochondriasis, conversion, and functional overlay. Until that time, study of these conditions had been problematic, as evidenced by the hysteria controversy of the mid 1960's. Since abnormal illness behavior, or dysnosognosia, was first introduced, *it* has not itself escaped controversy and was even described as a dangerous idea at a conference of the European Society for Psychosomatic Research in London in 1985. It is indeed gratifying that abnormal illness behaviour has been recognized as dangerous because its formulation was, to a considerable extent, intended to make quite explicit just how dangerous diagnoses such as hypochondriasis, hysteria, and psychogenic pain were, and hopefully, to point to ways in which any such danger could be eliminated, or at least minimized

Abnormal Illness Behaviour describes not only the problems of patients with bodily symptoms for which no adequate organic cause can be found, but also those who deny the presence of disease which is obvious to others. The former, regarded as manifesting somatization but often labeled pejoratively as hypochondriacs, hysterics and even malingerers, have a different perception of their health problems to that of the doctor and this often leads to misunderstanding and unhelpful emotional reactions in medical professionals interacting with these patients. There is growing interest in the phenomenon of somatization and its causes, which now forms an important research field within the disciplines of psychosomatic medicine, consultation liaison (general hospital) psychiatry, community psychiatry and general practice (primary care medicine)..

Definition of Abnormal illness behaviour: Abnormal Illness behaviour is thus defined as the persistence of a maladaptive mode of experiencing, perceiving, evaluating, and responding to one's own health status, despite the fact that a doctor has provided a lucid and accurate appraisal of the situation and management to be followed (if any), with opportunities for discussion, negotiation, and clarification, based on adequate assessment of all relevant biological, psychological, social, and cultural factors.

This definition grew out of the concept of illness behaviour introduced by Mechanic and Volkart which facilitated the adoption on one hand of a more sociological and, on the other hand, a more operational approach to clinical concepts, such as hypochondriasis, hysteria, and, more recently, *the* somatoform disorders. (Cockerhan, 2003)

4.0 CONCLUSION

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

on them. Also, a brief review of abnormal illness behaviour, which is a very important variable in the understanding of illness behaviour, provided some insight to illness behaviour

5.0 SUMMARY

In this unit, we looked at different perspectives of health behaviour as well as 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. We also looked at abnormal illness behaviour. So in the subsequent units, we will take a thorough look at each stage of illness experience

6.0 TUTOR MARKED ASSIGNMENT

1. Give a detailed definition of illness behaviour?
2. Identify the stages of illness experience/behaviour
3. Give a brief definition of abnormal illness behaviour

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MODULE 3 SYMPTOM EXPERIENCE

UNIT 1 SYMPTOMS: SIGNS AND SYMBOLISM IN MEDICAL DISCOURSE

CONTENTS

1.0 INTRODUCTION

Whether it is regarded as disease or illness, whether it occurs in a society practicing biomedicine or a culture practicing indigenous medicine, sickness is universal. Diseases and illnesses of all types plague each and every society throughout the world. Central to the idea of sickness is the diagnostic element of the symptom. Although man y cultures have unique ideologies regarding sickness, healing, and efficacy, these cultures use the symptom as the primary instrument to maintain their culturally constructed idea of health. Regardless of the healing system or society, globally, people tend to use the symptom as a tool to communicate illness to the appropriate medical practitioner. In seeking the healing action of practitioners and the advice of friends and family, the sick communicate their symptoms as a way of receiving social legitimization for their illness.

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.

2.0 OBJECTIVES

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

- Describe symptoms
- Determine the importance of symptoms
- Ascertain symptom as symbols
- Analyze culture and legitimization of symptoms

3.0 MAIN CONTENT

3.1 Definition of Symptom

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).

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 imperative, 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.

- While the personal significance of the symptom is important, the vitality of the symptom extends beyond personal emotions and cultural boarders.

- Symptoms function as a linguistic bridge that strengthens not only communication and understanding between the patient and the practitioner, but also communication between cultures and within society in general.

- The symptom plays more or less the "role of language action…" (Foucault 1973: 92). Without the linguistic support of the symptom, it would be interesting to imagine how the patient would convey the feelings of the discontinuity of health to his or her practitioner. It would also be interesting to imagine how the patient's perception of sickness, healing, and treatment would be altered due to this lack of linguistic communication. It may be argued by some that certain professional health practitioners would be nonexistent altogether. Therefore, if for no other reason, the symptom is vital for the communication of illness between many people in many health care systems.

- On the other hand, it may be argued that the vocal communication of symptoms is not important. Rather, it is the interpretation of these symptoms that become vital to health care. For instance, when communication of symptoms seems to "taint the truth behind the illness," (Ohnuki-Tierney 1984).

- Symptoms are often powerful enough to speak for themselves. This is evidenced by Emiko Ohnuki-Tierney's observation of *kanpo* physicians who request that their patients not tell them their self-perceived symptoms before they have had the chance to observe them (1984). Although this lack of communication of symptoms may be important to the *kanpo* system, this muting may be detrimental to other health care systems such as biomedicine. Without the verbal communication of symptoms, biomedical physicians may not be able to collect vital information regarding a particular illness. Biomedical physicians have become so dependent on the five senses that it would be

easy to overlook important biological information that did not manifest itself in visible symptoms or test results. Therefore, many cases would result in erroneous therapies that were themselves a shot in the dark.

- The linguistic communication of symptoms may also reveal the cultural construction of health ideology within a culture. The manner in which a person presents his or her symptoms may communicate how a person within the society views illness. Eric J. Cassell discovered the language of doctor-patient interaction within a biomedical health care system revealed that symptoms are frequently signified by the impersonal "the" or "it" forms (Cassell, 1976). For example, a forty-three-year-old woman in Cassell's study impersonally referred to her cancer when she asked her physician to "Make *it* go away" (Cassell 1976: 144). Cassell's research on the linguistic presentation of symptoms disclosed the "reflection of the mind-body relationship" (1976: 143). The presentation of the impersonal pronouns suggests that patients within the biomedical system view symptoms as external indications of disease pathogens. However, different cultures may not share this belief in the Cartesian dualism; these cultures may hold the disease to be a natural process that the body goes through in order to rid itself of a toxin or a possessed spirit. In this situation, the disease and the symptom may be regarded as one with the self.

- Other researchers, such as Setha M. Low, have pointed out that the verbalizing of symptoms communicates more than just bodily discomforts. Low believes that verbalizing symptoms is a "communication about self and the self's relation to the social systems expressed through a disturbance or 'discontinuity' of the body perception" (Low, 1985: 190). In this sense, the personal experience of enduring a symptom becomes extended to the social system.

- As many of these great minds have pointed out, it is very difficult to even discuss health and sickness without calling to mind the concept of the symptom. The extent to which the linguistic implications have on a given health care system does not matter. What does matter is that the communication of the symptom—whether that is a verbal presentation of symptoms or merely the silent healer's interpretation of the manifested symptoms—is a key influence in the healing process. Therefore, the symptom is regarded not only in many cultures and countless medical systems as the indicator of sickness, but the core concept to which diagnosis, treatment, and legitimization attend.

SELF ASSESSMENT EXERCISE

What are Symptoms?

ANSWER TO SELF ASSESSMENT EXERCISE

Symptoms are manifestations of bodily malfunctions. It also enables 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"

Now, we have briefly defined 'symptoms', let us have a look at symptoms as symbols.

3.3 Symptoms as Symbols

Contrary to Deborah R. Gordon's belief that symptoms are merely a "patient's somatic complaints," (1988: 25), the argument presented in this unit, holds that this definition of the symptom is too simple. Symptoms are symbolic and complex explanatory tools. Symptoms provide the sick person and the practitioner an opportunity to understand the cause behind a physiological or psychological ailment. The symptom is the form in which the disease is presented: "of all that is visible, it is the first transaction of the inaccessible nature of disease" (Foucault 1973: 90).

However, the symptom is also symbolic of the activities that may be occurring inside the sick body. Indeed in this situation, that the "signs" of sickness are actual "signs of truth" (Foucault, 1973), and the symptoms themselves resemble a symbol of the illness. Through the process of interpreting symptoms, it is the work of medical practitioners of all types to perceive the invisible in the manifested symptoms (Foucault 1973). It is during this process of interpretation that the symptom "abandons its passivity as a natural phenomenon and becomes a signifier of the disease" (Foucault 1973: 92). Since individuals are not able to "see into their bodies, feelings, in the form of symptoms, provide the lay-person with a way to detect illness and to follow its course" (Telles and Pollack 1981: 247). This is evidenced by the numerous individuals who take zinc lozenges at the onset of a sore throat.

In the same way symptoms are symbols of illness, they are often symbolic of the extent to which illness may extend. For instance, somatic symptoms are often symbolic of other psychological, social, or interpersonal problems (Low 1985). The complexity of a symbol and the complexity of a symptom go hand in hand.

Different types of health practitioners can also interpret symptoms differently. Although criteria defining sickness may differ between cultures, most practitioners do rely on symbols and symptoms to help them determine what is ailing their patient.

Disease is the collection of symptoms, and the definition of disease depends on the health practitioner's interpretation of the symptoms (Foucault 1973). The interpretation of the symptom is culturally constructed, and the cultural interpretation of the symptom plays a crucial role in the diagnosis and treatment of the symptom. Therefore, several ambiguities may result from the consultation of a single patient between several differing medical systems.

What is considered a proper diagnosis for a given set of symptoms in one culture may be construed as inappropriate in another culture. For example, in France, systematic prescription of lactobacillus to accompany the prescription of antibiotics is a common practice (Payer 1982). Although French theory supports that lactobacillus prevents the nausea caused by the destruction of good bacteria in the stomach by the antibiotic, this theory has yet to be experimentally proven. Therefore, this prescription of lactobacillus for nausea in patients receiving antibiotics may be viewed by some societies as the act of over-prescribing, and the symptom of nausea may be overlooked.

3.4 Culture and Legitimization of Symptoms

Healing is viewed differently across cultures and "in different sectors of health care" (Kleinman and Sung 1979: 8). The perception of symptoms and the way in which they are integrated into the healing process of a culture distinguishes the concept of health and healing between these cultures. Although each person may perceive sickness in a unique way, (Hahn 1995) symptoms allow the "invariable form of the disease to show through" (Foucault 1973: 90). This theory of invariability is the basis for the universal treatment that allopathic biomedical physicians give for a given set of symptoms.

As previously discussed, culture is imperative to the perception of a symptom. While some cultures, such as those supporting biomedicine, depend solely on physically visible symptoms, other more non-traditional cultures give value to inner workings of the body in the form of invisible symptoms. Cultural factors often dictate the severity of symptoms, therefore influencing the treatment a patient may receive. Cultural ideas play a "central role in determining who seeks medical attention, for what conditions, when, and with what results" (Hahn 1995: 68). For example, diarrhoeal diseases are taken seriously in many African societies because they are closely related to dehydration, and

ultimately death. However, in most western cultures, diarrhoea is not considered a severe symptom; therefore, most children do not seek medical care for this problem that can easily be remedied in the home environment.

Different aspects of symptoms affect the healing process of the patient in several ways. For example, if a biomedical physician does not believe the patient is presenting socially legitimate symptoms, the physician may choose to deliver a placebo to the patient. The placebo effect is an example of the power of culture on a person's perception of symptoms. The beliefs of the patient manifesting the placebo effect illustrate how culture can shape the healing process. If western biomedical societies did not stress the importance of taking medication as part of the effective healing process, the psychological benefits of the placebo would cease to exist. Therefore, the placebo effect is closely tied to the legitimization process.

Like the placebo effect, the legitimization process is culturally constructed and socially controlled. In biomedical health care systems, when individuals visit the physician, they are often examined "in light of reported feelings, behavior and other symptoms in order to establish whether or not illness exists" (Telles and Pollack 1981: 247). People may also seek others within their culture in regards to the management of their illness, and in doing so; they also seek legitimization for the symptoms they manifest before seeking the help of a practitioner. The actual presentation of symptoms "absolves the individual of responsibility and provides a culturally acceptable distress signal" (Low 1985: 191) to the community a signal that will legitimize the sick role.

The sick role is known as the title one receives when he or she has maintained social legitimization for his or her symptoms. Benefits of the sick role occur when the presentation of the symptoms "absolves the individual of responsibility and provides a culturally acceptable distress signal" (Low 1985: 191). However, the benefits that a patient may receive while participating in the socially legitimized sick role may be put to an end by the healer. This termination of the sick role often occurs when the patient and the healer have different concepts of efficacy, as evidenced by the numerous occasions in which the healer fails to eradicate the disease before terminating the sick role. When this occurs, the disease often re-emerges in the form of a "somatized syndrome". Abuse of the socially prescribed sick role occurs quite often. This abuse occurs when individuals perceive "some psychological or social reward from occupying a sanctioned sick role, these symptoms represent illness in the absence of disease" (Kleinman 1980: 366). The abuse of the sick role occurs when people linger within the role beyond the socially legitimated length of time. Patients

assigned to the sick role are "anticipated to pass through the system, not to remain within it" (Alexander 1982: 351). The social legitimization of disease, the assignment of the sick role, and the abuse of the sick role are all discussed here to illustrate the crucial role that the manifestation and presentation of symptoms play in the cultural legitimization of illness and the process of healing.

Culture is a vital element in medicine because it helps determine not only what a legitimate symptom may be, but it also dictates how the practitioner should treat the symptom, and the extent to which the therapy should be employed. For example, before repetition injury syndrome (RSI) and chronic fatigue syndrome were researched and socially accepted as legitimate illnesses, the biomedical society was quick to judge people suffering from these illnesses as malingerers and would often order a psychological consult (Reid 1990). It was difficult for societies supporting biomedicine to categorize these syndromes as illnesses due to the lack of visible symptoms. RSI has been described as "an illness for which there was no pathogen, characterized by symptoms in the absence of signs, and pain without discernible damage" (Reid 1990: 170). This example also sheds light on the importance of signs. Without bodily signs, symptoms are difficult for society to legitimate. The sign is the larger truth that announces and "indicates that which is further away" (Foucault 1973: 91). Every culture has rules for "translating signs into symptoms, for linking symptomatologies to aetiologies and interventions, and for using the evidence provided b y interventions to confirm translation and legitimate outcomes" (Telles and Pollack 1981: 245). The presence and interpretation of these signs indicates underlying truths regarding the symptoms present.

As opposed to biomedicine, societies supporting non-traditional health care systems take more stock in "invisible symptoms" (Foucault 1973). Charles L. Briggs's investigation of the Warao curers of the Delta Amacuro of east Venezuela illustrates the importance of invisible symptoms in this Venezuelan society. In his investigation, Briggs sheds light on the fact that the Warao curers treat many invisible symptoms such as those inflicted by a "ray whipping around inside their [patient's] bodies…" (1994: 149).

From the aforementioned examples, one can see that culture absorbs information about symptoms and signs and dictates what diagnoses and treatments would be culturally acceptable. In this sense, symptoms are given "sociocultural meaning based on the [cultural] values" (Low 1985: 188) that dictate the social and health care systems. Therefore, symptoms are valued in many cultures as the key to health and healing.

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.

The argument presented in this unit would be deficient without the discussion of the enormous bearing to which symptoms have on culture and the legitimization of illness as a social process. The specific example, and discussions of research projects and case studies presented in this unit offer supplemental evidence of the symptoms centrality to the healing process. Just as it would be difficult to discuss the process of healing without mentioning the symptom, a thorough discussion of the symptom itself would be incomplete without a discussion of the healing process. As discussed in the previous sections of this unit, the symptom functions similarly within many otherwise different cultures. Although the copious societies throughout the world maintain assorted ideologies regarding sickness and health, the significance placed on the symptom by each of these cultures creates the impression that the symptom is universally central to the concept of healing. Therefore, as long as illness and healing remain universally important concepts, the symptom itself will remain a vital attribute to the ideologies of health and healing.

5.0 SUMMARY

Symptoms are an integral part of the healing process in numerous ways. While the concept of the symptom may seem straightforward, one can see that the symptom is deeply embedded in many aspects of an integrated culture.

This unit therefore provided numerous concepts of symptom as well as its symbolisms. We also looked at culture and legitimization of symbols, as cultural ideas determines who seek medical care. We 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. Why are symptoms so important?
2. Give a brief analysis of culture and legitimization of symptoms.

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UNIT 2 SYMPTOM INTERROGATION, LIST, AND ASSESSMENT OF SYMPTOMS

CONTENTS

1.0 INTRODUCTION

Signs are what the doctors see or elicit. Symptoms are what you experience. It is worthy to note that about 90 – 95% of a doctor's diagnosis comes from what we say. Thus, if we do not give the doctor all of our symptoms and history, then we are asking for wrong diagnosis of illness. So in this unit, we will look at symptoms interrogation, lists and assessment of symptom.

2.0 OBJECTIVES

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

- Identify steps involved in symptom interrogation
- Ascertain various list of symptoms
- Describe factors involved in symptom assessment

3.0 MAIN CONTENT

3.1 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

3.2 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, ulcer, 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, 1999-2007)

SELF ASSESSMENT EXERCISE

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

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Onset, palliative, provocative, quality and radiating stages

ii. **a.** **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.

b. **Sudden weight loss (unexplained)**: - may be indicative of cancer, diabetes, thyroid condition (overactive), hepatitis, parasites, infection or mal-absorption syndrome.

c. **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.

d. **Abdominal Pain**: - may be indicative of appendicitis, food allergies, food poisoning, gastro-intestinal disorders, hernia or pre-menstrual syndrome.

e. **Backache:** - may be indicative of back strain, DJD (degenerative disc disease), lack of exercise, obesity, female disorders, spinal injury or pancreatic disorders.

This exercise is really very interesting. Here, we have been able to learn some useful medical symptoms. This course is indeed a very interesting one. Now, let us continue with our studies. Next is assessment of symptoms.

3.3 Assessment of Symptom

David Mechanic (1968), developed a theory of health seeking behaviour to facilitate an understanding of assessment process and how people act prior to (or instead of) seeking a health-care provider. Mechanic traces the variations in how people respond to illness to differences in how they define the illness situation and the differences in their ability to cope with the illness situation. The process of definition and the ability to cope are both culturally determined. As individuals mature through life stages, they are socialized with families and within communities to respond to illness in particular ways. Part of this socialization is observing how others respond to illness and noting the positive and negative reaction their behaviour, elicit. Sociologists refer to this as the Social construction of illness. Mechanic however identifies 10 factors that determine how individuals assess symptoms of illness. They are:

- **The visibility, recognizability or perceptual salience of symptoms** – Here, many symptoms present themselves in a striking fashion, such as in the case of sharp abdominal pain or intense headache and a high fever. Other symptoms have such little visibility (early stages of cancer and tuberculosis), that they require special check-ups to be detected at the early stages.

- **The perceived seriousness of the symptom** – if the symptom is familiar and the person understands why he/she has the symptom and what its probable course will be, he/she is less likely to seek care, than if the symptom is unusual, strange, threatening, and unpredictable.

- **The extent to which the symptom disrupts family, work and other social activities** – Symptoms that are disruptive and which cause inconveniences, social difficulties, pain and annoyance are more likely to be defined and responded to than those that do not.

- **The frequency of the appearance of symptoms, their persistence or frequency of reoccurrence** – The more persistently ill a person is, other factors remaining constant, the more likely for him/her to seek help. Also, frequent and persistent symptoms are more likely to influence a person to seek help than occasional reoccurring symptoms.

- **The tolerance threshold of those who are exposed to and evaluate the deviant signs and symptoms** – An individual's tolerance for pain and discomfort and his/her value about stoicism and independence may also affect how he/she respond to symptoms and what he/she does about them. Persons vary a great deal in how much discomfort they are willing to tolerate and the attention they give to bodily troubles.

- **Available information, knowledge and cultural assumptions and understanding of the evaluator** – The sophistication of patients about medical matters varies from those who are aware of the latest new therapeutic developments even before their doctors, to those who cannot identify the basic body organs and who have very naïve notions of bodily functioning. Such differences in medical knowledge and understanding have considerable influence in how people recognize, define and respond to symptoms.

- **Perceptual needs which leads to autistic psychological process** – Anxiety and fear may impact symptoms recognition and the decision to seek care in complex ways. Anxiety about illness may

prompt quicker care seeking, but fear of particular diagnosis may delay seeking help.

- **Needs competing with illness response** – People assign varying degree of priority to health. While illness symptom might be a central focus for some, family and work-related activities are more important to others.

