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Illness and Help-Seeking Behavior

In the past, the term *patient* designated a person who was suffering or enduring pain, related to the word *patience (Webster's Third New International Dictionary)*. Modern usage of the term *patient* denotes a person who is seeking or is being given medical care. Although an illness usually leads a person to seek medical help, not all who are ill become patients nor are all patients necessarily ill.

1. A man, age 39, has been experiencing occasional sharp pain in his chest for the last two months. Being a pressured junior executive, he has put off seeing a doctor, attributing the pain to indigestion associated with pressure at work. In fact, Alka-Seltzer seemed to help it somewhat. Last night, during an argument with his wife, he had another bout of chest pain that took several hours to subside even after he took Alka-Seltzer. He called his doctor this morning for an urgent appointment.

2. Three months ago, a 30-year-old woman developed severe headaches and fainting spells following a "head cold." She told her close friends, who then arranged a prayer meeting to chase away the "evil spirits" that they felt were causing her problems. Today, after the prayer meeting she felt much better.

3. A 45-year-old woman decided to do something about her varicose veins, which she had had for 20 years. She told her doctor today that she wanted to have the operation as soon as possible, even tomorrow.

4. A coal-mine worker came to see the company physician, complaining of chest pain and difficulty in breathing. Careful medical workup was negative for any physical disease. The physician felt that psychological factors might

be involved in his coming for medical evaluation when he learned that a co-worker of the patient had recently been found to have "black lung" disease and had been given a sizable compensation.

All four patient vignettes presented above involve help-seeking behavior, but the patients were quite dissimilar in how they perceived their symptoms and when and how they went about getting help.

How is help-seeking behavior to be conceptualized, and how are the wide variations in the form it may take to be understood? Medical sociologists have studied these questions and developed concepts, definitions, and data that are useful to the physician in his efforts to understand the circumstances that bring the patient for help and in facilitating development of a productive relationship with the patient from the very start.

CONCEPTS AND DEFINITIONS: HELP-SEEKING BEHAVIOR AND ILLNESS BEHAVIOR

Help-seeking behavior arises from the decision of an individual to do something about a symptom or distress. In *medical* help-seeking behavior, a patient contacts a doctor. This initiates a process whereby a small health-care system forms around the patient. Calling the doctor to make an appointment, visiting the doctor in his office, or going to the emergency room of a hospital are examples (vignettes 1, 3, and 4 above). *Nonmedical* help-seeking behaviors include going to a clergyman or to a variety of nonprofessional people such as "rootworkers" and faith healers, or asking a relative or friend for advice (vignette 2). Of course, nonmedical help-seeking behaviors often lead to medical contacts through advice and referral, and many patients engage in medical and nonmedical help-seeking behaviors simultaneously, for example, mobilizing family support and visiting a doctor. Quasi-medical help-seeking behaviors, such as self-medication or discussing symptoms with a druggist, while nonmedical by definition since they do not involve the immediate formation of doctor–patient contact, may also lead to it eventually. (In vignette 1, buying Alka-Seltzer, a quasi-medical help-seeking behavior, was an intermediate step toward medical help-seeking behavior.)

Help-seeking behavior is closely related to its antecedent, *illness behavior*. Illness behavior, described by Mechanic (1962), consists of the ways in which given symptoms may be perceived, evaluated, and acted (or not acted) on. Illness behavior does not always lead to help-seeking

Table 1. Factors That Affect Help-Seeking Behavior

Symptoms and signs
Commonality, familiarity, predictability, threat
Demography
Socioeconomic class, religion, ethnicity
Stress
Previous experience
Personal, others

behavior. Help-seeking behavior stimulated by a symptom can be expected to be influenced by the severity and quality of the symptom. It would seem that the more acute, severe, distressful, frightening, and persistent symptoms are, the more likely they are to lead to a quest for medical help, but these commonsense expectations are overly simple. Help-seeking behaviors as actually observed in clinical practice are often far more complex and hard to understand. Even in the presence of severe persistent and frightening symptoms like fainting spells, an individual often does not seek medical help (vignette 2). A patient's response to symptoms is modified considerably by a variety of factors that influence the ultimate decision whether or not to seek help, and, if help is sought, when and what kind (Table 1).

FACTORS THAT INFLUENCE HELP-SEEKING BEHAVIOR

Factors That Influence How Symptoms and Illness May Be Perceived

Four dimensions of an illness (or a symptom) are important in influencing how the illness is perceived: (1) the frequency with which it occurs in a given population *(commonality)*, (2) the familiarity of the symptoms to the average member of the community *(familiarity)*, (3) the predictability of the outcome of the illness, and (4) the amount of threat and loss likely to result from the illness (Mechanic, 1962). For example, since the common cold is familiar, easily recognized, and self-limited and carries minimal risk of major loss, a person with a cold is unlikely to seek medical help. Coughing up blood, in contrast, greatly increases the probability of contact with a physician, since this symptom is uncommon, unfamiliar, unpredictable, and threatening.

Naturally, the patient's personality is also important in determining help-seeking behavior. Personality factors are taken up in Chapter 18.

