ILLNESS BEHAVIOUR OF SOME WHITE SOUTH AFRICANS

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OPSOMMING

Hierdie artikel handel oor 'n studie van die siekte-gedrag van Blanke persone in die Durban area. Dit blyk dat siekte, waar dit verwys na die ervaring van simptome, meer voorkom as wat algemeen geglo word. Persone konsulteer 'n gesondheidswerker slegs vir 'n klein persentasie van hul simptome en verskil ook in hul interpretasie van, en derhalwe reaksie op, simptome. Siektegedrag word verder beïnvloed deur persepsies van die vermoeë van gesondheidswerkers en hul interpersoonlike verhoudings. Om doeltreffende gesondheidsdienste te kan lewer moet gesondheidswerkers kennis dra van die faktore wat siektegedrag beïnvloed.

THE author's interest was recently aroused by coming into contact with some of the literature dealing with "illness behaviour".[1,2] The study of illness behaviour basically involves an attempt to understand: what makes different people decide that they are ill; what action they take; how long they delay; what influences their decisions; and so on. In other words, there is a basic assumption that people *perceive* illness differently and that they *react* to it differently. The author believes it is essential for all health workers to be aware of the complexities of illness behaviour and therefore presents some of the data gathered recently in a study of illness behaviour among White adults in Durban.

SUBJECT AND METHODS.

The population under study consisted of 47 White Durbanites:

20 out-patients from the provincial hospital;
18 randomly selected residents from one of Durban's elite suburbs;
9 people currently consulting a chiropractor.

The central technique used was the interview. Interview schedules were divided into seven major sections, only three of which had relevance to the topic under discussion. The first of these dealt with very general health questions (eg "If I asked you to sum up the state of your health in one word, what would you say?") Respondents were later asked to think back over the two weeks prior to the interview and to indicate which of 28 groups of medicines, nostrums and devices on a check-list they had used (eg "Eye drops, ointment or lotion" or "Cold or congestion medicines"). A second check-list was then referred to, this time to establish which of 27 symptoms the respondent had experienced during the same two-week period. (eg "Aches in joints, rheumatism or arthritis" or "Nerves, depression or irritability").

Other techniques used in the study included participant observation and a postal survey, but these methods were concerned with aspects of illness behaviour not under discussion in this article.

RESULTS AND DISCUSSION

Is illness the statistical norm?

Illness is generally assumed to be a fairly objective and relatively infrequent phenomenon. When we consider the number of days spent in bed or the number of visits to the doctor each year, illness does indeed appear to be an abnormal occurrence.[3] There is, however, a growing body of literature that casts doubt on this conception of illness. Dunnell and Cartwright, for example, did a study in Britain and found that each respondent had experienced an average of 3,9 symptoms in the fortnight prior to the interview.[4] In Durban a staggering mean figure of 6,2 symptoms per person over the two week period was found. The break-down for the three sub-samples was (see also graph 1):

hospital group (mean age 65 years): 7,7 symptoms;
suburban group (mean age 42 years): 4,8 symptoms;
chiropractic group (mean age 36 years): 5,6 symptoms.

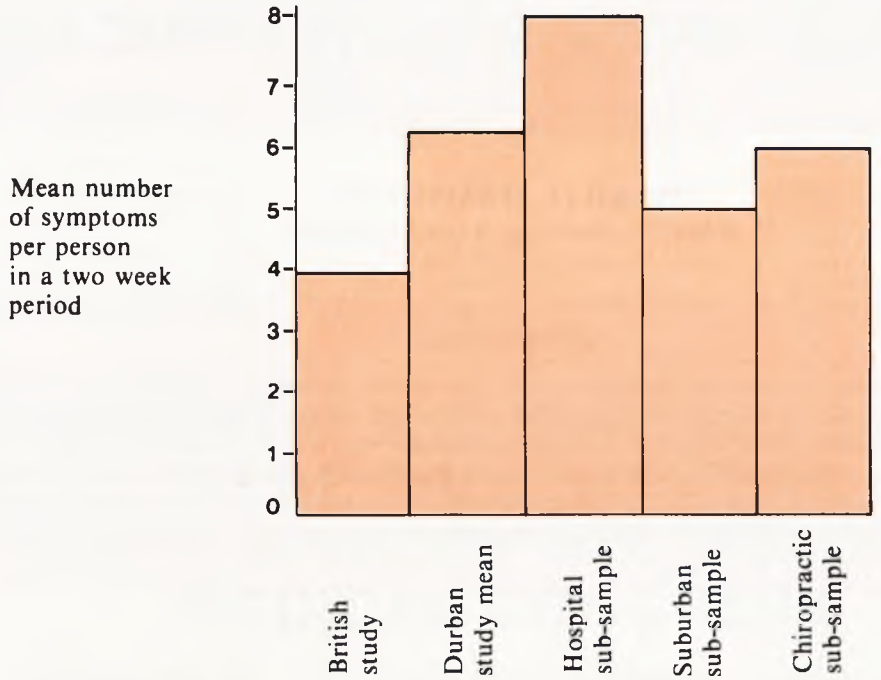
We see thus that even the young, well-off suburbanites had a mean number of symptoms that was considerably greater than the British mean. Only two of the 47 people interviewed in this study reported having had no symptoms at all over two weeks. Illness in one form or another does appear to be the statistical *norm* in South Africa.