- **Competing possible interpretations that can be assigned to the symptoms once they are recognized** – people who work hours expect to be tired and are therefore less likely to see tiredness as indicative of an illness. Also, people who do heavy physical work are more likely to attribute such symptoms as backaches to the nature of their lives and work rather than to an illness condition.

- **Availability of treatment resources, physical proximity and psychological and monetary cost of taking action** – The cost of treatment, convenience of treatment and the cultural and social accessibility of the provider all impact on the care seeking behaviour.

4.0 CONCLUSION

Like we note earlier, signs are what the doctor see, while symptoms are what we experience, as a result of illness and associated discomfort. We should therefore be very precise and open with the health specialist so as to avoid wrong diagnosis. Also, the list of symptoms provided above serves as a good reference point for symptom evaluation and assessment.

5.0 SUMMARY

We hope you find this unit very interesting. We started by discussing various stages of symptom interrogation employed by health care experts for more precise diagnosis. This unit also provided some list of symptoms and associated characteristics. Finally, this unit enumerated 10 factors that determine how individual assess symptoms. A good understanding of these factors would aid our appreciation of this course. Now, let us attempt the questions below.

6.0 TUTOR MARKED ASSIGNMENT

Identify and describe the 10 factors of symptom assessment.

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UNIT 3 SYMPTOM EXPERIENCE STAGE: PHYSICAL PAIN AND DISCOMFORT

CONTENTS

1.0 INTRODUCTION

Symptom experience stage is the first stage of illness behaviour proposed by Suchman (1965). The illness experience is initiated when an individual first senses that something is wrong – a perception of pain, discomfort, general unease or some disruption in bodily functioning. Suchman (1965) states that 3 distinct processes occur at this time, namely:

1. The physical pain or discomfort
2. The cognitive recognition that physical symptoms of an illness are present
3. The emotional response of concern about the social implication of the illness, including a possible disruption in ability to function.

This unit is thus focused on the first process of symptom experience stage which is experiencing physical pain and discomfort.

2.0 OBJECTIVES

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

- Define pain
- Enumerate types of pain experience
- Identify physiological factors in symptom experience

- Ascertain gender differences on pain experience
- Review the Gate Control Theory of pain

3.0 MAIN CONTENT

3.1 Defining Pain Experience

Pain is a very special sensation because in its nature it is unpleasant. The problem with defining and describing this sensation is that amongst other things pain is not a uniform concept with a single cause or basis. The phenomenon of pain has many underlying mechanisms, both neuro-physiological and psychological. The difficulty associated with defining pain is very relevant for Man, but is even more difficult so for animals - where the problems of recognizing and interpreting pain together with judging the level of pain are significant.

3.1.1 What is Pain?

Pain can be difficult to define. But an attempt to give a definition can be worthwhile in itself because it illustrates the difficulties associated with diagnosing pain in individuals.

A Choice of Different Definitions of Pain:

Definition 1- Pain, as the opposite of pleasure, is the sensation perceived when one is exposed to injury (in body or soul) or stress, bodily or mental suffering (Oxford English Dictionary).

Definition 2 - Pain is the sensation of being injured, or the feeling of considerable discomfort in a part of the body, caused by injury, disease or abnormal function, and conveyed through the nervous system (Webster's Dictionary).

This is a more limited definition that does not include mental pain, and avoids the commonly accepted fact that pain does not necessarily need to have a physical dimension.

Definition 3 - Pain is also the consciously perceived sensation that occurs with noxious agents of a sufficient strength to injure or threaten to injure the body or its tissues. Pain will result in attempts to avoid the source, and this can modify behaviour that is typical for the species, including social behaviour.

Regardless of which definition is used, one should accept that a conscious individual or even animals, is capable of perceiving

sensations that they will try to avoid, if possible. These sensations result in changes in the reaction pattern that humans show when they feel pain.

Pain can in its widest sense be said to cover all from mild discomfort (e.g. with a vaccination injection) to extreme pain as for example with the amputation of a limb without anaesthesia. This then leads us to types of pain experience.

3.2 Types of Pain Experience

Pain is often described as:

- None
- Moderate
- Severe
- Excruciating

Pain can also be measured on various scales (including picking a number between zero, for none, and ten, for excruciating). You are the only one who can determine the severity of your pain. How much pain anyone else has in similar circumstances is not important in figuring out what you need. However, you might feel comfort knowing that others have been through similar experiences and have found ways to cope. You might find some people to talk with about severity of pain, medications, or activities that affect pain in order to share experiences - just don't expect that things will be the same for you.

People experience pain differently and need different doses of medicine to relieve pain. Using more or less medicine than someone else doesn't reflect on your character or ability to tolerate pain. While some people, including doctors, may express surprise at your medications, it is usually because they do not under-stand one of the most important rules of pain control: The right dose of pain medicine is the dose that relieves the pain.

SELF ASSESSMENT EXERCISE

i. Define Pain
ii. Illustrate types and measures of pain experience

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Pain is the sensation of being injured, or the feeling of considerable discomfort in a part of the body, caused by injury, disease or abnormal function, and conveyed through the nervous system.

ii. Types and measures of pain experience are: None, Moderate, Severe or Excruciating; Pain can also be measured on various scales (including picking a number between zero, for none, and ten, for excruciating).

We hope you enjoyed this exercise. Let us look at another interesting aspect of pain experience – the physiological factor of pain.

3.3 Physiological Factor of Pain Experience

Physiological factors are very important in pain perception and provide a first step in assessment and treatment. Such awareness with physiological states begins with sensory receptors throughout the bod y that transmit nerve impulses to the brain, where they are interpreted as various sensations. Skelton and Pennebaker (1990), note three types of somatic senses that are relevant to perception of pain. They are:

Mechano-receptive senses – These detect the displacement of tissue and are sensitive to touch, pressure, vibration and kinesthetic changes.

Thermo-receptive senses – These distinguish heat and cold.

Pain senses – These are usually related to tissue damage.

Stimulation of the receptors related to these senses give rise to bodily sensations that we call pain and symptoms.

3.4 Gender Differences on Pain Experience

Pain has been an under-researched area of medicine, but today physicians are increasingly interested in the workings and treatment of various types of pain. In particular, a growing body of research exists on the different ways in which men and women may experience pain and the implications of these differences for medical treatment. Does the sex of an individual make a difference in their pain experience? Numerous researchers believe that women are more sensitive to pain than men, while others believe that the differences between the pain experiences of men and women are not significant. However, the problem in trying to answer the question lies in how scientists measure the pain experience of men and women.

The difference in the pain experience of men and women is an understudied area because most previous studies of pain and its potential treatments have only used men or male animals. For scientists, using only males was simpler since women have reproductive hormone cycles that could complicate the studies. The implication of this, of course, is

that sex differences in the experience of pain (and in many other aspects of health) has remained an understudied area. However, in 1993 President Clinton signed the National Institute of Health, Revitalization Act, which requires the inclusion of women in NIH research. In 1996 the NIH formed a Pain Research Consortium, and in 1998 the NIH held a conference entitled "Gender and Pain" (National Institute of Health, Gender and Pain Conference, 1998).

At the National Institute of Health (NIH), conference, some researchers argued that sex differences in pain are substantial and argued specifically that women are more sensitive to pain. For example, women report pain more often and also report it at higher levels than men. Additionally, when men and women are exposed to the same pain stimulus, women will say that they are in pain more quickly than men (National Institute of Health, Gender and Pain Conference, 1998).

However, others believe that sex differences in the experience of pain may not be so significant. The higher reported pain levels of women may be due more to gender socialization than to biological differences between men and women. For example, in most laboratory pain studies women report about twenty percent more pain than men (American Psychological Association Monitor Online). However, researchers at the University of Florida examined pain reporting of chronic pain patients in a clinical setting and found that women reported only three to ten percent more pain than men, a significantly smaller difference. The researchers believed that women may not always experience more pain, but rather are socialized to acknowledge pain and thus are more likely to report it in both laboratory and clinical settings. Men are taught to not acknowledge pain, so in a short-term lab experiment they are less likely than women to admit that they are in pain. However, men experiencing chronic pain want relief for their long-term suffering, so gender socialization is less of a barrier to acknowledging pain in a clinical setting (American Psychological Association Monitor Online).

A recent University of Washington study, presented at the NIH "Gender and Pain" conference, also suggests that men and women with chronic pain experience similar levels of pain. The study had two rounds, the first examining 202 men and 226 women with chronic non-cancer related pain. The researchers examined "prior treatment for pain, pain severity, emotional distress, interference of pain with life, and impact of pain on functional activities." Researchers did not find women reporting more severe pain, or "interference of pain with life" or "functional activities." The only area of significant difference between men and women was emotional distress, since women reported higher levels of depression. Since depression is generally thought to be higher among women, the researchers did not believe that the depression was

necessarily pain related (National Institute of Health, Gender and Pain Conference, 1998).

The second round of the study examined 91 men and 52 women with cancer-related chronic pain. In this sample, the researchers found no differences between the sexes in the various measures of pain. Unlike the first study, there was no difference in depression levels between men and women, perhaps because in the second sample all of the patients were suffering from a potentially deadly illness (cancer) and therefore more generally prone to depression. The University of Washington researchers concluded that in treating chronic pain, the sex of the patient is less important than their psychosocial characteristics such as coping ability, marital satisfaction, and the impact of outside life activities (National Institute of Health, Gender and Pain Conference, 1998).

Additionally, research on a genetic basis for pain differences between men and women is inconclusive. Researchers on pain differences in animals such as mice have found that generally the female animals appear more sensitive to pain and do not respond as much to pain relievers as males. However, the differences between males and females do not tend to be large (Fillingim, 2000). Furthermore, researchers believe that "even within gender, there are individual differences in feeling pain that are linked to still undiscovered genes" large. Researchers at Johns Hopkins University and the National Institute on Drug Abuse have located a gene that may be responsible for individual variations in pain sensitivity. The gene codes for the mu opiate receptor, which binds with endogenous painkillers such as endorphins as well as exogenous painkillers such as morphine and heroin. These receptors are found primarily in the thalamus, the cerebral cortex, the visual cortex, and the basal ganglia, but with a great deal of individual variation in their number (Leutwyler 1999). Researchers examined eight mouse strains with variations in the mu opiate gene, and found that the mice with more active form of the gene had a greater number of mu opiate receptors in the brain and a higher pain tolerance. While still a new area of research in humans, studies on human mu opiate genes have found individual variations in the regulatory portion of the gene that may account for individual variations in pain experience (Leutwyler, 1999).

How, then, do we know whether men and women experience pain differently? The genetic evidence for a gender basis of pain is not conclusive and points to individual variations as more significant than sex variations. Another challenge is that we cannot "see" pain, only a subject's reaction to a painful stimulus. In the case of humans, we also can use their description of their physical discomfort. However, women are socialized to more freely acknowledge their pain and men to minimize theirs, how can we know if the actual pain experience of men

and women is different? It is thus difficult to reach a conclusion, in part since this is a relatively new area of research. Additionally, while research focusing on chronic pain may be assessed, there is a huge range of types of pain that humans can experience. Therefore, examining pain solely through the person's sex gives an incomplete picture. The differences may lie more at the level of the individual and the intersection of their current pain experience with their psychological and social background.

3.5 Gate Control Theory of Pain

The **gate control theory of pain**, put forward by Ronald Melzack and Patrick Wall in (1962), and again in (1965), is the idea that physical pain is not a direct result of activation of pain receptor neurons, but rather its perception is modulated by interaction between different neurons.

Experiments were performed on dogs which, were raised confined in cages. When released, the dogs were excited, constantly ran around, and required several attempts to learn to avoid pain. When pain such as a pinch or contact with a burning match was encountered, the animals could not take action to avoid the stimulus immediately. This finding seemed to demonstrate that pain is understood and avoided only by experience- aversion to it is not inbuilt or automatic, and the organism has no way to know what will cause repeated pain without a repeated experience.

Physiology

Afferent pain-receptive nerves, those that bring signals to the brain, comprise at least two kinds of fibres - a fast, relatively thick, myelinated "Aδ" fibre that carries messages quickly with intense pain, and a small, unmyelinated, slow "C" fibre that carries the longer-term throbbing and chronic pain. Large-diameter Aβ fibres are nonnociceptive (do not transmit pain stimuli) and inhibit the effects of firing by Aδ and H fibers.

The peripheral nervous system has centres at which pain stimuli can be regulated. Some areas in the dorsal horn of the spinal cord that are involved in receiving pain stimuli from Aδ and C fibres, called laminae, also receive input from Aβ fibres (Kandel et al., 2000). The nonnociceptive fibers indirectly inhibit the effects of the pain fibres, 'closing a gate' to the transmission of their stimuli (Kandel et al., 2000). In other parts of the laminae, pain fibres also inhibit the effects of nonnociceptive fibers, 'opening the gate'.
An inhibitory connection may exist with Aβ and L fibres, which may form a synapse on the same projection neuron. The same neurons may

also form synapses with an inhibitory interneuron that also synapses on the projection neuron, reducing the chance that the latter will fire and transmit pain stimuli to the brain. The C fibre's synapse would inhibit the inhibitory interneuron, indirectly increasing the projection neuron's chance of firing. The Aβ fibre, on the otherhand, forms an *excitatory* connection with the inhibitory interneuron, thus *decreasing* the projection neuron's chance of firing (like the C fiber, the Aβ fibre also has an excitatory connection on the projection neuron itself). Thus, depending on the relative rates of firing of C and Aβ fibres, the firing of the nonnociceptive fibre may inhibit the firing of the projection neuron and the transmission of pain stimuli (Kandel et al., 2000).

Gate control theory thus explains how stimulus that activates only nonnociceptive nerves can inhibit pain. The pain seems to be lessened when the area is rubbed because activation of non-receptive fibres inhibits the firing of receptive ones in the laminae (Kandel et al., 2000). In transcutaneous electrical stimulation (TENS), non-receptive fibres are selectively stimulated with electrodes in order to produce this effect and thereby lessen pain.

One area of the brain involved in reduction of pain sensation is the periaqueductal grey matter that surrounds the third ventricle and the cerebral aqueduct of the ventricular system. Stimulation of this area produces analgesia (but not total numbing) by activating descending pathways that directly and indirectly inhibit non-receptors in the laminae of the spinal cord (Kandel et al., 2000). It also activates opioid receptor-containing parts of the spinal cord.

Afferent pathways interfere with each other constructively, so that the brain can control the degree of pain that is perceived, based on which pain stimuli are to be ignored to pursue potential gains. The brain determines which stimuli are profitable to ignore over time. Thus, the brain controls the perception of pain quite directly, and can be "trained" to turn off forms of pain that are not "useful". This understanding led Melzack to point out that **pain is in the brain**.

4.0 CONCLUSION

It is now obvious that there are different pathways to the understanding of pain and physical discomfort. Definition of pain was a bit tricky but we were able to recognize several working definitions. I hope they tallied with your conceptions of pain.

5.0 SUMMARY

I hope you enjoyed this unit. The concept of pain experience is really a very interesting and intriguing one. This unit provided definition of pain as well as enumerated different types of pain experience. This unit went further to critically examine gender differences on pain experience, which we found very interesting. This unit finally assessed the Gate Control Theory of Pain. I hope the terminologies used were not very confusing. You must agree with me that those are medical terminologies which are always constant. Now, let us attempt this exercise.

6.0 TUTOR MARKED ASSIGNMENT

1. Identify the 3 types of somatic responses that are relevant to pain experience.
2. Does the sex of an individual make a difference in pain experience? – Discus.

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UNIT 4 COGNITION AND SYMPTOM EXPERIENCE

CONTENTS

1.0 INTRODUCTION

Cognition or cognitive processes can be natural and artificial, conscious and not conscious; therefore, they are analyzed from different perspectives and in different contexts. The concept of cognition is closely related to such abstract concepts as mind, reasoning, perception, intelligence, learning, and many others that describe numerous capabilities of human mind and expected properties of artificial or synthetic intelligence. This unit therefore seeks to provide relevant information on the above concept.

2.0 OBJECTIVES

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

- Define cognition
- Define illness cognition
- Identify cognitive dimensions of illness belief
- Describe the psychological factors of symptom cognition

3.0 MAIN CONTENT

3.1 Defining Cognition

The term **cognition** (Latin: *cognoscere*, "to know") is used in several loosely related ways to refer to a faculty for the human-like processing of information, applying knowledge and changing preferences. Cognition is an abstract property of advanced living organisms; therefore, it is studied as a direct property of a brain or of an abstract mind on subsymbolic and symbolic levels.

In psychology and in artificial intelligence, it is used to refer to the mental functions, mental processes and states of intelligent entities (humans, human organizations, highly autonomous robots), with a particular focus toward the study of such mental processes as comprehension, inferencing, decision-making, planning and learning.
The term "cognition" is also used in a wider sense to mean the act of knowing or knowledge, and may be interpreted in a social or cultural sense to describe the emergent development of knowledge and concepts within a group that culminate in both thought and action.

Empirical research into cognition is usually scientific and quantitative, or involves creating models to describe or explain certain behaviours.

3.3 Defining Illness Cognition

Illness cognitions are defined as “a patient’s own implicit common sense beliefs about their illness”. Illness cognitions provide patients with a framework for coping with and understanding their illness, and telling them what to look out for if they are becoming ill.

3.3 Cognitive Dimensions of Illness Beliefs

Leventhal et al, (1992) identified the following five cognitive dimensions of these beliefs.

1. **Identity:** This refers to the label given to the illness (the medical diagnosis) and the symptoms experienced. For example, “I have a cold (the diagnosis) with a runny nose (the symptoms)”.

2. **Perceived cause of the illness:** These causes may be biological (for example, a virus or a lesion) or psychosocial (for example stress). For example, “My cold was caused by a virus” or “My cold was caused by my being run down”.

3. **Time line**: This refers to a patient’s beliefs about how long the illness will last, thus whether it is acute or chronic. For example, “My cold will be over within a few days”.

4. **Consequences:** This refers to the patient's perceptions of the possible effects of the illness on their life. Such consequences may be physical (for example, pain or lack of mobility), emotional (for example, loss of social contact or loneliness) or a combination of factors (for example, "My cold will prevent me from playing rugby, which will prevent me from seeing my team mates").

5. **Curability and controllability**: Patients also represent illnesses in terms of whether they believe that the illness can be treated and cured and the extent to which the outcome of their illness is controllable either by themselves or by powerful others. For example, "If I rest, my cold will go away" or "If I get medicine from my pharmacist, my cold will go away".

SELF ASSESSMENT EXERCISE

i. Define illness cognition
ii. Identify the cognitive dimensions of illness beliefs.

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Illness cognitions are defined as "a patient's own implicit common sense beliefs about their illness". Illness cognitions provide patients with a framework for coping with and understanding their illness, and telling them what to look out for if they are becoming ill.
ii. The cognitive dimensions of illness beliefs are: identity, perceived cause of illness, time line, consequences and curability and controllability.

Are you done with this exercise? If so, let us look at psychological factors of symptom cognition.

3.4 Psychological Factors in Symptom Cognition

Five psychological factors will be discussed in this section. They are: cognitive set, focus on attention, expectations, emotions and learning.

3.4.1 Cognitive Set

Observations have shown that the act of making certain symptoms more prominent by thinking about them often can increase symptom reporting. For example, in an experiment by Skelton, Oppler, Taylor and Thomas (1988), subjects were asked to imagine different physical symptoms such as 'stomach upset', "cold hands" and "itchy ankle", while the control group were asked to imagine non-health-related images such as a friend's face. It was observed that subjects that thought about symptoms reported experiencing more of the symptoms they were thinking of than the control group.

3.4.2 Focus on Attention

One of the more subtle, but pervasive, influences on our symptom perception is our focus on attention. Studies have shown that symptoms perception, often depend on what people happen to be attending to (Fillingim and Fine, 1986). This assertion, tallies with the common observations by parents concerning injury perception in their children. Children, particularly younger ones, often come home with various cuts and scratches, sometimes even bleeding, but think nothing of them until the injuries are pointed out, at which point they become extremely concerned, even bursting into tears.

3.4.3 Emotions

So far, we have been concerned with cognitive influences as well as focus of attention on symptom perception but what about our emotions? Do they also influence the symptoms that we perceive? Experience seems to suggest that they do. Of course, there are days when we are in such a good mood that we hardly notice our aches and pains, but we have also had bad days when we seem to notice every discomfort, no matter how minor. More general, mood disposition tend to influence symptom perception. In particular, research indicates that people who are prone to negative affectivity – a general disposition to experience negative emotions such as anger, disgust, depression and guilt – are more sensitive to illness and physical discomfort than are people less prone to negative states (Watson and Pennebaker, 1991).

3.4.4 Learning

In determining the illness symptoms that people experience, we also need to include the role of learning. In a very real sense, we learn how to experience symptoms. For example, children are taught both directly or through observations which symptoms are important and which are trivial. A mother's concern about a rash and seeming unconcerned about

a superficial cut might provide a child with cues about which symptoms to attend to and which to ignore. In addition, symptom report can be used as a means of communication. When we want attention and emotional support, or even avoid certain obligations, we can use statements about symptoms to achieve those ends (Skelton and Pennebaker, 1990).

3.4.5 Expectations

Observations indicate that the process of experiencing illness symptoms could be enhanced when individuals have specific ideas as to what they should be experienced. Pennebaker (1982); Pennebaker and Skelton (1981), contend that the process of experiencing symptoms can be thought of in terms of a hypothesis-guided search. Bodily sensation occur continually and are often rather vague and ambigious. Given this ambiguity, how we experience these sensations is likely to be influenced strongly by our hypotheses as to what we should be experienced.

In an experiment testing this idea, Pennebaker and Skelton, (1981), subjects were told that they would be exposed to two minutes of ultrasound noise. Further, these subjects were told that this noise would result in either an increase or decrease in finger temperature. After exposure to a tape with the "ultrasonic noise" (in actually all about 15 seconds of the tape was blank), subjects were asked to rate their finger temperature and indicate the extent to which they paid attention to the warmth and coolness of their fingers. Actual finger temperature was monitored during the session with a thermistor. During the experiment, there was in fact, no overall change in finger temperature for subjects in any of the conditions. However, those led to believe that they would experience an increase in finger temperature showed a rise in perceived finger temperature; and this was not the case for those expecting a decrease or who were given no hypothesis at all.

Particularly revealing was the finding that the amount of increase or decrease in perceived skin temperature was correlated with the number of fluctuations in recorded skin temperature during the session. Thus, this suggests that subjects were paying attention to the random fluctuations in skin temperature during the session and inferring from these the amount of increase or decrease. When expecting an increase in temperature, subjects inferred that more fluctuations indicated a greater increase in temperature whereas subjects expecting a decrease concluded that more fluctuation meant more of a decrease in temperature.

4.0 CONCLUSION

The role of cognition on symptom experience is indeed a very complex one. It influences how individuals perceive and interpret symptoms and also the health seeking behaviours. Cognitive set for example, portrayed that the act of making certain symptoms more prominent by thinking about them often can increase symptom reporting. Symptom experience is also influenced by emotions, learning, expectations and focus on attention. We hope you enjoyed your studies.

5.0 SUMMARY

In this unit, we provided a working and general definition of cognition. Also, since this course is more interested in illness behaviour, we also tried to be more specific by defining illness cognition. This unit also provided 5 dimensions of cognitive beliefs of illness experience. Finally, this unit identified and discussed various psychological factors in symptom experience. One may rightly ask, why focus only on the psychological aspect, and disregarding other aspects. It is thus of the opinion that cognition is directly related to psychological principles and it will be cumbersome to deviate from this. Now let us attempt the following questions below.

6.0 TUTOR MARKED ASSIGNMENT

Identify and describe the psychological factors of symptom cognition

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UNIT 5 SYMPTOM EXPERIENCE: ILLNESS AND EMOTIONAL EXPERIENCE

CONTENTS

1.0 INTRODUCTION

A positive attitude can contribute to anyone's good health. However, that sort of attitude can be difficult to maintain when one is faced with a chronic illness or disability. Such illness produces emotional reactions such as anger, sadness, frustration, and especially fear. These add to the distress and suffering, and may also make the physical symptoms worse. Sometimes people are ashamed of these feelings, or do not know how to express them.

When the negative feelings become overwhelming, depression sets in. You might be surprised to learn that depression is a coping mechanism (believe it or not!) that humans have evolved, as a response to man y stressful life situations, including chronic illness.

This unit, therefore, looks at various experiences and responses people employ in order to tackle symptom manifestations. This unit will also look at the debilitating effect of stress on symptom experience.

2.0 OBJECTIVES

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

- Identify the various forms of emotional response in illness
- Discuss stress and illness
- Illustrate three theories of stress
- Explain stress and biology

- Discuss stress and symptom experience

3.0 MAIN CONTENT

3.1 Forms of Emotional Responses in Illness

The following variables are thus identified:

- **Grief response**: Grief reaction occurs when patients mourn the loss of their previous healthier functioning or healthy state. The working through of these emotions is analogous to grieving for a loved one. Grieving entails recognition of the good and bad associated with a particular loss, which prompts a series of feeling states - *denial, anxiety, anger, and depression* - that a person must progress through before resolving those emotions and coming to terms with a temporary or permanent health impairment.

- **Denial Response** - Persistent denial is often reflected in noncompliance with therapeutic regimen, which may commence immediately after a medical crisis (e.g., refusal to maintain bed-rest) and continue throughout a chronic illness (e.g., continued smoking in a patient with chronic obstructive pulmonary disease).

- **Anxiety Response** - Patient becomes hypersensitive about illness; such absorption with one's physical status greatly detracts from all other aspects of life, progressively displacing former pleasures with a debilitating anxiety.

- **Anger Response** - Once patients feel secure they will survive, they direct their resentments of being sick globally and toward specific targets. They also engage in overt and covert struggles with people in their lives, which foster a progressive isolation from necessary support and undermines their medical care.

- **Depression** - Anger abates, and patient develops a growing sense of depression characterized by emotional, behavioural, and cognitive changes that reflect their extreme preoccupation with real and potential losses brought on by the illness experience.

- **Dependency Response** - Patient becomes excessively dependent on healthcare personnel or relatives and may haphazardly adhere to prescribed therapies. To that, caretaker must then compensate for patients self-neglect by providing an even greater degree of care.

3.2 Stress and Illness

Everyday we are confronted with problems. When we are confronted with a problem we must determine the seriousness of the problem and determine whether or not we have the resources (e.g., emotional resources) necessary in order to cope with the problem. If we believe that the problem is serious and we also believe that we do not have the resources necessary to cope with the problem, we will perceive ourselves as being under stress.

- **Stress** can be defined as a process in which environmental demands strain an organism's adaptive capacity, resulting in both psychological as well as biological changes that could place a person at risk for illness (Cohen et. al., 1995).

- Things that cause us stress are called **stressors** (Rubin, Paplau, & Salovey, 1993). Many events can be thought of as stressors. These include disasters, life crises, life changes, and daily hassles (Rubin, Paplau, & Salovey, 1993). Other examples of stressors include: hurricanes, earthquakes, disease, divorce, unemployment, marriage, and traffic jams. Stressors are things that interfere with an important personal goal (Rubin, Paplau & Salovey, 1993). The more important the goal is, the more stress a person will feel when that goal is threatened (Rubin, Paplau & Salovey, 1993).

Can suffering from too much stress make you sick? Scientists seem to think so. Stress can have a dramatic impact on the immune system. Experts in the scientific community are continually learning about the stress and related illness. Stress seems to be a contributing factor to everything from cancer and chronic fatigue syndrome illness to backaches and insomnia. Biologically speaking, when a person suffers from prolonged or chronic stress, hormones that have an effect on the immune system are affected.

Stress imparts health by lowering our resistance to disease and making us more vulnerable to illness. Our body responds to emotional stress the same way it reacts to physical danger. When we feel the effects of stress, our health is compromised by a primitive fight or flight response that produces stress hormones even when we are not really in immediate danger.

Each day, situations that cause stress affect our health by making us prone to illness, heart attacks, disease and making us age more rapidly. Stress, which research has related to a variety of illness and diseases,

becomes toxic to our overall health when we process stress as a negative factor and let it continually eat us up on an emotional level.

There are different kinds of stress that a person can experience. Some forms of stress can even be beneficial to the body. Shorter bursts of stress that are not considered chronic or prolonged, such as the stress encountered when going on a job interview or performing in public causes your body to produce adrenaline. This can improve your memory and increase your energy level. However, it is the continuous and prolonged or chronic forms of stress that can be detrimental to one's health.

This kind of stress can have a great impact on the rest of your body. Most commonly, it can make a person more susceptible to stomach problems, such as constipation or diarrhoea and can aggravate and make some disorders, such as ulcers, worse. Headaches are another common complaint made by people who suffer from stress. Some people have reported that stressful and pressure situations seem to trigger migraines. Stress can even affect the skin and complexion. Many have associated stress to acne breakouts and hives and research has shown that people suffering from chronic stress experience more frequent colds and upper respiratory infections.

3.3 Three Theories of Stress.

Stress affects everyone, young and old, rich and poor. Life is full of stress. There is work stress, school stress, financial stress, and emotional stress, illness stress, to name a few.
There are three theories or perspectives regarding stress. They are:

- Environmental Stress Perspective
- Psychological Stress Perspective
- Biological Stress Perspective.

The environmental stress perspective emphasizes assessment of environmental situations or experiences that are objectively related to substantial adaptive demands (Cohen et. al., 1995).

The psychological stress perspective emphasizes people's subjective evaluations of their ability to cope with the demands presented to them by certain situations and experiences (Cohen et. al., 1995).

Finally, the biological stress perspective emphasizes the activation of certain physiological systems in the body that have been shown time and time again to be regulated by both psychologically and physically demanding conditions (Cohen et. al., 1995).

SELF ASSESSMENT EXERCISE

i. Define stress
ii. Identify the emotional responses of illness

ANSWERS TO SELF ASSESSMENT EXERCISE

i. **Stress** can be defined as a process in which environmental demands strain an organism's adaptive capacity, resulting in both psychological as well as biological changes that could place a person at risk for illness (Cohen et. al., 1995).

ii. Emotional responses of illness are: Grief response, denial response, anxiety response, anger response, depression and dependency response.

Well done. Now let us look at stress and biology.

3.4 Stress and Biology

Stress is not necessarily a bad thing. A certain amount of stress is natural. None of us live stress free lives. However, while a certain amount of stress is normal, chronic negative stress may be harmful to our health. Thomas Holmes asserted that any and all change is stressful because it forces individuals to adapt to new, unfamiliar circumstances (Brehm & Kassin, 1993). Holmes acknowledged that some changes require more of an adjustment than other changes (Brehm & Kassin, 1993). Holmes believes that the change resulting from both positive (e.g., marriage, promotion, graduation) and negative (e.g., divorce, illness, unemployment) life events are stressful and might possibly do harm to an individual's health (Brehm & Kassin, 1993). When an individual, is faced with stress, his body mobilizes for action in what is called a fight or flight reaction (Rubin, Paplau, & Salovey, 1993). During a fight or flight reaction, the heart rate increases, breathing is accelerated, and the muscles tense up as if in preparation to throw something like a rock (fight) or to run away (flight) (Rubin, Paplau, & Salovey, 1993). For example, when approached by a thief, you can either fight him or you can try to run away from him. When an individual identifies a threat, activity in the sympathetic nervous system rises and the adrenal glands release the hormones epinephrine (or adrenaline) and norepinephrine into the blood stream (Rubin, Paplau, & Salovey, 1993). At the same time, corticosteriod hormones which release fatty acids for energy, are released by the adrenal glands (Rubin, Paplau, & Salovey, 1993). This nervous-system and hormonal activity causes digestion to stop, blood sugar levels to increase, and the heart to pump more blood to the muscles (Rubin, Paplau, & Salovey, 1993). All

of these reactions are not unlike the physiological aspects of strong emotions, like fear and anger (Rubin, Paplau, & Salovey, 1993). Spangler and Schieche (1998) examined the biobehavioural organization of infants with various qualities of attachment. Quality of attachment (security & disorganization), emotional expression, and adrenocortical stress reactivity were investigated in 12-month-old infants observed during Ainsworth's Strange Situation. They found that securely attached infants did not show an adrenocortical response. However, interestingly, adrenocortical activation during the Strange Situation was found for the insecure-ambivalent group, but not for the insecure-avoidant group. Pruessner, Hellhammer, and Kirschbaum (1999) studied the effects of burnout and perceived stress on early morning free cortisol levels after awakening. They found that higher levels of perceived stress were related to stronger increases in cortisol levels after awakening after a low dose dexamethasone pretreatment the previous night.

3.5 Stress and Symptom Experience

If stress persists after the initial fight or flight reaction, the body's reaction enters a second stage (Rubin, Paplau, & Salovey, 1993). During this stage, the activity of the sympathetic nervous system declines and epinephrine secretion is lessened, but corticosteriod secretion continues at above normal levels (Rubin, Paplau, & Salovey, 1993). Finally, if the stress continues and the body is unable to cope, there is likely to be breakdown of bodily resources (Rubin, Paplau, & Salovey, 1993). It is in this stage that there may be a reduction of the levels of epinephrine and norepinephrine in the brain, a state related to depression (Rubin, Paplau, & Salovey, 1993). Stressful life events are related to the risk of infected individuals developing symptoms and illness (Cohen et. al., 1998). Traumatic stressful events may trigger either behavioural or biological processes that contribute to the onset of disease. Chronic stress has been associated with increased reports of illness. Long-term exposure to chronic stress may facilitate the development of illness during exposure to stress (Cohen et. al., 1995). Exposure to chronic stress may result in permanent, or at the very least, long-term psychological, biological, or behavioural responses that alter the progression of illness (Cohen et. al., 1995). Cohen et. al. (1998) found that those who had either a work-related or interpersonal chronic stressors (defined as stress lasting one month or longer) had an increased risk of developing colds compared to those who had no chronic stressor. In addition, the longer the stress endured, the more likely a person was to become ill. Cohen, Doyle, and Skoner (1999) found that psychological stress predicted a greater expression of illness and a greater production of interleukin-6 in response to an upper respiratory infection. Finally, Zarski (1984) found no correlation between life experiences and health status. However, life experiences were

significantly correlated with somatic symptoms and energy level. Overall health status was highly correlated with somatic symptoms.

4.0 CONCLUSION

In conclusion, everyday we come in contact with billions of germs. Each one is capable of making us ill. Some people are more susceptible to illness than are others. Germs are necessary but not a sufficient cause of illness. Other factors are necessary in order for a person to become ill. Among the factors related to the development of illness are stress, coping style, and social support. Chronic negative stress increases our chances of becoming ill and experiencing symptoms. Coping style can decrease or increase our risk of illness. Engaged coping can lead to a decrease in illness; whereas, disengaged coping can lead to an increase in illness (Chang & Strunk, 1999). Having an increased number of social ties lowers the risk of developing colds (Cohen et. al., 1997). In sum, stress can increase our susceptibility to illness.

5.0 SUMMARY

This unit looked at several forms of emotional responses to illness and symptom experience. It also provided conceptual and theoretical dimension of stress, illness and symptom experience. We hope you enjoyed your studies. Now let us attempt this exercise below.

6.0 TUTOR MARKED ASSIGNMENT

Can suffering from too much stress make us sick? - Discuss

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MODULE 4 THE SICK ROLE

UNIT 1 SOCIAL ROLES AND THEORIES

CONTENTS

1.0 INTRODUCTION

In the previous module, (module 3), we looked at various facets of symptom experience. It is thus important to note that if an individual or the sick person accepts that the symptoms are a sign of illness, of which he or she is expected to, then, transition is made from the symptom experience to the sick role. Here, the individual begins to relinquish some or all social roles. In module 4, we will first look at the concept of social role and review the role theory. We will then provide detailed definitions of the sick role concept. The rights and obligations of the sick role will also form a pivotal part of this module. We will also look at the sick role and the new economy, as well as other related variables

like the sick role and the society, the family and different measures put in place in the society to check the sick role syndrome.

However, in this unit, we will focus the concept of social role in the society. Remember that a sick person, in the sick role is expected to relinquish some or all social roles, so we cannot proceed without a clear definition of the term 'social role' and subsequently, role theories.

2.0 OBJECTIVES

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

- Define social role
- Review role theories
- Ascertain the propositions of role theories
- Identify extentions of role theory
- Determine limitations of role theory

3.0 Main Content

3.1 What is Social Role?

Definition 1: A **role** or a **social role** is a set of connected behaviours, rights and obligations as conceptualized by actors in a social situation.

Definition 2 - Social role is mostly defined as an expected behaviour in a given individual social status and social position.
The term is used in two rather different but related senses. It is vital to both functionalist and interactionist understandings of society, but is of only peripheral relevance to conflict theory.

"Many social psychologists and sociologists, most notably Erving Goffman (1959), have used this dramaturgical analogy between social life and a stage play to talk about subtle, indirect forms of social influence. In doing so, these psychologists and sociologists typically emphasize three concepts:

- Social roles
- Social norms
- Reference groups

Within the dramaturgical analogy, social roles are the parts to be played, social norms the script of the play, and reference groups the audience.

Definition 3 - "Social roles may be formally defined as behaviour patterns that are characteristic, and expected, of a person or persons who occupy some position in a social structure.

Definition 4- Less formally, they are the parts to be played in the social drama.

Of course, playing roles in society is considerably more complex than playing a part in a play. Each of us is called on to play a number of different social roles at once. Some are very specific and well defined; others are general and ambiguous. For example, as a male or female, society expects us to play certain roles, like the role of mothers, bread winners, and so on. Each of these roles has its own more or less explicit script."

Let us now look at role theories.

3.2 Role Theories

Role Theory posits that human behaviour is guided by expectations held both by the individual and by other people. The expectations correspond to different roles individuals perform or enact in their daily lives, such as secretary, father, or friend. For instance, most people hold pre-conceived notions of the role expectations of a secretary, which might include: answering phones, making and managing appointments, filing paperwork, and typing memos. These role expectations would not be expected of a professional soccer player.

Individuals generally have and manage many roles. Roles consist of a set of rules or norms that function as plans or blueprints to guide behaviour. Roles specify what goals should be pursued, what tasks must be accomplished, and what performances are required in a given scenario or situation. Role theory holds that a substantial proportion of observable, day-to-day social behaviour is simply persons carrying out their roles, much as actors carry out their roles on the stage or ballplayers theirs on the field. Role theory is, in fact, predictive. It implies that if we have information about the role expectations for a specified position (e.g., sister, fireman, prostitute), a significant portion of the behaviour of the persons occupying that position can be predicted. What's more, role theory also argues that in order to change behaviour it is necessary to change roles; roles correspond to behaviours and vice versa. In addition to heavily influencing behaviour, roles influence beliefs and attitudes; individuals will change their beliefs and attitudes to correspond with their roles. For instance, someone over-looked for a promotion to a managerial position in a company may change their beliefs about the benefits of management by convincing him/her that

they didn't want the additional responsibility that would have accompanied the position.

Many role theorists see Role Theory as one of the most compelling theories bridging individual behaviour and social structure. Roles, which are in part dictated by social structure and in part by social interactions (see the two approaches outlined below), guide the behaviour of the individual. The individual, in turn, influences the norms, expectations, and behaviours associated with roles. The understanding is reciprocal and didactic.

3.2.1 Functional Perspective

The functionalist approach sees a role as the set of expectations that society places on an individual. By unspoken consensus, certain behaviours are deemed appropriate and others inappropriate. For example, it is appropriate for a doctor to dress fairly conservatively, ask a series of personal questions about one's health, touch one in ways that would normally be forbidden, write prescriptions, and show more concern for the personal well-being of his clients. Electricians or shopkeepers may also show concern for the well-being of their clients, but if they start touching their clients, especially where doctors are allowed to touch, they'll get in trouble; they will have stepped outside of the norms associated with their roles.

In the functionalist conception, role is one of the important ways in which individual activity is socially regulated: roles create regular patterns of behaviour and thus a measure of predictability, which not only allows individuals to function effectively because they know what to expect of others, but also makes it possible for the sociologist to make generalizations about society. Collectively, a group of interlocking roles creates a social institution: the institution of law, for example, can be seen as the combination of many roles, including: police officer, judge, criminal, and victim.

Roles, in the functionalist perspective, are relatively inflexible and are more-or-less universally agreed upon. Although it is recognised that different roles interact *(*teacher and student), and that roles are usually defined in relation to other roles (doctor and patient or mother and child), the functionalist approach has great difficulty in accounting for variability and flexibility of roles and finds it difficult to account for the vast differences in the way that individuals conceive different roles. Taken to extremes, the functionalist approach results in *role* becoming a set of static semi-global expectations laid down by a unified amorphous society. The distinction between role and norm (or culture) thus becomes sterile.