Let us now examine the assumption that, in general, illness is fairly objective.

Illness versus disease

Several authors have made a distinction between illness (the human experience of sickness)[5,6,7] and disease (the physical processes involved in sickness). It has been suggested that medical training all but ignores the treatment of *illness;* that medical students are graduating

Graph 1 Symptoms experienced by respondents in a two-week period in a British study and in the Durban study.



as vets who treat humans rather than as doctors . . .[8]. When the distinction between illness and disease is grasped we can see that people may experience any combinations of illness and disease. Consider four people in the community (see also Diagram 1):

"A" is not ill and has no disease,
"B" is ill (he perceives himself to be sick) and has a disease (eg. pneumonia)
"C" is ill but has no disease (eg. psychosomatic headaches)
"D" is not ill but has a disease (eg. carcinoma in an early stage).

The important aspect for health workers to note is that only two of these people are likely to seek help of any kind, to display illness behaviour in a public manner. "A" does not need help and will not seek it; "B" is ill, is experiencing his disease, and will find help somewhere — not necessarily from a doctor as we shall see; "C" is also ill and despite the fact that there is nothing physically wrong, he will look for help; "D", perhaps the sickest of all, will continue his life as usual for many months, making no effort to seek help for his disease. From this example it becomes evident that their personal, *subjective* experience of symptoms — not the objective presence of disease — is what drives people to seek health care.

To take the argument one step further, let us consider two people, "X" and "Y", who have exactly the same objective problems; they both have very swollen ankles. "X", an upper-class and well-educated lady, perceives her problem to be an abnormality — a sign that she must consult her doctor immediately. "Y", a lower-class lady, accepts the swelling as a normal part of ageing and overwork and regardless of the fact, carries on working. Their differential perceptions of the same problem thus cause very different patterns of illness behaviour.

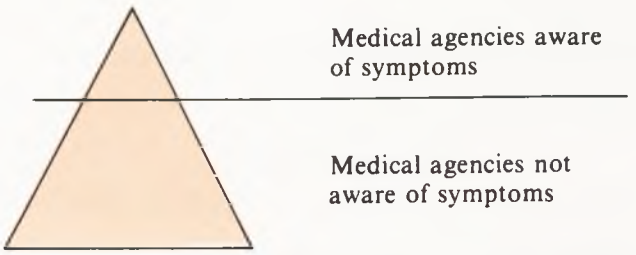
Such perceptual processes would partially account for the fact that, for example, of the fourteen hospital respondents who reported having had "backache or pain in the spine" in the two weeks prior to the interview, only seven were taking prescribed treatment; four were doing nothing; two were trying exercises; and one was consulting a chiropractor. In sum, different people perceive symptoms differently and therefore react to them differently. As far as illness behaviour is concerned, illness must be thought of as more than merely an objective phenomenon.