The functionalist approach has been criticized for its static understanding of roles. Even so, it remains a fundamental concept which is still taught in most introductory courses and is still regarded as important.

Interestingly, this conception has crossed over from academic discourse into popular use. It has become commonplace to speak of particular *roles* as if they were indeed fixed, agreed upon by all, and uncontroversial (e.g., the role of the teacher or a parent's role). This everyday usage nearly always employs *role* in a normative way, to imply that this is the proper behaviour for a teacher or a parent, or even for an entire institution.

3.2.2 Interactionist Perspective

The interactionist definition of *role* is more fluid and subtle than the functionalist perspective. A *role*, in this conception, is not fixed or prescribed but something that is constantly negotiated between individuals.

One of the ways Mead (1947) explained the idea of roles was by using a development model for children. According to Mead, children adopt roles in the development of a self. In so doing, they pass through three stages:

1. preparatory stage - meaningless imitation by the infant; assumes roles but doesn't understand what they are
2. play stage - actual playing of roles occurs; but no unified conception of self
3. game stage - completion stage of self; child finds himself/herself must respond to simultaneous roles; the individual can act with a certain amount of consistency in a variety of situations because he/she acts in accordance with a generalized set of expectations and definitions he/she has internalized

Adults, of course, are beyond the game stage, but continue to adopt roles and adapt them through interpersonal interactions. This can be most easily seen in encounters where there is considerable ambiguity. For instance, let's assume person X has a friend who is also a lawyer; we'll call him Y. If X approaches Y as a friend but then asks for legal advice, this forces Y to either switch roles completely or merge the roles temporarily. Until Y decides on his course of action, role ambiguity will exist.

3.3 Additional Approaches

- Structural - little attention given to norms; attention is focused on social structures conceived as stable organizations of sets of persons (called social positions or statuses) who share the same, patterned behaviours (roles)
- Organization - focuses on social systems that are preplanned, task-oriented, and hierarchical; roles in such organizations are assumed to be associated with identified social positions and to be generated by normative expectations
- Cognitive role theory - focuses on relationships between role expectations and behavior (Briddle, 1986).

3.4 Propositions of the Role Theory

Role Theory includes the following propositions:

1. People spend much of their lives participating as members of groups and organizations
2. Within these groups, people occupy distinct positions
3. Each of these positions entails a role, which is a set of functions performed by the person for the group
4. Groups often formalize role expectations as norms or even codified rules, which include what rewards will result when roles are successfully performed and what punishments will result when roles are not successfully performed
5. Individuals usually carry out their roles and perform in accordance with prevailing norms; in other words, role theory assumes that people are primarily conformists who try to live up to the norms that accompany their roles
6. Group members check each individual's performance to determine whether it conforms with the norms; the anticipation that others will apply sanctions ensures role performance (Role, 2006)

SELF ASSESSMENT EXERCISE

i. Define Social Role
ii. What are the propositions of the Role Theory

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Social roles are behaviour patterns that are characteristic, and expected, of a person or persons who occupy some position in a social structure.
ii. Propositions of Role Theory are:

People spend much of their lives participating as members of groups and organizations and within these groups, people occupy distinct positions. Each of these positions entails a role, which is a set of functions performed by the person for the group. Groups often formalize role expectations as norms or even codified rules, which include what rewards will result when roles are successfully performed and what punishments will result when roles are not successfully performed. Individuals usually carry out their roles and perform in accordance with prevailing norms; in other words, role theory assumes that people are primarily conformists who try to live up to the norms that accompany their roles. Group members check each individual's performance to determine whether it conforms to the norms; the anticipation that others will apply sanctions ensures role performance.

3.5 Extensions of the Theory

Role Theory has been a fruitful approach to understanding humans and society. As a result, various derivatives and additional concepts have developed.

3.5.1 Role Confusion

Role confusion is a situation where an individual has trouble determining which role he/she should assume. For example, if a graduate student were to attend a department party at a professor's home, the student may find it difficult to determine if he/she should act as a student toward the professors, exhibiting deference or respect, or as a friend or associate, showing collegiality and familiarity.

3.5.2 Role Conflict

Role Conflict results when an individual encounters tensions as the result of incompatible roles. For instance, a mother who is employed full-time may experience role conflict because of the norms that are associated with the two roles she has. She may be expected to spend a great deal of time taking care of her children while simultaneously trying to advance her career.

3.5.3 Role Strain

Role Strain refers to the felt difficulty in fulfilling role obligations. In contrast to **role conflict**, where tension is felt between two competing roles, the tension in role strain comes from just one role. Returning to the example of a mother, if she were to find that she is unable to fulfill her obligations as defined by, say, an overly demanding spouse (or religion, or child), she would experience role strain. The **role**

expectations may be beyond what she is able to achieve or may push her to the limits of her abilities (Role, 2006).

3.5.4 Role Distance

Role Distance is the effectively expressed pointed separateness between the individual and his putative role. The individual is not denying the role but the virtual self that is implied in the role for all accepting performers. The concept of *role distance* provides a sociological means of dealing with one type of divergence between obligation and actual performance. For example, the *maturing* adolescent who is forced to ride a merry-go-round may display role distance by acting as though the ride does not challenge her physical abilities or frighten her. This may be displayed by riding backwards or leaning dangerously from her horse.

Immediate audiences figure very directly in the display of role distance; actors need an audience or a co-conspirator for role distancing to work. There are two ways of establishing role distance:

1. Isolating one's self from the contamination of the situation, which can be displayed through indifference (e.g., a waiter saying, "I'm just doing this to put myself through college.")
2. Joking about the situation (e.g., the young merry-go-round rider saying, "I can do this with my eyes closed.")

It is often possible to determine incidents in which **role distance** might be displayed solely on the grounds of the performers' gross age-sex characteristics. A seventeen year-old boy riding a merry-go-round (especially with peers) will likely display significant role distance.

3.5.5 Role Embracement

Role Embracement refers to the complete adoption of a role. When a role is truly embraced, the self disappears completely into the role. Three things seem to be involved in the earnestness with which people assume roles or the degree to which they embrace a role:

1. an admitted or expressed attachment to the role
2. a demonstration of qualifications and capacities for performing it
3. an active engagement or spontaneous involvement in the role activity at hand, that is, a visible investment of attention and muscular effort (Role, 2006).

3.6 Limitations of Role Theory

Role theory has a hard time explaining social deviance when it does not correspond to a pre-specified role. For instance, the behaviour of someone who adopts the role of bank robber can be predicted - she will rob banks. But if a bank teller simply begins handing out cash to random people, role theory would be unable to explain why (though *role conflict* could be one possible answer; the teller might have taken the job wanting to be a modern day Robin Hood).

Another limitation of role theory is that it does not and cannot explain how role expectations came to be what they are. Role theory has no explanation for why it is expected of male soldiers to cut their hair short, but it could predict with a high degree of accuracy that if someone is a male soldier they will have short hair. Additionally, role theory does not explain when and how role expectations change.

4.0 CONCLUSION

This unit thus conceptualized social roles as a set of connected behaviours, rights and obligations as conceptualized by actors in a social situation. The role theory is thus of the assumption that human behaviour is guided by expectations held both by the individual and b y other people. In the functionalist conception, social role is one of the important ways in which individual's activity is socially regulated: roles create regular patterns of behaviour and thus a measure of predictability. The interactionist definition of role is however more fluid and subtle than the functionalist perspective. A role, in this conception, is not fixed or prescribed but something that is constantly negotiated between individuals.

Also, certain proposition of role theory indicates that people spend a lot of time observing and adhering to social norms obtainable in social role and thus, it is a pivotal aspect of social life. Other extensions of social roles include; role confusion, conflict, strain, distance and embracement. The fact that role theory is a bit vague in explaining social deviance and it does not correspond to pre-specified role was however observed as its limitations.

5.0 SUMMARY

In this unit, we looked at the concept of social role. We further examined the basic role theories as well as other extensions of role theory – role confusion, conflict, strain, distance and embracement. We further attempted a criticism of the role theory. We hope you thoroughly enjoyed your studies. Now let us try the following exercises.

6.0 TUTOR MARKED ASSIGNMENT

Identify and describe the extensions of the Role Theory

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UNIT 2 ASSUMPTION OF THE SICK ROLE

CONTENTS

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 Parsons sick role theory
- 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). Like we rightly observed in Unit 16, 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

(1) 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 gain, or additional privileges afforded to ill persons).

(2) 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

ANSWERS TO SELF ASSESSMENT 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 unequal relationship requires a high level 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); individuals or groups may 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.

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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UNIT 3 THE SICK ROLE IN THE NEW ECONOMY

CONTENTS

1.0 INTRODUCTION

Despite challenges, Parsons' theory provides a theoretical model of how, in particular medical system, patients were placed within the structure in a particular role (Beck and Kauffman, 1995). His model also provides a point of comparison which helps in focusing on the changes which the concept of the patient has undergone since the 1950s, and the ways that the institution of medicine has been able to manage changing demands for services. The following section addresses another important element that must be added into this shifting mix of doctors and patients and structures and roles -- the sick role in the new economy. It also determines economic discipline imposed by the New Economy. This is of the assumption that the 'lure' of sickness – the attraction of escaping responsibilities – requires society to exercise some control over the sick person and the sick role so that disruption is minimized.

2.0 OBJECTIVES

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

- Identify the characteristics of the 'New Economy'
- Ascertain the new economy and the fiscal crisis in medicine.
- Describe the sick role in the era of economic discipline

3.0 MAIN CONTENT

3.1 The Characteristics of the 'New Economy'

Like many other keywords, the "New Economy" is rarely defined, making it somewhat slippery as a referent. One attempt at definition

may be found in a Newfoundland government pamphlet, "At the Crossroads: The New Economy in Newfoundland and Labrador." It claims that the New Economy began with Japan's rise after the Second World War and the move toward a global economy and the increase in information technology. According to (Economic Recovery Commission, 1994), the New Economy contains the following characteristics:

- Globalization (free trade, global competition for businesses);
- Prominence of the services sector of the economy;
- Knowledge-intensive industry;
- Competitive advantage (automation helps short runs to be cost-effective);
- Niche marketing (customization, to meet specific requirements);
- continuous and rapid change, shorter product life cycles, compressed time for the introduction of new technologies (cited in Economic Recovery Commission, 1994: 5).

SELF ASSESSMENT EXERCISE

Identify the characteristics of the New Economy?

ANSWERS TO SELF ASSESSMENT EXERCISE

Characteristics of the ‘new economy’ are: globalization, competition, knowledge intensive industry, continuous and rapid change, etc.

We are sure you must agree that the variables identified here are very typical of the ‘new economy’; an aggressive and competitive economy, quite different from that obtainable in the past. Now let us continue with the rest of the unit. Next are ‘new economy’ and the fiscal crisis in medicine.

3.2 The New Economy and the Fiscal Crisis in Medicine

Throughout the 1990s, the phrase "New Economy" rose to prominence in discussions of economic and social policy. It is encountered in numerous discourses disseminated by government and industry, often presenting a gloss of opportunity, freedom, competition and entrepreneurship. This positive rhetoric may hide some of the concrete effects of the New Economy (cutbacks in public services, heightened regional competition, privatization, layoffs, an eroding public sphere, growth without increased employment, economic insecurity, rising corporate power).

As a result of these conditions, the New Economic Actor should be a self-reliant information processor, always ready to take another course or to look for another job. All of these characteristics may result in higher levels of stress among workers (and especially non-workers) and increased health problems (as well as more reticence to interrupt work by seeking medical assistance). The Economic Recovery Commission of Newfoundland and Labrador lectured that: "It should be recognized that few jobs are secure in the new economy, and many people will change their places of employment - even their careers - several times during their lifetimes" (Economic Recovery Commission, 1994: 29).

In this economic context, there is increased pressure on our medical system and a resultant shift in conception of patients' roles. There are dire warnings in magazines about the loss of medicare which is, for many, a sacred trust. Panel after panel of buffed experts fill the TV screens to tell us we cannot have tomorrow what we've got today. Clearly, one of the major issues in health care today is the crisis in funding, which is sometimes presented as a result of the unrealistic demands of patients. This positions patients as the cause of the funding shortfall and ignores other contributing causes, including: the expansion of medical knowledge and technology, resulting in increased interventions; the heavy reliance on pharmaceuticals, even when they are sometimes unnecessary (Mickleburgh and Nasrulla, 1994); and the way in which doctors get paid, based on the nature of their assistance and the number of patients they see (Canadian Press, 1995).

Proposed solutions to the fiscal crisis intend to affect patient behaviour. For example, one solution is to impose user fees. A 1993 poll found that 73% of respondents were in favour of a $5 user fee for visits to hospital emergency wards (Came, 1993). While this may not result in significant revenues, it may dissuade patients who are in the habit of using emergency rooms for health care, instead of their doctors. Thus, such fees may be designed more to change patient behaviour than to recover costs, illustrating that changes prompted by the New Economy go beyond the economic sphere.

With this brief context of the New Economy in mind, we now turn to the sick role and economic discipline.

3.3 The Sick Role and Economic Discipline

From the anonymous victim of epidemics as collective scourges, from the traditional image of the alienated and passive "patient" to the "self-provider of medical care" as a new cultural figure, to the "health-care user" as a collective actor in the public-health system, and finally to the militant for whom the body is the basis of a new political action, the

"sick person" appears to have traveled a long way, about which a number of questions must be asked (Herzlich and Pierret, 1987: 229).

A system of healing, like any other structure, includes a set of roles for the major agents. Within our modern health-care system, there is a set of social expectations around what it means to be a "patient," how one comes to be a patient and, especially, what one is to do upon becoming a patient. Nevertheless, it is rare that one finds a serious consideration of the role of the patient within the whole practice of medicine. Indeed, one overview of a study of the sociology of health and illness stated:

'We are prompted to note the absence of patients in most theories, explanations, or descriptions of occupations and professions.... The general absence of patients in the conceptualization of the "health care system" suggests that sociologists have not defined "the system" in sociological terms (Coburn and Eakin, 1993: 100-101).

However, there have been different social roles for patients, each of which has been influenced by scientific, social and cultural shifts. Indeed, the experience of being "sick" is influenced by prevailing social and historical attitudes toward illness. For example, at various times in western history, illness has been claimed to be evidence of sin or guilt or a lack of self-control or just plain bad luck. Each of these conceptions of the causation of illness will affect the treatment of the ill.

This unit considers the emerging view of the patient, one which is primarily influenced by economic forces. For example, a part of the retrenchment of medical services involves a conception of patients as more fully responsible (both socially and fiscally) for their sickness, and thus not deserving of total state assistance in their recovery. The major question we wish to ask is: should patients be sanctioned for being ill, in the new economy? This appears in line with the assumption that the new "sick role" is developing, in response to economic and structural forces.

4.0 CONCLUSION

As a result of the conditions presented by changes in the new economy, the new economic actor is expected to be self-reliant and an active information processor, always ready to take another course if need be. All of these characteristics may result in higher levels of stress among workers (and especially non-workers) and increased health problems (as well as more reticence to interrupt work by seeking medical assistance). Also, actors in the new economy are most times expected to perceive sick role as a commodity not as an experience. In order to move with the tides and prevent disruption in the social life, patients in the new economy are oftentimes expected to think of the society first before self.

It is therefore not surprising that some patients may sometimes perceive the sick role as a time out, from all the stress and aggressiveness that characterize the New Economy.

5.0 SUMMARY

This unit presented a brief summary of the concept of the 'New Economy' as well as that of the fiscal crisis in medicine. Also, the role of sick and different economic sanctions placed on the sick individual was also analyzed. It suffices to observe that contemporary society appears to be an economic driven one and, it is not an overstatement to state that we are obviously in the era of the new economy. Thus, illness behaviour is greatly influenced by the dictates of the new economy.
Hope you enjoyed this unit. Now let us attempt the questions below.

6.0 TUTOR MARKED ASSIGNMENT

Should patients in the 'new economy' be sanctioned for being ill?

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UNIT 4 CHARACTERISTICS OF THE PATIENT'S ROLE IN THE 'NEW ECONOMY'

CONTENTS

1.0 INTRODUCTION

To paraphrase Marx: "we make our own health, but not always under conditions of our own choosing." This underscores a basic complexity in relation to illness -- that it is a result of both individual and social (or public) factors. To emphasize one source of disease causation and to ignore the other is poor medicine, though it may make for good ideology. What follows are five characteristics of the patient's role in the New Economy. This is not meant to be exhaustive, but simply to bring together some of the changes which the concept of the patient has been encountering since Parsons' initial definition of the sick role. Furthermore, just as the New Economy is only partially set in place, this new sick role is also still in the process of being implemented.

2.0 OBJECTIVES

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

- Identify and discuss the characteristics of patient's role in the new economy

3.0 MAIN CONTENT

3.1 Characteristics of Patient's Role in the New Economy

3.1.1 Patients in the New Economy are Responsible for their Own Illnesses.

The attribution of responsibility for disease has become an important part of the sick role of the patient. Kirkwood and Brown (1995) argue that attribution of responsibility is frequently a rhetorical strategy that is used by medical professionals to promote behavioural changes in their patients, but the effects of this go beyond the walls of the clinic. While being held responsible for having an illness may make disease similar to a crime, the flip side to an imposition of responsibility is the potential for patient empowerment. (Brenckenridge and Westell, 1995).

Ideally, the patient who is responsible for her/his health would also be given more control over its maintenance. This would put the locus of control back at the individual level, and there is evidence that people with an individual locus of control will engage in more positive healing behaviours (Kirkwood and Brown, 1995). If people are convinced that their actions have some effect on their illness, then they are more likely to be involved in decisions regarding therapy and to claim more control over the illness experience. Indeed, the rise of "patient's rights" movements may actually facilitate this shift of responsibility from the system to the patient. Such patient-oriented movements are often seen as inherently positive, and as a natural outgrowth of self-empowerment groups (Burston, 1990).

However, an increasingly prevalent effect of holding individuals responsible for their illness is to also hold them economically responsible for its cure. Thus, one result of this "privatization" of responsibility is then a privatization of medical assistance. Some openly question, for example, whether the State should pay the medical costs of people who fall ill due to "lifestyle choices." As Canadian physician R.E. Goldberg stated:

If a patient is injured in an auto accident while not wearing a seat belt or while intoxicated, his or her health benefits should be denied for that accident. This would emphasize personal responsibility for irresponsible lifestyle choices (cited in Francis, 1993).

The belief that individuals are responsible for ill health can lead to a parallel pursuit, that of the attribution of "blame." This is most pronounced in the case of illnesses related to "lifestyle," an ambiguous word which comes to stand in for many things, such as eating patterns, sexual desires, work schedules, leisure pursuits, etc. The word "lifestyle" assumes that we have choice in all of these matters, and this may not be

accurate. As a counter, medical research on genetic predispositions to disease may alleviate some of the blame that is placed on the sick. If the disease which will terminate our life is already marked in our genes, then there is little possibility in altering the outcome and patient responsibility is diminished.

Ivan Illich claimed that the notion of responsibility for our health, in the midst of our manufactured environment, was absurd. As he contends: "I believe it is time to state clearly that specific situations and circumstances are 'sickening,' rather than that people themselves are sick" (Illich, 1994: 11). This point to a significant effect of holding individuals responsible for their own health -- the obscuring of the social causes of disease. While individuals can no doubt be in certain senses responsible for their diseases, we must be careful not to obscure other causes. We must ask: Are employers responsible when they create a work climate that rewards over-work and stress? Is a society responsible when it creates a social system that keeps people struggling at low-wage jobs? A number of researchers have stressed the ways in which the social and economic structure of our society can have effects on health, from its effects on the environment to the manner in which it structures relationships in the workplace (D'Arcy and Siddique, 1984; Schwalbe and Staples, 1986; Livesey, 1989; Taylor, 1993). However, medical intervention tends to focus on individual solutions to disease, rather than fundamental social changes. For example, while stress is often a (dis)product of one's social environment, it is treated through pharmaceutical drugs, thus obscuring and even legitimating underlying social causes of the illness (McKinlay, 1981; Labonte, 1985). This tendency to hold individuals responsible for their own illness fits with both the fiscal and ideological needs of the New Economy. It decreases the legitimacy of claims for medical assistance and it depoliticizes the negative effects of social structure on individuals.

The increased focus on a patient's responsibility for her/his own illness, results in both a new conception of the patient and a new conception of the state's responsibility toward the ill. Even before the current fiscal crisis, Crawford (1977) noted that the ideology of "victim blaming" (or seeing individuals as responsible for the onset of their own illnesses) was one result of the threat of high medical costs. In order to lower expectations, and lower the sense of entitlement to health care, Crawford argued that there was a refocussing onto individual responsibility for the onset of illness. It is ironic that we are being convinced to be ever more cautious about our own behaviour at the same time as the social causes of disease (pollution, social disruption, economic insecurity) are increasing. Clearly, behavioural change can affect health outcomes. However, to focus on individual change without also looking at social change is to provide a partial and thus distorted analysis.

SELF ASSESSMENT EXERCISE

Patients in the 'New Economy should be responsible for their illnesses – Discuss.

ANSWERS TO SELF ASSESSMENT EXERCISE

An increasingly prevalent effect of holding individuals responsible for their illness is to also hold them economically responsible for its cure. Thus, one result of this "privatization" of responsibility is then a privatization of medical assistance. Some openly question, for example, whether the State should pay the medical costs of people who fall ill due to "lifestyle choices." As Canadian physician R.E. Goldberg stated: If a patient is injured in an auto accident while not wearing a seat belt or while intoxicated, his or her health benefits should be denied for that accident. This would emphasize personal responsibility for irresponsible lifestyle choices.

While individuals can no doubt be in certain senses responsible for their diseases, we must be careful not to obscure other causes. We must ask: Are employers responsible when they create a work climate that rewards over-work and stress? Is a society responsible when it creates a social system that keeps people struggling at low-wage jobs? However, medical intervention tends to focus on individual solutions to disease, rather than fundamental social changes. For example, while stress is often a (dis)product of one's social environment, it is treated through pharmaceutical drugs, thus obscuring and even legitimating underlying social causes of the illness. This tendency to hold individuals responsible for their own illness fits with both the fiscal and ideological needs of the New Economy. It decreases the legitimacy of claims for medical assistance and it depoliticizes the negative effects of social structure on individuals.

We hope you enjoyed this exercise. Now let us review other characteristics of patient's role in the 'new economy'

3.1.2 The Patient in the New Economy is instructed to tread lightly on the System.

A part of the current sick role in the 'new economy' is to use as few medical services as possible. For example, in 1994 the Ontario government undertook a pilot campaign to get people to stop going to a doctor for minor complaints. The government targetted the city of London, and it distributed pamphlets, giving home remedies for the cold and flu (including such time-tested therapies as chicken soup). The purpose was to keep patients from clogging doctors' offices, and in the

process spreading their colds even further, through waiting room contacts (Mickleburgh, 1994).

However, a concurrent study found that people overwhelmingly knew that one should not go to see a doctor for a simple cold or flu, even before the government education program had been launched (Breckenridge, 1994). Nevertheless, the fact that a provincial government went ahead with a campaign explicitly to cut down on the number of medical consultations, despite the lack of any evidence showing the necessity of such a campaign, illustrates an underlying conception of the patient as ill-informed, over-serviced and deserving of cutbacks.

3.1.3 In the New Economy, the Requirement to get Better Relates to One's Duty to the State, Rather than One's Duty to Self.

What is our underlying reason to undergo medical therapy (beyond the relief of painful symptoms)? Is it solely for the well-being of ourselves or is it for the benefit of others, especially institutions? In the New Economy, we are told that the government deficit is the fault of all of us, and that we must all do our part in reducing it. This includes reducing the extent to which we rely on medical assistance, and the length of time we might spend as "unproductive" members of society. Thus, we are to get better so that the State does not suffer.

This view of the patient fits with a new moralism about the way in which individuals are held responsible for their own health. Thus, in the New Economy, one has a duty to take care of one's body not just for the good of the self, but also for the good of the State. Furthermore, b y shifting the public health and preventive focus onto individual behaviours and individual responsibility, corporate contributions to ill health are ignored and the exercise of social control becomes even more effective. For example, the majority of cancer information to consumers focuses on individual risk factors, rather than societal or cultural risk factors (Breckenridge and Westell, 1995). While individual sacrifice to the public good is not in itself undesirable, in the contemporary situation the ideology of health care is one that is more and more individualistic. And yet, the proposed motivation for maintaining a healthy population relate to issues of productivity and economic advantage, and not to the simple well-being of citizens, or to the common good.

3.1.4 Patients in the New Economy are not to see Health as an Experience, but as a Commodity.

In the New Economy, which is solidly permeated with marketing, health has ceased to be simply a condition of one's body, but it has become a commodity -- a thing to be purchased and even traded for further gain. This fits with the general government emphasis on privatization (which is really an expansion of commodification, or the invasion of the cash nexus into more and more spheres of life). Illich (1994) argued that "life" itself has become an idol in today's Western culture, a fetish. It is talked about as if it were property -- a commodity rather than an experience -- which then fits in with our bias toward possessive individualism.

Along with this commodification of health, there is also an alienation of the patient from the process of medical intervention itself. New techniques of diagnosis and observation can "identify symptoms without depending on the subjective perceptions of the patient" (Doyal and Doyal, 1984: 90). For example, in relation to people with HIV, the decision regarding when to begin prescribing drugs such as AZT or DDI may depend on the results of laboratory testing (such as a T4-cell count or a CD4 count), rather than a consideration of how the person is "feeling." A patient may arrive at a doctor's office with few complaints and in a positive frame of mind (thus, they are "feeling" well), but will leave with a new prescription due to test results. Some have argued that the discourse around hypertension ("a symptom without a disease") likewise subjects patients to treatment when they receive certain test results, regardless of how they "feel" (Banerjee, 2000).

3.1.5 Patients in the New Economy are not to be Trusted

The concern over the abuse of the medical system is an ideological plank of the New Economy, and a further attempt to shift the blame for the fiscal shortfall on to the patients and off of the system.

In an article summing up a week's special coverage of the health care funding crisis, the *Globe and Mail* noted that: "There will be more public education aimed at ending abuse of the health-care system" (Valpy, 1992: A5). This, despite the fact that there was no significant evidence in the stories of any such "abuse." The only thing mentioned, in the summation, was the number of people with a cold seeing a doctor.

Mickleburgh (1993) reported that, according to studies, less than one percent of health-care spending could be due to the provision of "unnecessary" services. Thus, the introduction of user fees would be of little value, and would deter many who truly need medical care (thus

resulting in a net decrease in the nation's health status). So, while we have no solid evidence of abuse, we see it used as a justification for stricter surveillance of patients in the New Economy.

4.0 CONCLUSION

In sum, in the New Economy, the doctor has two patients -- the ill individual who comes looking for physical relief, and the ill economy, which is in need of some fiscal relief. Medicine has been asked to balance these two in some way. It is thus no wonder that the conception of the patient has been altered as well.

Following the characteristics of patient's role in the new economy, the state is of the opinion that individuals should be held economically responsible for their illness and its cure. In advising the individual to tread lightly on the system, the patients were advised to stop going to a doctor for minor complaints. In the New Economy, we are also told that the government deficit is the fault of all of us, and that we must all do our part in reducing it. This includes reducing the extent to which we rely on medical assistance, and the length of time we might spend as "unproductive" members of society. Thus, we are to get better so that the State does not suffer. In the New Economy, health was also to be regarded as a commodity—a thing to be purchased, and not as an experience. Also, the concern over the abuse of the medical system over minor ailments, or faked symptoms, indicates that patients in the New Economy could not be trusted sometimes.

5.0 SUMMARY

Unit 4 looked at five major characteristics of patient's role in the new economy. Of course, this is by no means, exhaustive, but simply to bring together to the fore, the changes which the concept of the patient has been encountering since Parsons' initial definition of the sick role. We hope you enjoyed your studies. Below are some exercises we need to attempt.

6.0 TUTOR MARKED ASSIGNMENT

Patients in the 'new economy' should not be trusted, and also should not see health as an experience but as a commodity – Discuss.

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UNIT 5 SICK ROLE AS DEVIANCE BEHAVIOUR

CONTENTS

1.0 INTRODUCTION

We've looked at the assumptions and characteristics of the 'New Economy' as well as the sick role in the new economy. It is thus obvious that the dictates of the new economy imposes huge responsibilities on the patient, while a good number would not mind sick role as a time-out from the stress of the new economy. So in line with such dictates and expectations, it is not surprising that the sick role could sometimes be viewed as a deviance. In this unit, we will look at the biological as well as the social underpinnings of sick role as deviance behaviour.

2.0 OBJECTIVES

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

- Describe the biological approach of illness as deviance behaviour
- Illustrate sociological approaches of illness as deviance behaviour
- Assess the functional approach of illness as deviance behaviour
- Discuss labeling theory and illness as a deviance behaviour
- Discuss labeling and mental illness

3.0 MAIN CONTENT

3.1 Illness as Deviance Behaviour – The Biological Approach

According to Cockerman (2003), the medical view of illness is that of *deviance from biological norms of health and feelings of well-being.* This view involves the presence of a pathogenic mechanism within the body that can be objectively documented. The diagnosis of a disease, for example, results from a correlation of observable symptoms with knowledge about the physiological functioning of the human being. Ideally, a person is defined as ill when his or her symptoms, complaints or the results of a physical examination and/or laboratory tests indicate an abnormality. The traditional identifying criteria for disease are:

- The patient's experience of subjective feeling of sickness
- The finding by the physician that the patient has a disordered function of the body
- The patient's symptoms confirming to a recognizable clinical pattern.

The clinical pattern is thus a representation of a model or theory of disease held by the diagnostician. Thus, in diagnosis, logic is the basic tool.

The physician logical function in the treatment of an illness involves, first, arriving at a diagnosis and second, applying remedial action to the health disorder in such a way as to return the patient into a normal state as possible. The evaluation of illness by the physician contains the medical definition of what is good, desirable and normal as opposed to what is bad, undesirable and abnormal. This evaluation is interpreted within the context of existing medical knowledge and the physician's experience. On this basis, the medical profession formulates medical rules defining biological deviance and seeks to enforce them by virtue of its authority to treat those persons defined as sick.

3.2 Illness as Deviance Behaviour – The Sociological Approach

The conceptualization of illness as a deviance behaviour does makes it a sociologically relevant variable. However, it restricts the analysis of illness to the framework of a social event. This is in accord with the intention of the sickness-as-deviance perception in sociology - to focus exclusively on social properties of being ill, and thus to exclude biological properties defined only by the physician. Yet by dwelling exclusively on the social properties of sickness, the deviance perspective severely limits its capacity to deal with the biological aspects of illness as a condition of suffering.

It can then be argued that while deviance is behaviour contrary to normative expectations of society, sickness itself does not counteract social norms. The members of any society are expected to become ill now and then during their lives. Accordingly, if sickness is deviance and since deviance is regarded as a violation of expectations of behaviour, it would be necessary to assume that society expects people not to become ill, just as it expects them not to commit a crime or become a drug addict. People who are sick are different from the norm of wellness, but this situation does not make them bad as the concept of deviance implies (Cockerham, 2003).

3.3 Illness as Deviance Behaviour – The Functionalist Approach

While Sociologists reject biological model of deviance, present-day functionalism, stressing societal-level processes, systems, equilibrium and interrelationships, represents a modern version of a homeostatic theory of deviance. This model is not organic or physiological. It does not find the causes of deviant behaviour in individual needs, drives, instincts and genetic combination, or any other purely individual patterns. It does find the source of deviant behaviour in the relationship between the individual and the social systems. This approach is based on the view that society is held together in a state of equilibrium be harmonious patterns of shared norms and values. What makes social life possible is the expectation that people will behave in accordance with the norms and values common to their particular social system. This process is 'functional' because, its results in social harmony and counterbalances, 'dysfunctional' processes like, crime and mental illness, that disrupt the social order.

The tendency of a society towards world maintenance, through equilibrium is thus very similar to the biological concept of homeostasis in which the human body attempts to regulate physiological (internal) conditions within a relatively constant range in order to maintain bodily functioning. A person may suffer from indigestion or broken leg and perhaps even from a nonmalignant cancer and still be generally healthy. Likewise, a social system is viewed in the functionalist perspective as maintaining social functioning by regulating its various parts within a relatively constant range. A social system may have problem with crime and delinquency but be 'healthy' because of its overall capacity to function efficiently.

Because functionalist theorists perceive social system as composed of various closely interconnected parts, they argue that changes, decisions and definitions made in part of the system inevitably affects to some degree all other parts of the system. Thus, a person's position within the

social system subjects him or her to events and stresses originating in remote areas by the system. Behaviour that is adaptive from one's own perspective and peculiar circumstances – like turning to alcohol abuse – may be regarded as deviant by society at large. The individual then has the choice of continuing the maladaptive behaviour and being defined as deviant or try to change that behaviour, even though the person sees it at necessary for his or her own survival. Many people, not surprisingly, continue the disapproved behaviour and are pressured b y society into being deviant. Such people run the risk of confronting with those authorities like psychiatrists, the police or the court. Deviance in social system is thus reduced through the application of social sanctions against the offender. These sanctions include the use of jail or mental hospitals to remove the deviant from society and thus maintain social order and cohesion.

SELF ASSESSMENT EXERCISE

Identify the assumptions of biological, sociological and functional perspectives of illness as deviance behaviour

ANSWERS TO SELF ASSESSMENT EXERCISE

- The biological view of illness is that of deviance from biological norms of health and feelings of well-being. This view involves the presence of a pathogenic mechanism within the body that can be objectively documented.

- The sociological view of illness is that of deviance from normative expectations of society. It can then be argued that while deviance is behaviour contrary to normative expectations of society, sickness itself does not counteract social norms. The members of any society are expected to become ill now and then during their lives. Accordingly, if sickness is deviance and since deviance is regarded as a violation of expectations of behaviour, it would be necessary to assume that society expects people not to become ill, just as it expects them not to commit a crime or become a drug addict. People who are sick are different from the norm of wellness, but this situation does not make them bad as the concept of deviance implies

- The functionalist approach finds the source of deviant behaviour in the relationship between the individual and the social systems. This approach is based on the view that society is held together in a state of equilibrium to be harmonious patterns of shared norms and values. The tendency of a society towards world maintenance, through equilibrium is thus very similar to the

biological concept of homeostasis in which the human body attempts to regulate physiological (internal) conditions within a relatively constant range in order to maintain bodily functioning. A person may suffer from malaria or broken leg and perhaps even from a nonmalignant cancer and still be generally healthy, but the functionalist view of illness is worried when such individual is unable to function properly in the society, and thus a likely cause of disequilibrium.

3.4 Labeling Theory and Illness as Deviance Behaviour

By failing to account for the behavioural variations within the sick role, the functionalist approach to illness has neglected the various aspects of acting sick. For example two people having much the same symptoms may act quite differently. One person may become concerned and seek medical care while the other may ignore the symptom completely. Lipowski (1970) has noted that individual strategies in coping with illness vary from passive cooperation to positive action to get well and from fear of being diagnosed as ill to actual pleasure in anticipation of secondary gains.

Several writers, Friedson (1970a), in particular, have taken the position that illness as deviant behaviour is relative and must be seen as such; this is the perspective of labeling theory.

Labeling theory is based on the conception that what is regarded as deviant behaviour by one person or social group, may not be regarded as such by the other person or social groups. Labeling theory (or social reaction theory) is concerned with how the self-identity and behaviour of an individual is influenced (or created) by how that individual is categorized and described by others in their society.

Originating in sociology and criminology, the theory focuses on the linguistic tendency of majorities to negatively label minorities or those seen as deviant from norms, and is associated with the concept of a self-fulfilling prophecy and stereotyping. The theory was prominent in the 1960s and 1970s but is less so today, although a common usage rejects an unwanted descriptor or categorization (including terms related to deviance, disability or a diagnosis of mental illness) as being a label, often with attempts to adopt a more constructive language in its place.

3.5 Labeling Theory and Mental Illness

Becker (1973), one of the leading proponents of labeling theory, illustrates the concept in his study of marijuana users. His analysis reveals a discrepancy in American society, between those people who

insist that smoking marijuana is harmful and that use of the drug should be illegal, and those who support a norm favouring marijuana smoking and who believe that use of the drug should be legalized. While the wider society view marijuana smoking as deviant, groups of marijuana smokers view their behaviour as socially acceptable within their own particular group (Cokerham, 2003).

In addition, labeling theory has also been applied to the mentally ill. This was first done in 1966 when Thomas Scheff published *Being Mentally Ill*. Scheff challenged common perceptions of mental illness by claiming that mental illness is manifested solely as a result of societal influence. He argued that society views certain actions as deviant and, in order to come to terms with and understand these actions, often places the label of mental illness on those who exhibit them. Certain expectations are then placed on these individuals and, over time, they unconsciously change their behaviour to fulfill them. Criteria for different mental illnesses are not consistently filled by those who are diagnosed with them because all of these people suffer from the same disorder, they are simply fulfilled because the "mentally ill" believe they are supposed to act a certain way so, over time, come to do so.

Scheff's theory has had many critics, most notably Walter Gove. Gove has consistently argued an almost opposite theory; he believes that society has no influence at all on mental illness. Instead, any societal perceptions of the mentally ill come about as a direct result of these people's behaviours. In Gove's view, the mentally ill behave unnaturally a lot of the time because of their disorders, so we treat them differently (Cockerham, 2003).

Most sociologists' views of labeling and mental illness fall somewhere between the extremes of Gove and Scheff, especially considering recent research on the biological roots of manic depression and schizophrenia, it is difficult to believe that mental illness is always a result of society. On the other hand, it is almost impossible to deny, given both common sense and research findings, that society's negative perceptions of "crazy" people has had some effect on them. It seems that, realistically, labeling can accentuate and prolong mental illness, but it is rarely the full cause of symptoms.

Bruce G. Link and his colleagues have conducted several studies which point to the influence that labeling can have on mental patients. Through these studies, which took place in 1987, 1989, and 1997, Link has demonstrated that expectations of labeling can have a large negative effect on the mentally ill, that these expectations often cause patients to withdraw from society, and that the mentally ill are constantly being rejected from society in seemingly minor ways but that, when taken as a

whole, all of these small slights can drastically alter their self concepts. It is obvious that the mentally ill both anticipate and perceive negative societal reactions to them, and that this can potentially damage their quality of life.

Many other studies have been conducted in this general vein. To provide a few examples, several studies have indicated that most people associate being labeled mentally ill as being just as, or even more, stigmatizing than being seen as a drug addict, ex-convict, or prostitute (for example: Brand & Claiborn 1976). Additionally, Page's 1977 study found that self declared "ex-mental patients" are much less likely to be offered apartment leases or hired for jobs. Clearly, these studies and the dozens of others like them serve to demonstrate that labeling can have a very real and very large effect on the mentally ill. None of these studies, nor any other published ones, however, prove that labeling is the sole cause of any symptoms of mental illness.

Unlike when applied to the criminal world, the label of "mentally ill" can sometimes have a positive effect on the person who receives it. Once a person is labeled, he or she knows attempts to seek the correct help. Being diagnosed also usually means being prescribed with medication and psychotherapy. This, while not helpful for everyone, has been shown to significantly improve the quality of life for many (Davis 1975, Clomipramine Collaborative Study Group 1991). Labels, while they can be stigmatizing, can also lead those who bear them down the road to proper treatment and (hopefully) recovery. If the label of mental illness did not exist, then treatment for it would never have existed either. If one believes that being mentally ill is more than just believing one should fulfill a set of diagnostic criteria, then one would probably also agree that those who are mentally ill need help. This could never happen if we did not have a way to categorise (and therefore label) them.

4.0 CONCLUSION

As indicated earlier, the new economy, an economic environment quite different from what was obtainable in the past, imposes more restrictive measures on the citizens, even in sick roles and thus a perception of illness as deviance behaviour. From the reviews above, we observed that the biological view of illness is that of deviance from biological norms of health and feelings of well-being. This view is however mainly situated in the biological context. However, the sociological view, focuses exclusively on social properties of being ill, and thus to exclude biological properties defined only by the physician. Yet by dwelling exclusively on the social properties of sickness, the deviance perspective severely limits its capacity to deal with the biological aspects of illness

as a condition of suffering. However, while Sociologists reject biological model of deviance, present-day functionalism, stressing societal-level processes, systems, equilibrium and interrelationships, represents a modern version of a homeostatic theory of deviance. Also, as an application of phenomenology, the labeling hypothesizes that the labels applied to individuals influence their behaviour, particularly the application of negative or stigmatizing labels, promote deviant behaviour, becoming a self-fulfilling prophecy, i.e. an individual who is labeled (such as being ill), has little choice but to conform to the essential meaning of that judgment.