Diagram 1. Possible combinations of "Illness" and "Disease"

ILLNESS (the human experience of sickness)

DISEASE (the physical process of sickness)	PERCEIVED	NOT PERCEIVED
PRESENT	B (pneumonia)	D (early stage carcinoma)
ABSENT	C (psychomatic headaches)	A (healthy)

Diagram 2. The Iceberg Theory of Disease



± 5% have no symptoms in a two week period

The iceberg theory of disease

The figures quoted above for responses to backache introduce another important point: only a small percentage of the total "pool" of diseases is ever treated by a medical agency — in other words, only the tip of the iceberg is ever glimpsed by health workers. Dunnell and Cartwright's study confirmed this theory: 91% of adults reported symptoms in the two week period but only 16% had consulted a doctor during that time.[4] In the Durban study 45 (96%) of the total 47 respondents indicated that they had symptoms in the two weeks and only 36% had seen a doctor or surgeon. This last figure is somewhat greater than the British one because twenty of these respondents were out-patients at the time. If we look at the figures for the suburban and chiropractic subsamples only, we find that 93% had symptoms and only 19% had seen a doctor or surgeon. So the "iceberg theory" is very applicable to South African practice. (See Diagram 2.)

The fact that many illnesses are not treated by medical agencies has far-reaching consequences of which all health workers should be aware. Consider the implications for our national health statistics which are gathered largely from medical institutions. Are we getting even a glimpse at the realities of morbidity and mortality in South Africa? The provision of health services might also be entirely inadequate if decisions are made in the absence of detailed studies of the *actual* incidence of disease in the population. The same applies to health education: is the present focus largely on irrelevant problems?

People's perceptions of their health

From overseas literature it is known that people tend to judge themselves far healthier than a doctor would.[9] This tendency was noted in the Durban study. Several people with many symptoms which were potentially very serious reported being in "excellent health" or "100% fit". Health is so highly valued that it seems as though some people are reluctant to admit its absence. This tendency to overrate health status and de-emphasise the importance of various symptoms could largely account for the "iceberg theory" discussed above. People think of themselves as being healthier than their objective condition warrants — they merely gloss over the symptoms they experience from day to day.

In general, the criterion used to judge health status seemed to be the *number* of different symptoms experienced in a period rather than their seriousness in medical terms. (This is illustrated in Table I).

21% had few symptoms (three or less), of whom 80% reported good health;
51% had an average number of symptoms (4 to 8), of whom 67% reported good health;
28% had many symptoms (9 or more), of whom 23% reported good health.

The conclusion can thus be made that people generally over-rate their health and judge it according to inappropriate criteria. Health educators should make it one of their major tasks to impress on the public that certain signs and symptoms simply cannot be ignored even if the person *feels* well and has no other complaints. It may be that once the *medical* significance of symptoms becomes common knowledge people will present themselves for treatment much earlier.

The prevalent symptoms

The symptoms that were reported in the Durban study most often were "headache" and "nerves, depression or irritability". Each of these symptoms were mentioned 28 out of 47 times. "Backache or pain in the spine" was the next most prevalent, being reported 27 times (57%). "Arthritis, rheumatism or pain in the joints" was reported in 19 cases (40%), followed by "sleeplessness" (38%) and "undue tiredness" (29%).

The remarkable point here is the prevalence of mental symptoms — notably "nerves, depression or irritability". Many of the headaches were probably stress-related or psychosomatic and when the problems of sleeplessness and undue tiredness (often considered to be signs of stress, emotional strain or mental disturbance) are also taken into account, mental symptoms are by far the major health problem among urban Whites in this country. Are the training of doctors and nurses and the organization of health services geared to meet these needs?

TABLE I.

Number of symptoms experienced in two weeks and people's perceptions of their health

Number of symptoms experienced in two weeks	Perception of health			
	Good	Mediocre	Poor	Total
Few (0—3)	8	2	0	10
Average (4—8)	16	6	2	24
Many (9 or more)	3	4	6	13
Total	27	12	8	47

TABLE II

RESPONSES TO SYMPTOMS IN TWO WEEKS BY SUB-SAMPLE

(means of sub-sample in parentheses)

RESPONSE TO SYMPTOM	SUB-SAMPLE						TOTAL
	Hospital		Suburban		Chiropractic		
Number treated by prescription	58	(2,9)	18	(1,0)	7	(0,8)	83
Number treated by self	32	(1,6)	19	(1,1)	13	(1,4)	64
Number treated by alternative	0	(0,0)	2	(0,1)	8	(0,9)	10
Number not treated at all	64	(3,2)	47	(2,6)	22	(2,4)	133
TOTAL	154	(7,7)	86	(4,8)	50	(5,6)	290

Responses to symptoms

It has been shown that people will, depending on their subjective interpretation, react differently to symptoms. In the study the actual responses varied greatly and the options open to urban Whites appear to be:

- to do nothing at all about the symptom;
- to mix some home-remedy, take a pill bought over the counter, or otherwise treat oneself;
- to visit a doctor, clinic, hospital or other orthodox institution;
- to consult an alternative healer (such as chiropractor, herbalist or homeopath).