5.0 SUMMARY

In this unit, we looked at approaches of illness as deviance behaviour. Specifically, we looked at the biological, sociological and functionalist views. We also introduced 'labeling theory', a rather interesting but sensitive view of illness as deviance behaviour. We further looked at labeling and mental illness. There is an adage that states 'call a child a thief and he or she will steal' This also applies to illness behaviour, if one is labeled ill, he or she may have little choice but to conform to the meaning of that judgment, even when the symptoms could be overlooked or managed.
We hope you enjoyed this unit. Let us attempt the following questions.

6.0 TUTOR MARKED ASSIGNMENT

1. Discuss labeling and deviance illness behaviour
2. Examine the role of 'labeling' on mental illness.

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MODULE 5 MEDICAL CARE CONTACT/SELF CARE STAGE

UNIT 1 THE RATIONAL CHOICE AND GAME THEORY

CONTENTS

1.0 INTRODUCTION

When Suchman's (1965) stages of illness experience were devised in the mid-sixties, the third stage was labelled as medical care contact. This was described as the point at which an individual sought professional medical care. Today, we are aware of variety of options available to persons who have entered the sick role, the increasingly common practice of self care, and the importance of the individual's social and cultural environment in shaping the action taken.

How do people decide how to behave in response to being sick? Borrowing from rational choice and game theories, the common approach has been to view sick individuals as people who have preference and goals in life, who often meet constraints in satisfying these preferences, and who must make choices from available options. The rational individual will identify possible options, determine the advantages and disadvantages of each option, and then select the option that will maximize the opportunity to satisfy preferences. A sick

individual, for example, might consider the cost, availability and convenience of seeing a medical doctor and recall the satisfaction or dissatisfaction produced in a prior visit (Weiss and Linnquist, 2005). This unit will elaborate more on these.

2.0 OBJECTIVES

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

- Define rational choice theory and illustrate its influence on medical consultations and care.
- Determine the concept of game theory and its influence on medical consultation

3.0 MAIN CONTENT

3.1 Rational Choice Theory

Rational Choice Theory is an approach used by social scientists to understand human behaviour. The approach has long been the dominant paradigm in economics, but in recent decades it has become more widely used in other disciplines such as Sociology, Political Science, Anthropology and Medicine.

The main purpose of this section is to provide an overview of rational choice theory for the non-specialist, first outline the basic assumptions of the rational choice approach, then provide several examples of its use and finally, to illustrate how widely the rational choice method could be applied to medical care and consultation.

3.1.1 Definition of Rationality

What does it mean to say that a choice is "rational?" In rational choice theory it means only that an agent's choices reflect the most preferred feasible alternative implied by preferences that are complete and transitive (that is, choices reflect utility maximization.) This is a quite narrow definition of rationality (Alchian et al, 1972).

More generally, a "rational" choice must by definition be a choice based (somehow) on *reason*. Reason has been defined as "the faculty or process of drawing logical inferences." (Alchain et al, 1972). Logical inferences relate premises to conclusions. In this context one might ask two kinds of questions. First, does a stated conclusion follow from a given set of premises? Second, one might ask judgmental questions about premises – that is, are premises justified or well-defended? The second kind of question inevitably involves an appeal to another set of

premises, so any exercise in logic must rest ultimately on one or more undefended premises.

As applied to rational choice theory, the first kind of question involves whether a given choice is consistent with utility maximization -- given whatever preferences happen to be. The second kind of question involves judgments about the nature of assumptions about preferences.

3.1.2 Rational Choice and Medical Consultation

Rational Choice Theory generally begins with consideration of the choice behaviour of one or more individual decision-making units – which in basic economics are most often consumers and/or firms. The rational choice theorist often presumes that the individual decision-making unit in question is "typical" or "representative" of some larger group such as buyers or sellers in a particular market. Once individual behaviour is established, the analysis generally moves on to examine how individual choices interact to produce outcomes.

A rational choice analysis of the medical care and consultation, for example, would generally involve a description of

- The desire to get well
- The desire to visit a health practitioner
- The cost of getting well

The typical patient is faced with the problem of how much of his income could provide adequate health care as opposed to some other good or service. Also the typical health care provider is faced with the problem of how many patients he can cater for.

Exactly how does the buyer (the patient) choose how much of his/her income to spend on medical services?
Exactly how does the seller (health care provider) choose what price to charge?

One could imagine a number of answers to these questions. They might choose based on custom or habit, with current decisions simply a continuation of what has been done (for whatever reason) in the past. The decisions might be made randomly. In contrast, the rational choice approach to this problem is based on the fundamental premise that the choices made by buyers and sellers are the choices that best help them achieve their objectives, given all relevant factors that are beyond their control. The basic idea behind rational choice theory is that people do their best under prevailing circumstances (Green, 2002).

SELF ASSESSMENT EXERCISE

i. What is Rationale choice?
ii. The rational choice analysis of medical care and consultation involves ------ Variables

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Rational choice means the choice that reflects the most preferred feasible alternative. More generally, a "rational" choice must by definition be a choice based (somehow) on *reason*. Reason has been defined as "the faculty or process of drawing logical inferences." (Alchain et al, 1972). Logical inferences relate premises to conclusions.

ii. A rational choice analysis of the medical care and consultation, for example, would generally involve a description of: the desire to get well, the desire to visit a health practitioner, the cost of getting well.

3.2 Game Theory and Medical Consultation

The medical consultation is best understood as a two-way social interaction. In a typical consultation the doctor elicits information from the patient, then offers a diagnosis or opinion and may also discuss and offer treatment. The patient can choose what information to disclose and how to present it, can ask questions that influence the doctor's perception of the problem, can make explicit requests and, above all, can choose how to respond to the advice offered or the treatment prescribed. The outcome of the consultation is affected by the actions and choices of both participants. In other words, a consultation involves *interactive* decision making. The closely related notion of *shared* decision making—the idea that doctors should collaborate with patients in making treatment or management decisions—has been the focus of extensive conceptual and empirical research, particularly in the context of primary care (Elwyn et al. 1999). There is little evidence that shared decision making routinely happens in consultations (Stevenson, et al. (2000), but it is clear that even if the decision making *process* is not shared, the outcome of the consultation will still usually depend on the choices of both the doctor and the patient—the doctor's decision about treatment or management and the patient's decision about whether or not to follow the advice or prescribed treatment.

A conceptual apparatus for describing and analyzing interactive decision making is supplied by game theory. The theory emerged in the 1940s (Von Neumann (1994). following preliminary work by the French

mathematician Borel and the Hungarian mathematician von Neumann in the 1920s and 1930s. Its influence in the social and behavioural sciences began to grow after the publication of a more accessible account of the theory by Luce and Raiffa, culminating in the award of Nobel prizes to three leading game theorists in 1994. Game theory has found wide application in social psychology where it has been used to model decision making in a range of contexts (Colman, 2003), including economics (Camerer, 2003; Sugden, 1991), politics, (Axelrod, 1984; 1997), and biological sciences (Maynard, 1982).

Hockstra and Miller (1976) were among the first to recognise the interactive nature of decision making in medical consultations, and hence the value of game theory in modeling this decision making process. There has also been some interest in the use of game theory to develop prescriptive models of medical decision making (Diamond, et al, 1986). Game theory has the potential, however, to provide a valuable theoretical basis for broader questions about the medical consultation. This approach has received little attention, with the exception of the work by Batifoulier which explored the relevance of game theory models to the doctor-patient interaction, and drew on this theoretical perspective to address the question of what produces cooperation between the doctor and the patient (Batifoulier, 1997). Palombo also used game theory principles as the bases of a discussion on the development of the therapeutic alliance in psychiatry (Palombo, 1997).

Game theory may have particular value in increasing our understanding of doctor-patient relationships. A recent narrative review of empirical research has found evidence that continuing relationships between doctors and patients are associated with a range of measurable positive outcomes, including quality of care, adherence to treatment, and patient satisfaction, but may also be associated with negative outcomes including poorer control in diabetic patients and difficulty in the application of evidence based care (Pereira, 1997). However, much of this research is pragmatic, lacking a theoretical basis through which findings can be integrated and from which new hypotheses can be developed and tested. The theoretical and experimental literature on game theory and experimental games includes a huge body of research on the factors promoting cooperation, reciprocity and trust, which could be applied to developing an understanding of cooperation and trust in the consultation.

Work carried out by Gutek and colleagues in the US and Australia (Gutek, 1995; 1999, 2000), provides a good example of the use of game theoretic principles to model the organization of service provision and its impact on service quality. Based on game theoretic principles, Gutek asserted that continuing relationships between providers and consumers

are conceptually distinct from the other modes of service provision and have unique features that help to promote cooperation and quality of care. Her empirical work provided evidence to support this assertion. Customers who received service within relationships were more likely to trust their providers and recommend their providers to others. They reported more personalized service within relationships and were more likely to direct complaints to their individual providers than to managers (Gutek, 2000). Service relationships were also found to be linked to higher customer satisfaction and higher frequency of service use (Gutek, 1999). Gutek's work provides an illustration of the use of game theory to develop a theoretical model and to generate and test predictions about service quality. Although this work did not have a specific focus on medical care, it does point to the value of further research using game theory models to identify predictors of quality in health care.

We propose that game theory has the potential to provide models of the consultation and its organizational context—models that can be used to generate empirically testable predictions about the factors that promote good quality health care.

4.0 CONCLUSION

This review has indicated that rational choice and game theories can be applied to the medical consultation and used to generate predictions about how the context of a doctor-patient interaction influences cooperation and quality of care. In particular, rational choice theory indicates how individual make rational but comfortable choice in medical care and services. Game theory also indicate that a history of past interactions between a doctor and patient and anticipation of future interactions make cooperation and good quality care more likely.

5.0 SUMMARY

In this unit, we looked at rational choice and game theories, drawing assumptions and principles from them to illustrate medical seeking behaviours. Hope this unit was interesting and insightful. Let us attempt the questions below:

6.0 TUTOR MARKED ASSIGNMENT

Discuss medical consultation behaviour, employing the concepts of Game Theory.

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UNIT 2 MEDICAL CARE: HEALING OPTIONS

CONTENTS

1.0 INTRODUCTION

In the previous unit, we reviewed the rational choice and game theories, which provided insights on how the players (patients) make health care choices. For the patient to make such critical choices, he or she needs to identify the healing options available, therefore unit 2 seeks to identify several options available for medical care –healing. Basically, such healing options are usually categorised 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

i. Identify the three health practitioners available in the modern health care
ii. Identify some healing options and specializations available in the modern health care.

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Primary care provider, Nursing care and the pharmacist
ii. 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 and 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:

1. Self-treatment through prayer
2. Treatment by a lay person thought to be able to communicate with God
3. Treatment by an official church leader for whom healing is only one of many tasks
4. Healing obtained from a person or group of persons who practice healing fulltime without affiliation with a major religious organization
5. 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 booster 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. 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 3 SOCIODEMOGRAPHIC & SITUATIONAL VARIABLES OF MEDICAL CARE/SELF CARE BEHAVIOUR

CONTENTS

1.0 INTRODUCTION

Suffice to note that decision to seek medical attention for any illness is an important aspect of illness behaviour and this also forms part of coping and adaptation. However, observations indicate that for an important majority of illness, people seek professional help. Thus, this unit seeks to provide information on the variables that determine the class of people that are more likely to seek medical help.

2.0 OBJECTIVES

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

- Identify and describe the socio-demographic variables of medical care/self care
- Identify and describe the situational variables of medical care/self care.

3.0 MAIN CONTENT

3.1 Socio-Demographic Factors

Generally, how likely a person is to seek medical care depends in part on the following socio-demographic factors:

3.1.1 Age

How young or old a person is influences health seeking behaviour. The very young and old are thus more likely to seek medical attention than those in between, partly because of the particular health needs of these age groups. The very young generally receive periodic vaccinations and well-baby checks and are prone to developing various infectious diseases of childhood. Also, the aged, due to wear and tear on the bod y over the years, are prone to various communicable and non-communicable diseases and are thus more in need of health care than others.

3.1.2 Gender

This is another important factor. Overall, females use health care services more than do males, with the exception of early childhood, when males and females see the doctor equally. This finding holds across age groups and persists even when gender-specific conditions, such as pregnancy and gynaecological problems are excluded (National Center for Health Statistics, 1987). These differences are particularly striking when we take into account the controversial notion that, women live longer than men. Interestingly, the recent Nigerian census report of 2006 that judged men to be more in population than women, seem to add an interesting twist to this gender issue.

3.1.3 Socio-Economic Status

Interestingly, socio-economic status could serve a dual function of increasing as well as reducing health care seeking behaviour. For example, the low-income group may appear to visit the doctor more and are likely to be hospitalized than the affluent. Thus, the greater use of health services by the poor, at least in part, reflects social class differences in overall health. For some reason, poor people have more health problems than the affluent. In addition, where people at different socio-economic levels obtain their care as well as the type of care they seek differ. Those with higher income are likely to receive their care at private doctors office, are more likely to receive more thorough and expensive medical care, thus, falling illness less often.

3.1.4 Health Orientation

This is of the opinion that when people have good knowledge of the causes and effect of different health conditions and also the need to consult professional help if need be, they are likely to seek health care services when ill. For example, surveys on health attitude indicate that poor people often see themselves susceptible to illness and take less personal responsibility for their health. As a result of this, they are less likely to seek preventive health care, which, in turn, leads to higher illness rates (Cockerham, et al., 1986).

SELF ASSESSMENT EXERCISE

i. Identify the socio-demographic variables influencing medical seeking behaviour
ii. Ascertain the role of socio-economic status on medical seeking behaviour

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Age, gender, socio-economic status, health orientation, etc.
ii. The socio-economic status could serve a dual function of increasing as well as reducing health care seeking behaviour. It is believed that the low-income group may appear to visit the doctor more and are likely to be hospitalized than the affluent. Thus, the greater use of health services by the poor, at least in part, reflects social class differences in overall health. For some reason, poor people have more health problems than the affluent. In addition, where people at different socio-economic levels obtain their care as well as the type of care they seek differ. Those with higher income are likely to receive their care at private doctors office, are more likely to receive more thorough and expensive medical care, thus, falling illness less often.

We hope you enjoyed this exercise. Next is the situational variable guiding medical seeking behaviour.

3.2 Situational Variables

The seeking of medical care is definitely more that just a matter of going to the doctor, or influenced by certain socio-demographic variables. Observations have shown that the decision to seek health care is further determined by the other situational variables like - nature of symptom experienced, the situational functions, the personal needs, the person's illness schemata and other factors (Bishop, 1994). Such situational variables are thus described below:

3.2.1 Type of Symptom Experienced

Perhaps, the most obvious determinant of medical seeking behaviour is the type of symptom experienced. In particular, symptoms that are unexpected, visible or defined as serious or disruptive are particularly likely to lead people to seek medical care (Mechanic, 1978). Thus, a serious affliction like leprosy or HIV/AIDS deemed very serious could trigger prompt medical seeking behaviour.

Additional insight into how symptoms affect illness behaviour, come from a study of the basic cognitive dimensions used by middle-class whites. Results suggest four different dimensions used in thinking about symptoms. Specifically, people in this study seem to be organizing symptoms on the basis of whether those symptoms are caused by a virus, have a physical or psychological cause, are disruptive to activities, and where they are located in the body.

These dimensions were in turn, related to three types of action. Perception of a symptom as caused by a virus was associated with self-care, for example, taking a non-prescriptive medicine or using a home remedy. Attributing a symptom to physical causes and location in the lower part of the body were related to seeking professional help. Disruptiveness of the symptoms was related to curtailing activities (Bishop, 1994).

3.2.2 Situational functions

Whether a person seeks medical care also seemed to be a function of the situation. Zola (1964) identified some "triggers" that determine when a person will seek medical care.

Interpersonal crisis - First, seeking medical attention may be the result of interpersonal crisis. In this case, an interpersonal situation causes the individual to notice symptom and to dwell on them. A good example could be the case of a wife that feigns illness to attract the husband's attention or desist from doing house chores.

Social Interference – This occurs when a person's symptom disrupts valued social activities, such as when a 'running stomach' prevents a person from attending a very important job interview.
Sanctioning – This is a situation where a person is mandated by others to seek medical help for a problem. This is likely to happen when a person's illness becomes so obvious for others to continue to ignore. A good example is when a person's progressive hearing loss begins to make normal conversation difficult for others.

3.2.3 Personal Needs

Beyond the symptom and situation, individual's personal needs play a pivotal role on medical seeking behaviour. The phrase "health is wealth" comes to fore here because it is natural to think of good health as one of our paramount values, after all, if you have good health, you have just about everything, or rather be in a better position to pursue set goals. However, some needs may lead a person to ignore symptoms or put off medical seeking care. For example, the fear of being diagnosed with cancer or AIDS can lead a person to delay seeking help for suspected medical symptoms. Practical reasons like the need to go to work and earn a living or huge medical fee can prevent a person from seeking help (Mechanic, 1980).

3.2.4 Cognitive Representation or Schemata for Different Illnesses

As noted in previous unit, people understand symptoms in terms of schemata for specific illnesses. These schemata include ideas about the kind of actions to take. Whether a person seeks medical care or engages in self-medication is likely to depend on the illness schema that the person uses for interpreting the symptoms. For example, consider the case of a young man who experiences weight loss, diarrhoea, general weakness and rashes on the body. These symptoms fits people's schema for HIV infection, thus he will probably conclude that that is what he has. On the bases of this, he may conclude that what is best for him is to go for voluntary HIV counseling and testing.

4.0 CONCLUSION

As we have seen, there exist several social and demographic variables as well as contributory situational variables that influence decisions to seek health care. These observations, however, should be kept in perspective when seeking medical care/self care.

5.0 SUMMARY

Unit 3 of this module provided a review of situational variables and socio-demographic variables that influence health seeking behaviour. I hope you enjoyed your studies. Below are questions you need to provide answers to. Good luck.

6.0 TUTOR MARKED ASSIGNMENT

Identify and describe the situational variables influencing medical care/self care?

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UNIT 4 DOCTOR-PATIENT INTERACTION

CONTENTS

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). Unit 4 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

ANSWERS TO SELF ASSESSMENT 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 Poor 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 inpatient 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 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

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 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 two 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 5 DELAY OR OVERUSE OF MEDICAL CARE

CONTENTS

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 unhealth y 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 the delay 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 cure showed less delay than others.

SELF ASSESSMENT EXERCISE

Examine the factors that trigger delay of medical care

ANSWERS TO SELF ASSESSMENT 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, which normally exist in a physician-patient relation
- 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, which is the last for module 5, 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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MODULE 6 DEPENDENT-PATIENT ROLE AND RECOVERY AND REHABILITATION

UNIT 1 DEPENDENT – PATIENT ROLE

CONTENTS

1.0 INTRODUCTION

In the dependent-patient role, the patient enters the fourth stage of illness experience – the 'dependent-patient role', when the recommendations of the health care provider for treatment are accepted. This thus creates new role expectations that include increased contact with the provider and altered personal relationship. The patient is expected to make every effort to get well. Some people of course enjoy the benefit of this role (eg, increased attention and escape from work responsibilities) and attempt to malinger. Eventually, however, the acute patient will either get well and move to stage 5 (recovery and rehabilitation), or terminate the treatment (and perhaps seek alternative treatment.

In this unit, we will look at various efforts patients are required to make to get well. We will also look at several difficulties encountered at these stages.

2.0 OBJECTIVES

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

- Describe the roles of the dependent patient in the hospital setting
- Identify expectations and responses of patients in the hospital setting
- Examine children's behaviour when hospitalized
- Examine issues of compliance

3.0 MAIN CONTENT

3.1 Hospitalization and the Dependent-Patient

One of the efforts at getting better is hospitalization. People receive most of their medical care as outpatients. Occasionally, however, a person needs to be hospitalized, either for treatment or to receive tests that for one reason or another cannot be performed on an out-patient basis. Although, the points made earlier in module 5, about patient-physician relationship still applies, the experience of hospitalization and a resolution to comply with treatment and get well goes well beyond simple interaction. Thus, being hospitalized means dealing with large scale institution that is strange, and oftentimes overwhelming. This is because, hospitals have their own rules and procedures, often developed primarily for staff convenience and efficiency that many times seem to be at cross purposes with patients needs (Bishop, 1994). For this reason, hospitals are generally considered aversive places and hospitalization, is seen as a very negative experience, thus making the patients resolution to get well a much hectic one. The following are thus, expectations at the hospital setting.

3.1.1 Expectations at the Hospital Setting

In a bid to get well, and also make healing experience comfortable for the patient and the care giver, patients are expected to perform various roles. Ostensibly, patients are the entire reason for the existence of hospitals. However, patients are seen as guests in the hospitals environment and generally powerless ones at that. They come unbidden into an environment that most find entirely alien and generally confusing (Wilson, 1965). Some of patients' expectations at the hospital setting thus include:

A Adhere Completely to Hospital Rules and Regulations

Also, hospital as an institution takes control of virtually every aspect of patients' lives. They are thus expected to follow the hospital rules and schedules, eat and sleep at designated times, receive visitors only during specified hours and most importantly make their bodies available for examination when requested. For some people, this may be a bit embarrassing, especially for those admitted in teaching hospitals where students are required to learn from patient's medical symptoms and experiences.

B Accept to be Treated in a Depersonalized Manner

In addition, patients are treated in a depersonalized manner. They are treated more like objects than subjects. This may be for a variety of reasons, to either minimize emotional involvement, or to keep the patient quiet. For example, during medical examination, the focus may be so much on the medical problems at hand that it is almost as if the patient weren't there.

3.1.2 The Dependent Patient: Types of Responses at the Hospital

Lober (1979) has identified three basic types of patient's response, as seen by hospital staff. They are:

Good Patients: This group of patients is generally cooperative and conforms to the requirements of the patient role. They are also uncomplaining and loved by hospital staff.

Average Patient: Average patients could also be seen as good, but they have minor complaints that can be easily handled. They are also liked by the hospital staff.

Problem Patients: Problem patients complain a great deal, become emotional about their problems, demand extra attention or refuse to cooperate with treatment. When problem patients are seriously ill, and the staff can attribute their disruptiveness to the seriousness of the illness, they are generally forgiven. However, problem patients who are not viewed by the staff as seriously ill are likely to be roundly condemned. In this case, they are likely to be seen as troublemakers and may be tranquilized, referred for psychiatric evaluation, or even discharged early (Bishop, 1994).

SELF ASSESSMENT EXERCISE

i. Identify the 3 basic types of patients responses
ii. In the hospital setting, patients are expected to ------

ANSWERS TO SELF ASSESSMENT EXERCISE

i. Response style ranges from good patient, average patient and bad patient. The good patients are generally cooperative and conform to the requirements of the patient role. They are also uncomplaining and loved by hospital staff. The average patient could also be seen as good, but they have minor complaints that can be easily handled. They are also like by the hospital staff. The problem patient complains a great deal, becomes emotional about their problems demand extra attention or refuse to cooperate with treatment. But when problem patients are seriously ill, and the staff can attribute their disruptiveness to the seriousness of the illness, they are generally forgiven.
ii. In the hospital setting, patients are expected to: adhere completely to hospital rules and regulations and accept to be treated in a depersonalized manner.

3.1.3 Determinants of Different Response Patterns in Hospitalization

Loss of Control: One major determinant appears to be how individuals respond to loss of control that is expected when hospitalized. Disruption to familiar and controlled lifestyle to a helpless and uncontrolled state in the hospital is certainly stressful enough.

Low Information: Patients are sometimes made vulnerable, placed at the mercy of an institution and are kept in a state of low information. The result is likely to be considerable amount of anxiety and confusion.

Learned Helplessness: Even though some patient may enter the hospital environment with the expectation of maintaining control, frustrating experiences with hospital routine and that of low information may convince them that their efforts at control is futile. When this happens, the patient is likely to enter into a stage of learned helplessness (Seligma, 1975). In this state, people show characteristics cognitive deficit and fail to exercise even the control that they have.

3.2 Dependent-Patient Role: Children and Hospitalization

- Hospitalization is a stressful experience for almost everyone. However, it can be particularly stressful for children, and they are

likely to show significant behavioural disturbances. Such responses to hospitalization among children are certainly understandable. As we have noted earlier, hospitals are alien and confusing environments for almost everyone because of its sometimes straight-jacket rules and expectations. When the patient is a child, however, developmental factors intensify emotional response to hospitalization. Such emotional factors include:

- When young children are separated from their parents and placed in a strange environment such as hospital, they typically become distressed and exhibit emotional behaviours such as crying (Ainsworth, 1979).
- Children often have a great deal of difficulty understanding what is going on in the hospital and why they are there.
- They may also blame themselves for illness or see treatment as punishment.
- Beyond separation from friends, school mates and family, the enforced inactivity of hospitalization, fears about the outcome of the illness and its treatment, and the embarrassment of being physically examined by strangers, all contribute to the young patient's distress. The result is likely to be a great deal of anxiety as well as possible bed-wetting, temper tantrums, behavioural aggression and general acting out (Eiser, 1985).

3.3 Issues of Compliance

We have discussed patient's expectations and response styles. Now let us examine issues of compliance. Compliance to medical care is another factor that could broaden our understanding of patient-dependent role, and the measures to get well. Factors affecting compliance therefore include:

3.3.1 Factors that Enhance Compliance

1. Good rapport between physician and patient
2. Simple regimens
3. Clear instructions that patient can repeat back to physician
4. Positive feedback for adherence
5. Increased level of distress
6. Decreased waiting room time
7. Increased time with physician
8. Family support and involvement

3.3.2 Factors that Impede Compliance

1. Low level of subjective distress

2. Denial of illness
3. Poor communication between physician and patient
4. Complex regimens
5. Treatment that is embarrassing or humiliating
6. Outside factors that make compliance difficult
7. Patient's perception that it is beneficial to remain ill
8. Side effects that, are significant for the patient

4.0 CONCLUSION

The dependent patient, in a bid to fully accept his or her illness state and subject self to medical care may go through hospitalization, which is one of the many measures geared at getting well and relinquishing the sick role. Thus, hospitalization is indeed a very stressful experience for almost everyone, because of the sometimes strict measures put in place to make the hospital institution function effectively. Patients are thus expected to adhere to these rules and this can be a very uncomfortable experience.

5.0 SUMMARY

This unit tackled the issue of the dependent patient and hospitalization. It highlighted expectations of patients in the hospital settings as well as different responses exhibited by them. Furthermore, it looked at children and hospitalization and also the issue of compliance. We hope your enjoyed your studies. Let us attempt the following questions below.

6.0 TUTOR MARKED ASSIGNMENT

1. Identify the factors that enhance and impede compliance
2. Discuss the experiences of children in the hospital setting

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UNIT 2 CARING FOR THE DEPENDENT PATIENT: THE COSTS TO THE FAMILY

CONTENTS

1.0 INTRODUCTION

A number of different groups of people, as a result of illness or handicap, may be in need of a significant level of care from family members and friends for some parts or even all their lives. While patients with acute illnesses (malaria, flu, etc), may depend on family member for care and support over a shorter period of time, the chronically ill, the elderly, the mentally retarded, the physically challenged and the younger chronically sick depend on family care for a very long time. There is, unfortunately, increasing evidence that providing care for the seriously and chronically ill patients is both stressful and challenging. This unit focuses more on the difficulties faced by families who care for the chronically ill, because care is expected to be over a long period of time and thus likely to trigger emotional reactions. Also, emotional reactions experienced by the patients will also be identified.

2.0 OBJECTIVES

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

- Identify changes in the family that occur as a result of a caring for a chronically ill member
- Illustrate stages of stress experienced as a result of a sick family member

- Identify changes in structure of care that could ameliorate the burden of caring for the chronically ill in the family
- Identify the emotional and behavioural reactions of patients in the home setting

3.0 MAIN CONTENT

3.1 The Family and the Chronically Ill

Over the years, changes in philosophies concerning the nature of care, increasing medical sophistication, and tighter financial strategies have meant that the majority of people of all ages requiring constant medical care now live within the relatives, and are cared for by women, parents, spouse, children, and siblings. Much of this caring work is essentially invisible, becoming visible only when there is breakdown or crisis. Many caring families do not question their role in looking after their sick or handicapped relatives, although considerable time away from other activities and disruption from family and social patterns may occur.

It has been said that individuals do not develop chronic diseases, families do. The reason for this belief is that the family is a social system (Minuchen, 1977), and disruption in the life of one member invariably affects the lives of others. The following could be regarded as changes brought about by chronic illness in the family.

3.1.1 Caring for the Chronically Ill: Changes in the Family

- One of the chief changes brought about by chronic illness is an increased dependency of the chronically ill individual on other family members. If the patient is married, the illness places huge responsibilities on the spouse. Care giving responsibilities may also fall on the children and other relatives living at home.

- The immediate family may feel that their lives have gone out of control and may have difficulties coping with the changes. Thus, increased responsibilities may be difficult to handle if family members' resources are already stretched to the limit, accommodating new tasks is usually very difficult (Compass, et al., 1996).

- Young children who are suddenly forced into taking on more responsibilities than would normally be expected for their age group may react by rebelling or acting out. Disturbances may

include regression (such as bed wetting), problems at school, truancy, drug use and antagonism towards other family members.

- Many chronic illnesses like stroke, heart disease, cancer and even HIV/AIDS, lead to a decrease in sexual activity. In some cases, the condition itself prompts temporary restrictions on sexual activities. Sexual problems may compound existing strains in the marital relationship

- In addition, chronically ill patients often experience alteration in mood, such as increases in anxiety or depression, which in turn may affect the family members adversely (Compass, et al., 1994).

- Observations indicate that the burden of care is not equally distributed within the family, caring is predominantly seen as a female occupation. A study by Nissel et al., 1982, showed that 50% of wives caring for elderly relatives (who may well include the husband's parents) spent more than three hours a day caring, while their husbands do not contribute at all (Cockerham, 2003).

- There is also growing evidence that providing care for a sick relative has enormous implication in terms of demands on interpersonal relationships, and on the psychological and physical well-being (Broome and Llewely, 1995). Using the example of caring for the handicapped child, Bicknell, (1983), points out that 'a handicapped child is a handicapped family'. In other words, the fact of having to provide care is as disruptive to patterns of living as the handicap or illness itself.

SELF ASSESSMENT EXERCISE

Identify changes in the family that occurs as a result of caring for a chronically ill member.

ANSWERS TO SELF ASSESSMENT EXERCISE

One of the chief changes brought about by chronic illness is an increased dependency of the chronically ill individual on other family members. The immediate family may feel that their lives have gone out of control and may have difficulties coping with the changes. Thus, increased responsibilities may be difficult to handle if family members' resources are already stretched to the limit, accommodating new tasks is usually very difficult. Young children are also forced into taking on more responsibilities. In addition, chronically ill patients often experience alteration in mood, such as increases in anxiety or depression, which in turn may affect the family members adversely.

3.2 Caring for the Chronically Ill: Stress in the Family

The overwhelming picture of the experience of caring is that it can be stressful. But in addition, there are more deep-seated causes of stress and these are factors of which the care giver may not be fully aware. These are feelings of anger, guilt and grief.

Bicknell (1983) describes the typical responses of parents when told of handicap of their child as being essentially similar to that facing any bereaved parent, except that there are additional problems of adaptation and acceptance of the child in the long term. The parents may feel on some level that the handicap is a punishment for some past misdemeanor or immoral act, or may impute blame to their partner. Such feelings may never be voiced out because on a conscious level, they are acknowledged as illogical and are also recognized to be socially unacceptable. The parents may also dread the future or feel very angry with a child who has been born handicapped and seriously ill, but again will be unable to voice such feelings. Similarly, Cooper, (1985) describes the immense stress of caring for a beloved child or sibling, whose personality has radically changed as a result of progressive mental retardation. In this case, unrecognized and unacceptable feelings and behaviours may have to be tolerated by family members, while the feelings may have to be suppressed or denied only adding to a sense of stress and resentment.

Nevertheless, it has also to be pointed out that caring for a loved one can bring many satisfactions and while some may feel that caring is just a duty others provide care because they love the patient.

3.3 Caring for the Chronically Ill: Changes to the Structure of Caring

Stress experienced by care givers in the family is caused by an imbalance between perceived demands and resources. It can also be caused by feelings of anger and grief which may not be recognized. Yet, most care givers are not able to express these frustrations in any public forum, nor are they often encouraged doing so in the family itself. For example, a woman looking after a sick husband, instead of empathy, may be scorned over little mistakes. Also, no financial assistance is given to female care givers since it was assumed that caring was part of a woman's job. Several changes to the structure of caring are therefore necessary:

First, it is essential that the financial cost of caring for relatives is recognized. Though, this may be almost impossible in the present day Nigeria and other developing world, with unemployed and cost of living

on the high side. It is hoped that such emphasis on the plight of care givers in the family may trigger empathic policies in the nearest future. Although, money cannot possibly compensate for the distress of caring for a loved one, it can make life easier and less isolated.

Second, Individual family members, and in particular boys and men need to be educated to regard caring for the sick, the elderly and the handicapped as an essential part of their responsibility in life. Only then will the burdens of care become more truly shared and some aspects of caring become less stressful (Broome and Llewely, 1995).

3.4 The Dependent Patient: Emotional and Behavioural Responses

It is erroneous to assume that the care givers are the only parties likely to experience stress when caring for the sick relatives or child. The patients themselves, being at the receiving end are also affected by such activities around them. Below are some of the contributory factors:

- The loss of control and overdependence on family members may trigger guilt feeling and anger among the patients.
- Dependent role could trigger irritability and short temperedness among the patients as a displaced aggression over their medical state.
- It can sometimes trigger feelings of helplessness and hopelessness, especially among patients with more severe chronic illnesses like Cancer or HIV/AIDS.
- Loss of privacy could result when patients are unable to perform simple daily activities like bathing, using toilets or feeding self. This, of course, could be very embarrassing to many.
- Dependency state may also trigger learned helplessness on the part of the patients. Here patient is unable to perform certain cognitive or motor tasks and depends on family members for them.
- In a bid to reduce the stress on family members, some patients may develop the habit of staying alone and quietly bearing pain. This could trigger depression and more complicated caring environment.

4.0 CONCLUSION

The global experiences particularly, that of changing expectations of the sick role in the new economy subject many families with chronically ill member to very stressful experiences. Caring for such family members is thus much more difficult than previously felt, especially with little or no assistance from the government. Most often, the family members

efforts at caring for their loved ones go unnoticed, unless in a state of crisis. Obvious interference with social and family life triggers several emotional and behvaioural difficulties on the part of family members as well as the patients themselves. Several measures that could ameliorate the plight of care givers were however identified.

5.0 SUMMARY

This unit looked at the issue of the family and the chronically ill, highlighting the difficulties and the stress experienced by the family members as well as the patients. I hope you enjoyed your studies. Below are some questions we need to attempt.

6.0 TUTOR MARKED ASSIGNMENT

Caring for the sick in the family is both stressful and fulfilling. Discuss.

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UNIT 3 RECOVERY – REHABILITATION

CONTENTS

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 b y 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 the illness itself and treatment
ii. Identify the goals of physical rehabilitation of the chronically ill

ANSWERS TO SELF ASSESSMENT EXERCISE

i. 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.
ii. 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 reestablishing 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, 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. We 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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UNIT 4 COPING IN ILLNESS

CONTENTS

1.0 INTRODUCTION

Illness is an emotionally as well as physically depriving experience. The acute illness, like a severe case of malaria or flu is likely to trigger temporary discomfort and disruptions in family, work and social life. But chronic illness like HIV/AIDS, Cancer, Diabetes, can do lasting harm by threatening a person's sense of well-being, competence, and feelings of productivity. At their worst, emotional reactions to illness may culminate in the feeling that life is meaningless. Each stage in the progress toward wellness involves loss, grief, and acknowledgment of internal pain. This unit therefore hopes to broaden our understanding of coping strategies in illness.

2.0 OBJECTIVES

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

- Illustrate conditions for coping in illness

- Identify stages of coping in illness
- Recommend realistic positive coping skills

3.0 MAIN CONTENT

3.1 Conditions for Coping in Illness

How people react to chronic illness depends on many conditions:

- The first is the severity of the illness. Here, if the illness is chronic and severe, the patient may have more difficulties coping, unless, he or she is very determined to do so.
- The second is the social support available: When friends, family and societal support is positive, it makes coping behaviour a lot easier
- The third condition is the pre-illness personality of the person. A flexible and accommodating personality, prior to illness may, likely cope better than a rigid and catastrophizing personality.

3.2 Stages of Coping in Illness

Illness is a process, and like all processes it has different stages with different characteristics. We will discuss the stages below.

The stages are not part of a once-through programme, but are repeated as symptoms recur or losses come about. The stages can occur in varying orders; often they are repeated. If a sick person lacks emotional support or social support, the process can stagnate. These aids are of critical importance in the stages of the ongoing emotional process. These stages are *crisis, isolation, anger, reconstruction, intermittent depression,* and *renewal.*

3.2.1 Crisis Stage

In the crisis stage, the patient is seriously ill and very frightened. Both psychologically and physically, he or she has a decreased ability to respond to others. The sick person's energies are directed inward toward healing, and controlling panic. The patient is often too sick to even be frightened. Events are often confused. Time is distorted. Disorientation is common. At these times we fall back on our innate biological ability to heal. The support network, on the other hand, is feeling a highly stressful increase in anxiety, especially as it must carry the full responsibility for arranging for medical care, covering finances, and seeing that children's lives, if children are involved, can go on with a minimum of disruption. The family's anxiety can be energizing. The

family may feel a need, sometimes an obligation, to be highly supportive of the patient.

By and large, everyone responds well in a crisis. Everyone knows the patient is terribly ill. And they respond. Unfortunately, those most affected by the patient's illness do not always receive the support and help they need at this time.

Friends sometimes respond by showering the sick person with cards, and get-well-soon wishes.

During the crisis stage almost all of the patient's energy and attention are focused on responding to the physical onslaught of the illness. Surviving is the primary concern.

In addition, the patient and the family must cope with the fear of an unknown and unknowable future. It is all too clear that the comfortable patterns of the past have been shattered. It is not clear at all what may lie ahead (La Maistre, 1995).

SELF ASSESSMENT EXERCISE Identify the

conditions for coping in illness **ANSWERS TO**

SELF ASSESSMENT EXERCISE

The first is the severity of the illness. Here, if the illness is chronic and severe, the patient may have more difficulties coping, unless, he or she is very determined to do so. The second is the social support available. The third condition is the pre-illness personality of the person.

3.2.2 Isolation Stage

In time, the acute nature of the illness may abate. But total recovery does not occur, and the illness persists. There is a dawning awareness of everyone's part that the situation has become a chronic one. There will be no full recovery. There is so much uncertainty about the future that the patient may not be able to sleep at night and may seem restless and distracted during the day. The lack of an expectable future constitutes a major assault on one's self-image.

The patient's anxiety often produces a stiffness in dealings with others and oneself. There is a belief, usually partially justified, that no one can understand the devastation of the losses. Isolation most troubles patients who have been the most independent.

The family has often exhausted itself during the acute crisis stage. Family members may become aware that they are angry, fearful, and disgusted about the sick member's situation. Both patient and family members retreat into themselves and their thoughts, now haunted by the knowledge that life may never be the same.

Friends also tend to give out at this point -- the idea of chronic illness is really terrifying to most people. After an initial burst of energy, some friends may find it too overwhelming a personal struggle to continue having contact with either patient or family. Some patients have been devastated by an apparent lack of concern shown by people for whom they care.

In the isolation stage open communications are vital. Blame must not play a part. Talking about feelings is very important. Communication and sharing are ways to break the isolation (La Maistre, 1995).

3.2.3 Anger Stage

The sick person has been suffering severe upset, terror, anxiety, and helplessness. Add to this the sense of injustice, unfairness, and senselessness of being struck down by a disease, and the result may be a rage reaction of tremendous proportions. Often the target of this rage is the patient himself or herself. The ultimate, most dangerous, expression of this rage at self is suicide. The commonly experienced feelings of despair may result in contemplation of suicide.