A person may decide on any one, or a combination of two or more, of these courses of action. (For example, many instances of people taking prescribed medicines and visiting alternative healers for the same problem were found. They seemed reluctant to "put all their eggs in one basket".)

Table II shows the actual responses to individual symptoms in two weeks in the different subsamples.

From the above it is evident that the most common reaction to symptoms in very passive, 46% were not treated at all; people simply wait for the body to recover. Hospital outpatients treat a great number of their symptoms with prescribed treatments, thus the image of the overworked doctor scribbling out prescriptions is probably quite accurate. Only about one in five symptoms is self-treated — a heartening statistic, considering the very toxic nature of many of the over-the-counter preparations. Finally, the table shows that only a small number of people used alternative practitioners in the two week period.

The responses to the mental symptoms were often alarming. People used such remedies as hot cocoa or headache tablets for depression (14%); three people (11%) said they would try to "snap out of it", "buck up" or "pray about it"; eight respondents (28%) were taking prescribed drugs (eg. tranquillizers or anti-depressants); and thirteen (46%) were doing nothing at all. Only one woman admitted seeing a psychiatrist for her "nerves"; all the others on prescribed medicines were careful to state that their "doctor" had given them the medication. The stigma associated with psychiatry, even among well-educated people, was very evident. When asked if they had ever visited a psychiatrist only 19% reported such contact and most of these added a hasty qualification such as: "He said he didn't know why the doctor had sent me"; "He said I was just a bit overtired".

Perceptions of healers

The subjective processes involved in illness behaviour have been stressed and hopefully readers are convinced that illness is a complicated phenomenon with many factors influencing reactions to it. It has been shown that two people with exactly the same objective problems may perceive them very differently and that people perceive different problems as serious or deserving of medical treatment. (The role of culture, class, education, previous exposure to medicine influence these perceptions.) One last factor influencing illness behaviour which must be considered is patients' perceptions and evaluations of the various healers.

It has been suggested that people carefully weigh up the pros and cons of various plans of treatment open to them.[1] They may give themselves a time limit and vow to consult a doctor after a week if the pills from the supermarket don't help or they may decide to spend a day in bed and then only visit a chiropractor if the fibrositis doesn't improve. The author is convinced that this type of rational planning does in fact occur before people proceed to action.

If this is the case, perceptions of various therapies and practitioners must play an essential role in illness behaviour. A man who considers orthopaedic surgeons to be largely unsuccessful in the treatment of backache will surely consider *other* healers instead — such as chiropractors, herbalists and acupuncturists. Should he subsequently develop pneumonia, however, he may not hesitate to see a doctor believing that antibiotics are called for.

What is being proposed therefore — with Fabrega[1] — is a rational decision-making process in illness behaviour. It appears to be highly significant that people are taking *certain* symptoms to *certain* healers for treatment. Chiropractors were treating a large amount of backache and fibrositis. Homeopaths were getting a great number of the hormonal complaints and acupuncturists seemed to be treating many joint problems. This appears to indicate that particular

healers have developed reputations for highly effective treatment of certain problems and that people decide who to consult depending on their specific health needs at the time. Such decisions are evidently being made with less and less concern about the professional status of the practitioner — people want results and are willing to go almost anywhere to get them.

The above refers to peoples' perceptions of the healer's ability to cure physical ailments. A last crucial perception is the patient's view of the practitioner as a humane, caring, interested healer. If you were deciding whether to visit "P" practitioner or "Q" and the only difference between them was that "P" was always abrupt, rushed and unkind, while "Q" was reassuring, explained things to you, and greeted you in a kind manner, is there any question about who you would consult?