There are two reasons why the patient targets himself or herself for these feelings of anger and despair. First, it is almost impossible to be furious with fate; there is no external opponent. In order to provide some meaning for what has happened, many people irrationally conclude they have brought disease on themselves by being faulty or wicked in some way. It is difficult to keep clear that it is the disease that introduced the disruption into one's life.

Another reason for suicidal thoughts is that illness breeds a sense of helplessness. The chronic disease cannot be wished away. The disabilities are there to struggle with every day, and the threat of a major recurrence or increase in symptoms may be a constant anxiety tucked away not far from consciousness. With the feeling that the underlying problem cannot be solved and the belief that it is the patient's fault, many patients suffer intense unhappiness. Sadly, the patient's feeling of self-blame is greatly reinforced by society. Often families are unable to help because they are angry at the patient. The changes in their life style are directly attributed to the patient and not to the patient's illness. Even supposedly neutral medical personnel may be furious with the patient

for having a chronic condition they cannot cure. This anger directed at the patient from all sides is psychologically understandable but it is very destructive.

The flirtation with suicide, the patient's worst hazard of the anger stage, is a statement of the extent of one's rage with oneself and with those one cares about.

Another serious problem of the anger stage is the strain on the family. Families who fare better during this stage understand that the sick person is not the same entity as the disease and they see that the whole family is in this predicament together and are committed to coming out of it as well as possible. Family members need to devise ways to nurture and adequately support each other in order to cope with both the anxiety and the practical life changes accompanying chronic illness (LaMaistre, 1995).

Anger is the stage most hazardous to your emotional well-being. It is also where most people get trapped. Take back control in small steps. The basic reasons for the anger, in most cases cannot be avoided. It does no good to assign blame. The response must become task-oriented. "Today I will walk the length of my room, or call a friend, or answer one inquiry." Striving toward a goal, even in small doses, is an antidote to anger. Patients, family, friends, and helpers should all focus on the strengths that remain, on the accomplishments that can still be achieved. This basic rule is a key to dealing with anger.

3.2.4 Reconstruction Stage

The sick person may now be feeling much stronger physically or may have had enough time to begin mastering new living skills. Important decisions or new social contacts may be in the picture. What is common is a growing sense of safety based on new competencies. Moods are happier and the difficulties seem a bit further away. The sick person is learning the possibilities and limits of the new competencies. Friends are selected on how well they react to the fact of illness. The family establishes new routines -- or it dissolves.

What exactly has been reconstructed? Certainly it is not life like it was before. Instead, it is a reconstruction of the sense of oneself as a cohesive, intact entity. The reconstruction takes on many concrete aspects, such as the development of new skills, but the most important value is emotional. When a customary pattern of living has been shattered by illness, the patient fears that he or she is no longer recognizable as a whole being. It is the reemergence of a positive self-image that constitutes reconstruction.

Often people do well for a few weeks and then are devastated by some incident. But each experience with trusting and succeeding is a building block for the next step of reconstruction.

3.2.5 Intermittent Depression Stage

Now that everything is looking brighter, everyone is tempted to relax and may, therefore, be caught off guard when a significant depression recurs. The elation associated with new skills can give way to new feelings of despair as the patient recalls how much simpler it was to do routine things the old, pre-illness way. Nostalgia and grief may combine to produce sadness and discouragement.

Many people know exactly when they expect to hit these rough spots. Medical appointments and anniversaries are notable examples. Seeing a doctor, who confirms your intuition that your condition is not improving or is worse, often lead to depression. To many the third anniversary of having to give up the car, the first anniversary of a divorce, the time of the year the physical problems first occurred -- the list is endless. It may be best to seek counseling during these difficult times as a way of shortening their duration and providing new understanding of what all the feelings of loss are attached to. New understanding brings new resilience; it does not make the losses go away.

Intermittent depressions seem to combine two feelings. One is the awareness of loss of function that occurs several times a day in the course of ordinary living. But clearly, an amputee or chronically ill does not become depressed each time there is a reminder of the inability to walk normally. There is a second element involved. If the awareness of loss arouses a distinct image of what life would be like if the amputation or illness had not occurred, and if this fantasy has strong emotional meaning for the person, depression is very likely. This image of how you would be without the illness we call the *phantom psyche.*

The phantom psyche is usually not far from consciousness. It is the self-punishing mechanism whereby the chronically ill person continually erodes his or her own self of self-worth and competence. "If only I didn't have this arthritis [or whatever illness] I could still be bicycling [or whatever activity]." "If only" statements are the bread and butter of the phantom psyche. They contain harsh judgments of worthlessness. In a happier mood, you might experience the same feeling of loss, but say to yourself, "I really miss bicycling, but at least I can take a walk today."

3.2.6 Renewal Stage

The losses, and the sadness they cause, never go away entirely. There is a sense of lingering regret for all the capacities that have been lost. A person who has mastered the technique of using a wheelchair can feel very proud of this achievement and know full well that this device is essential for retaining an active life. But the person does not have to like it.

It is not necessary to like or to resign yourself to the compromises you need to make to get on with living. It is only necessary to acknowledge that changes in life style and skills have to be made. Acknowledging that your skills are different from your pre-illness days is not the same as "adjusting" to illness. There is no surrender involved, only growth -- the creation of new options through new means.

The creation of renewal comes from the experiences that teach us not to waste the present on fearing the future.

The truly handicapped of the world are those who suffer from emotional limitations that make it impossible to use the capacities and controls they possess. If you have a chronic disease, you need not be emotionally handicapped if you continually strive to be able-hearted. Able-heartedness is within the grasp of all of us. We don't think of able-heartedness as a permanent, static state, however. Developing and maintaining this quality is a process that ebbs and flows, depending on how helpless you feel. Even if you feel in the grip of hopelessness, you are behaving in an able-hearted way by any expression of interest in another. Shared interest and compassion is what establishes meaning and purpose in life.

When you feel discouraged, you feel all alone -- and there is some truth to this feeling. But in many important ways you are not alone. There are hundreds of people in your city who have similar feelings at times. If disturbing thoughts wake you in the night, know there are others struggling with their pain. No one can share your unique experience, but there is kinship and strength among all of us who are no longer able-bodied.

3.3 Positive Coping Skills

We looked at stages of coping in illness. Now let us identify positive coping skills needed for better adjustments in illness.
There are some positive coping skills that are required by unavoidable health changes. These are summarized below.

3.3.1 Make Expectations Realistic

The most important aspect of making expectations realistic is the recognition that they are time-limited. "What can I do now on the basis of the way I feel at this moment?" If you have two minutes, what are you going to do? Illness can make you feel that you must surrender all goals, all wishes. But that is not necessary. Make your expectations run like this. "Within the limits of my physical ability I will do whatever it is I want to do for as long as I can."

3.3.2 Approach Problems Actively

A second essential skill is an active approach to problems. What is an active approach? It consists of defining the problem and determining the outcome you want. It involves trying to ensure that any energy expended constitutes a step toward the solution. Rarely does it constitute the complete solution. The admission "*I can do something*" is often the first step in solving a problem realistically.

Define what you want and then use every ounce of creativity you possess to determine how you are going to make it happen. Creativity is *not* impaired by illness. When you define the problem you figure out how many facets there are to achieving some kind of resolution, and then you expect yourself to make only that part of the effort that is realistic. What this means is that you need a broader sense of community. There are going to be a number of things you cannot do alone. Your dreams do not have to change. How they are realized will probably change. The creative, flexible use of your energies and creativity to get as much satisfaction as possible is your mission.

3.3.3 Seek Appropriate Help

The next skill to learn is to ask for appropriate help. It is not a moral weakness to ask for assistance, but many can probably recognize the tendency to regard asking for help as shameful. It is a limitation if one does not know how to determine whether or not assistance makes sense. It is a limitation if one is harsh or angry with the helper. Asking for help can become a more and more graceful skill. It is certainly not the first choice for people who would rather do everything themselves, but it should be your choice if you are going to pursue what you need and want -- when you cannot do it alone.

3.3.4 Manage the Anger

The next skill involves learning how to become emotionally efficient and energy conscious. Energy is a tremendous problem for those with

chronic illness. There is none to waste. Some of the most wasteful expenditures of energy are for resentment and anger. These emotions are not bad in themselves, but they do wear you out.

If you are angry, it helps to have some consciousness of what you are angry about, and whether you want to be angry about that. Sometimes you will want to be angry because that is the appropriate response. Sometimes you will want to be angry because it is more efficient to be openly angry than to deal with bitterness or other forms of calcified anger. The better you get at being direct about anger early, the more energy you save and the more efficient you are. Surprisingly, many people do not know how to recognize their own irritation or anger. If you are feeling irritated, it might be helpful to be assertive, even if in the short run you feel uncomfortable.

3.3.5 Participate

Another skill that is especially restorative for those with illness is to put positive energy back into the world. You can do this with family, friends, with self-help groups connected with your illness, or with community groups. Put your talents, your compassion, your knowledge, and your experience out there in a way that can benefit others. Be a good friend to yourself and don't overlook your finer qualities.

3.3.6 Live In the Present

Another skill, that is a challenge to learn, is to look neither too far backward nor too far forward. If you are only looking backward, you are giving up on yourself emotionally. Your losses are major issues, but losses do not get people through one day at a time or one day after another. Losses are not a good reason for living. If you use all your emotional energy considering how things were before the illness and comparing it to how things are now, you are being very self-punishing. Living in the moment with consciousness, patience, compassion, and appreciation for yourself and others lets you get on in a creative way, in spite of the pain of your losses.

3.3.7 Cherish the Good Times

Pay attention to the positives. This can only be done if you have already mastered the skill of living fully in the present moment. You go through every twenty-four hours with enough of yourself available to the world that when something positive happens you let it in. There was a rainbow yesterday, or you had a close, warm exchange with someone you care about. These are the kind of positive moments we mean. Once you notice the positives, you have to hold on to them? The best way is to

slow down -- to use relaxation, meditation, and your own internal capacity for joy to feel that moment inside.

4.0 CONCLUSION

We have seen that illness is really an emotionally as well as physically depriving experience that triggers certain coping measures for better adjustment to it. However, conditions necessary for coping, especially with chronic illness ranged from severity of the illness, availability of social support and perhaps, most importantly, the pre-illness personality of the patient. Stages of coping in illness – crisis, isolation, anger, reconstruction, intermittent depression and renewal, provided insights into emotional experience and reactions to illness. Lastly, several positive coping skills like seeking appropriate help, anger management, active participation, making expectations realistic, further equipped us with skills relevant for coping behaviours and illness.

5.0 SUMMARY

In this unit, we looked at coping behaviour in illness. First, we highlighted conditions necessary for coping. Also, stages of coping in illness were enumerated, as well as positive coping skill needed for better adjustment to illness. Well done for studying this far. Now let us attempt the following questions.

6.0 TUTOR MARKED ASSIGNMENT

1. Identify and briefly discuss stages of coping in illness
2. Identify some positive coping skill needed for illness experience

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UNIT 5 ILLNESS AND THE ISSUES ON DEATH AND DYING

CONTENTS

1.0 INTRODUCTION

It is thus obvious that sometimes people go into the sick role, hoping to gain and enjoy the attentions obtainable in playing the role. So man y saw the sick role as a distraction from their usually busy schedule and hope or do everything possible to get well. Unfortunately, death and dying is a very scary and uncomfortable process or event, and all health behaviours are geared towards prolonging this process. Although many people die suddenly as a result of one trauma or another, but illness experience places one even more vulnerable to that. For those with a huge bout of malaria, or an infectious acute disease, death may be unpredictably sudden and unfortunate. But for those with more severe chronic illnesses, or the terminally ill, death may be predictable and most times, gradual. Thus, advancing illness brings with it the gradual awareness of death; as a consequence, a variety of medical, social and psychological issues arises for the patient. In this unit, we will focus on the issues of death and dying.

2.0 OBJECTIVES

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

- Illustrate the effect of continued treatment on advancing illness
- Discuss stages to adjustment to death and dying

3.0 MAIN CONTENT

3.1 Continued Treatment and Advancing Illness

Advancing and terminal illness, frequently bring the need for continued treatments with debilitating and unpleasant side effects (Levy, 1983). For example, radiation therapy and chemotherapy for cancer may produce discomfort, nausea and vomiting, chronic diarrhea, hair loss, skin discoloration, fatigue and loss of energy. Surgical intervention is also commonly required. The patient with advancing diabetes may require amputation of extremities such as fingers or toes because poor circulation has made them gangrenous. The patient with advancing cancer may require removal of an organ to which the illness has now spread, such as lung or part of the liver. The patient with degenerative kidney disease may be given a transplant in the hope that it will forestall further deterioration (Taylor, 2006).

Many patients find themselves repeated objects of surgical or chemical therapy in a desperate effort to save their lives; after several such efforts, the patient may resist any further such intervention. Patients who have undergone repeated surgery may feel that they are being disassembled bit by bit. Or, the person who has had several rounds of chemotherapy may feel despair over the apparent uselessness of the new treatment. Each procedure raises anew the threat of death and underscores the fact that the disease has not been arrested, and in many cases, the sheer number of treatments can lead to exhaustion, discomfort and depression (McCorkle, 1973). Thus, there comes a time when the question of whether to continue treatment becomes an issue. In some cases, refusal of treatment may indicate depression and hopelessness, but in many cases, the patient's decisions may be supported by thought choices (Taylor, 2006).

These issues are given additional importance by several legislative and social trends. An important social trend affecting the terminally ill is the right-to-die movement, characterized by the insistence that dying should become more a matter of personal choice and personal control. Derek Humphry's book 'Final Exit' virtually leaped off bookstore shelves when it appeared in 1991: A manual of how to commit suicide or resist in suicide for the dying. It was perceived to give back to the dying people the means of achieving a dignified death at a time of one's choice. Some also argue that, at present, only those dying patients who can afford treatment have access to life-sustaining technologies or good terminal palliative care (Henifin, 1993, Taylor, 2006). Also, observations indicate a lot of undocumented cases of suicide as a result of illness, and these are mainly found among patients receiving care at home. Until genuine and affordable access to comprehensive health care becomes a reality for all dying patients and their families, the fear and hopelessness of illness, death and dying continues.

SELF ASSESSMENT EXERCISE

Identify the emotional and physical side effects of continued treatment in advancing illness.

ANSWERS TO SELF ASSESSMENT EXERCISE

Physical side effects could be, for example, radiation therapy and chemotherapy for cancer may produce discomfort, nausea and vomiting, chronic diarrhea, hair loss, skin discoloration, fatigue and loss of energy. Surgical intervention is also commonly required. The patient with advancing diabetes may require amputation of extremities such as fingers or toes because poor circulation has made them gangrenous. The patient with advancing cancer may require removal of an organ to which the illness has now spread, such as lung or part of the liver.
Emotional side effects could be: fear, hopelessness, anxiety, depression, anger, denial, etc.

3.2 Stages in Adjustment to Death and Dying?

For some illnesses, death may be sudden and abrupt for the patient and the family, but for some also, death may be gradual, thus, predisposing patients to different adjustment stages to dying.

The idea that people pass through a predictable series of stages of dying in coming to terms with the prospect of death has appeared commonly in research literature on death and dying (e.g., Falek and Briton, 1974, Glaser, 1972, Pattison, 1967, Kubler-Ross, 1969). Of different formulations that have developed, Elizabeth Kubler-Ross has had the most impact; it is accordingly to her work that we turn.

Death and Dying: Suggestions from Kubler-Ross's Five Stage Theory

Kubler-Ross suggested that people pass through five predictable stages as they adjust to the prospect of death: Denial, Anger, Barganing, Depression and acceptance.

3.2.1 Denial

The first stage, denial, is thought to be a person's initial reaction on learning of the diagnosis of terminal illness. The immediate response may be that some mistake has been made, that the test result or X-ray has been mixed up with those of someone else, and that the diagnosis will shortly be reversed. For most people, this shock and the denial that anything is wrong lasts only a few days. Thus, denial early on in

adjustment to life-threatening illness is both normal and useful (Lazarus, 1983).

Sometimes, denial lasts longer than a few days. Extreme denial ('that is not happening to me, it is happening to someone else') may be manifested by terrified patients who are unable to confront the fact of their illness or the likelihood that of their eventful death. But it is not helpful to a patient to be able to deny death, because it could mask reality. It may also mask anxiety without making it go away. The patient who is denying the implications of illness often appears rigidly over-controlled.

3.2.2 Anger

Denial usually abates because illness itself creates circumstances that must be met. Decisions must be made regarding future treatments, if any, where the patient will be cared for, and by whom. At this point, according to Kubler-Ross, the second stage, anger may set in. The angry patient is asking the question 'Why me?'. Considering all the other people who could have gotten the illness, all the people who had the same symptoms but got a favourable diagnosis, and all the people who are older, dumber, more bad tempered, less productive, or just plain evil, why should the patient be the one who is dying?

Thus, the angry patient may show resentment toward anyone who is healthy. Angry patients who cannot express their anger directly by shouting or being irritable may do so indirectly by becoming embittered. Bitter patients show resentment through death jokes, cracks about their deteriorating appearance and capacities or pointed remarks about all the exciting things that they will not be able to do because events will happen after their death.

Anger is one of the harder responses for family and friends to manage. They may feel they are being blamed by the patient for being well. Thus, the family may need to understand that the patient is not really angry with them but at fate; they need to see that this anger will be directed at anyone who is nearby, especially towards people whom the patient feels no obligation to be polite and well-behaved. Unhappily, family members often fall into this category (Kubler-Ross, 1969; Taylor, 2006).

3.2.3 Bargaining

Bargaining is the third stage of Kubler-Ross Formulation. At this point, the patient abandons anger in favour of a different strategy: trading good behaviour for good health. Bargaining frequently takes the form of a pact with god in which the patient agrees to engage in good works or at

least to abandon selfish ways in exchange for health or more time. A sudden rush of charitable activity or uncharacteristically pleasant behaviour may be a sign that the patient is trying to strike such bargain (Kubler-Ross, 1969; Taylor, 2006)

3.2.4 Depression

Depression, the fourth stage in Kubler-Ross model, may be viewed as coming to terms with lack of control. The patient acknowledges that little can be done to stay the course of illness. This realization may be coincident with a worsening of symptoms, tangible evidence that the illness is not going to be cured. At this stage, patients may feel nauseated, breathless, and tired. They may find it hard to eat, to control elimination, to focus attention and to escape pain and discomfort.

Kubler-Ross (1969), refers to the stage of depression as a time for 'anticipatory grief', when patients mourn the prospects of their own deaths. This grieving process seem to occur in two stages, as the patient first comes to term with the loss of past valued activities and friends and later begins to anticipate the future loss of activities and relationships. The stage of depression, though far from pleasant, can be functional in that patients begin to prepare for what will come in future.

3.2.5 Acceptance

The fifth stage in Kubler-Ross theory is acceptance. At this point, the patient may be too weak to be angry and too accustomed to the idea of dying to be depressed. Instead, a tired, peaceful, though not necessarily pleasant calm may descend. Some patients use this time to make preparations, write will, deciding how to divide their personal possessions and saying goodbye to friends, associates and family members.

4.0 CONCLUSION

This unit focused on a not too pleasant topic: illness, death and dying. A broad overview of continued treatment and advancing illness highlighted some of the complications of treating the terminally ill patients and also the issue of suicide or assisted death. Using Kubler-Ross five stage theory of death and dying, we traced stages of adjustment to dying from initial stage which is 'anger' to the last which is 'acceptance'. For example, we observed that the 'anger stage' was characterized by denial while at the acceptance stage the patient is even too weak to be angry, having gone through all the other stages of adjustment to dying. Suffice to note that the stages identified here appeared similar to those identified at the previous unit, stages of coping

in illness – crisis, isolation, anger, reconstruction, intermittent depression and renewal stages. This thus indicates that emotional reactions that characterize coping and dying are somewhat similar, except that in coping emotional response terminates at the renewal stage while it is acceptance stage, for death and dying.

5.0 SUMMARY

If you have read up to this point, then I say a big 'thumbs up' to you. Congratulations! You have done justice to this course. I hope you found this unit and others helpful. Unfortunately, this course appears to be ending on a somehow scary note. Not to worry, the issue of death and dying should logically be at the last unit of this course and I hope you would agree to that. Ok, don't relax yet, let us attempt the following questions.

6.0 TUTOR MARKED ASSIGNMENT

What are the stages in adjustment to death and dying? Discus using Kubler-Ross Five stage theory.

7.0 REFERENCES/FURTHER READINGS

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