It is a sad reflection on medical workers that respondents often reported dissatisfaction with doctors in terms of their *social* behaviour. Alternative healers received flying colours in this regard. The alternatives were often as busy as doctors, so could not spend more time with their patients. They simply managed to use the limited time available in the best way. The figures for the quality of relationships with *doctors* over the whole sample were:

45% good
28% mediocre
28% poor.

The equivalent figures for the quality of relationships with *alternative healers* were:

77% good
19% mediocre
4% poor.

If health workers want patients to report regularly to clinics, to take their medicines compliantly and to encourage their family and friends to seek medical advice when necessary, they will simply have to improve the quality of interpersonal relationships between themselves and their patients. Nurses probably contribute greatly to improving patients' impressions in this regard, but they cannot bear the responsibility alone. Doctors must be made aware of the fact that their behaviour as *social beings* is causing widespread dissatisfaction.

CONCLUSION

Several factors which influence illness behaviour among White South Africans have been examined. The author believes that only when we know about the *actual* health problems in the population, about the public's perceptions, expectations, dissatisfactions and about their day-to-day health practices, can we work to provide really suitable and effective health services at all levels.

References

1. Fabrega, M. Towards a Model of Illness Behaviour. *Medical Care*. Vol. XI No. 6. 1973. p471-6.
2. Mechanic, D. *Medical Sociology*. The Free Press. New York. 1968.
3. Zola, I.K. Culture and Symptoms: an analysis of patients' presenting complaints. *American Sociological Review*. Vol. 31 No. 5, Oct. 1966. p615.
4. Dunnell, K.; Cartwright, A. *Medicine Takers, Prescribers and Hoarders*. Routledge and Kegan Paul. London. 1972. p13.
5. Field, D. The Social Definitions of Illness in Tuckett, D. (ed) *Introduction to Medical Sociology*. Tavistock Publications. London. 1976. p334.
6. Tuckett, D. op. cit. p159-60.
7. Friedson, E. *The Profession of Medicine*. Dodd, Mead and Co., New York. 1970. p223.
8. Kleinmann A.; et Al Culture, Illness and Care in *Annals of Internal Medicine*. Vol. 88. 1978. p252.
9. Tuckett, D. op. cit. p164.

BOOK REVIEW BOEKRESENSIE

CANCER NURSING — SURGICAL

Robert Tiffany (Ed)
Faber en Faber. London. 1980.
Prys ongeveer R12,00

Die boek bestaan uit bydraes van verskillende skrywers en dek die verpleegsorg van die pasiënt wat chirurgie ondergaan vir kanker.

Algemene voor- en na-operatiewe versorging word bespreek in twaalf hoofstukke en sluit die tipes kanker in wat die grootste bedreiging inhou vir die gesondheid.

Die ondersteunende rol van die verpleegkundige word beklemtoon binne die konteks van die multidissiplinêre spanbenadering.

Epidemiologiese en etiologiese aspekte word telkens op interessante wyse bygebring terwyl die verpleegsorg goed uiteengesit is en maklik toegepas kan word in die saalsituasie.

Die boek bevat ook 'n aantal goeie sketse en fotos en die byskrifte is verstaanbaar en duidelik.

Die uitgawe is 'n aanwins vir kankerverpleging en behoort in kankersale en biblioteke beskikbaar te wees.

M.J. Vallun

INTERPRETING CARDIAC ARRHYTHMIAS

deur Mary Branbilla McFarland
Macmillan. London. 1980.
Prys ongeveer R5,00

Hierdie boek voorsien in die behoeftes van die naregistrasie student in intensiewe verpleegkunde. Elke student wat die Diploma in Intensiewe Verpleegkunde volg behoort dit haar eiendom te maak.

Die boek begin met 'n goeie beskrywing van die anatomie en fisiologie van die hart.

Daar is 'n volledige en eenvoudige beskrywing van elektrokardiografie en verskillende ritme stoornisse.

Die beskrywing van tydelike en permanente pasaangeërs en die metode van inplasing is goed.

Die inligting wat die verpleegkundige aan haar pasiënt met 'n permanente pasaangeër moet oordra met ontslag word ingesluit.

'n Selftoets volg met antwoorde agter in die boek. Sketse en illustrasies is goed en daar is ook 'n verwysingslys.

V. Loubser