Demographic Factors

Socioeconomic Class. Whether or not symptoms lead to help-seeking behavior may be influenced by the patient's socioeconomic class. For example, upper-class persons tend to report themselves ill more often than lower-class persons (Koos, 1954). This class difference can be related in large part to realistic economic considerations—the upper classes being more easily able to afford medical bills and lose a day's work to see a doctor—as well as to the higher educational level and greater awareness of methods of getting help. The very poor on public assistance can take the time to engage in help-seeking behavior more readily than the working poor, since they do not have to lose hourly pay to make use of the medical facility in the community, but there is some evidence that these social-class differences in medical-care utilization are diminishing (Ross, 1962).

Orientations toward illness differ according to social class (Mechanic, 1968). In general, lower-class populations are more fatalistic about contracting disease and thus less likely to be oriented toward preventive medicine (Deasy, 1956; Rosenstock, 1969) and toward consultation with medical professionals when ill (Brightman *et al.*, 1958; Koos, 1954; Redlich *et al.*, 1955).

There is some evidence to suggest that similar disease processes may present differently in patients in different socioeconomic classes. Upper-class persons with coronary disease often present themselves to the medical facility with angina pectoris, while lower-class persons are more likely to present themselves with acute myocardial infarction or sudden death (Shekelle and Ostfeld, 1969). It is not clear why this is so, although upper-class persons might be readier to come to a medical facility with a milder distress.

Diagnoses of neuroses and personality disorders have been made with higher frequency in upper-class persons, while diagnoses of psychoses, "psychosomatic" reactions, or hysterical reactions have been more commonly made in lower-class populations (Hollingshead and Redlich, 1958). This difference may indicate both an actual prevalence difference and a tendency on the part of doctors to diagnose more benign conditions in the upper-class persons because of their own biases. Greater prevalence of schizophrenia (psychosis) in lower-class populations may be explained in one of two ways: either (1) lower-class environment and genetic pool contribute to the development of the disorder

("origin hypothesis") or (2) schizophrenic individuals wind up in lower classes because of the disability caused by the illness ("drift hypothesis").

Age. Illness behavior may be modified in the elderly patients (Levkoff *et al.*, 1988). Elderly patients tend to attribute various symptoms as a normal part of aging and not seek help promptly. As many elderly patients have chronic illnesses, the presence of the condition may be less significant than the physical disability, pain, or discomfort in leading to help-seeking behavior. Psychological distress is strongly associated with the elderly patient's poor appraisal of health and subsequent help-seeking behavior. The loss of social roles and isolation, common among the aged, often set the stage for increased preoccupation with the one object that remains available—the person's own body (Verwoerdt, 1981).

Religion and Ethnic Origin. Religion and ethnic origin influence illness behavior through different cultural attitudes and expectations. Some cultural groups (e.g., English-speaking people in the Southwest) are more likely than others (Spanish-speaking people in the same area) to seek medical care and support. The Hispanics rely on folk medicine when ill (Saunders, 1954), while English-speaking people in the same area tend to seek modern medical treatment. In a questionnaire study in a large university, Jews and Episcopalians reported that they would have a higher inclination to use medical facilities for various hypothetical symptoms than did Christian Scientists and Catholics (Mechanic, 1962). Religious influence on illness behavior is independent of social class.

Zborowski (1952, 1969) studied attitudes and responses to pain of patients belonging to different ethnic groups. His subjects consisted of "Old American," Irish, Jewish, and Italian male patients. The Old American and Irish patients tended to minimize pain, to delay seeking consultation with a physician, and to respond to pain stoically, while the Jewish and Italian patients tended to exaggerate pain and react to it more emotionally. The Jewish and Old American patients were more concerned about pain as a "warning signal," that is, its implications as a symptom; the Irish were more concerned about its crippling indications; and the Italians were more concerned about the immediate consequences of the painful experience and its instant relief. Ethnic differences were also related to help-seeking behavior and attitude toward doctors. The Old Americans tended to consult druggists, osteopaths, chiropractors, and other nonphysicians before finally consulting the doctor, but had implicit trust in the professional competence of the doctor on the basis of his being an M.D., once he was consulted. The Jewish patients, on the other hand, tended to consult the doctor quite readily and also to

check into the doctor's qualifications and to "doctor shop." The attitude and warmth of the doctor rather than his professional skills were seen to be of overriding importance to the Italian patients.

Although these findings represent a cross-sectional picture of illness behavior in the recent past and their validity at present is uncertain, they nevertheless demonstrate the importance of socioethnic milieu with respect to the development of psychological sets concerning symptoms, illness, and the medical profession.

Role of Stress

Psychosocial stress plays a major role in transforming illness behavior into help-seeking behavior (Mechanic, 1962).

The type of stress is particularly important. By and large, *interpersonal stresses* such as difficulties with loved ones are more likely to lead to medical help-seeking behavior than are noninterpersonal stresses such as financial hardship. This may be because communication, interaction, and nurturance usually expected from a doctor are especially (and unconsciously) sought after by persons in interpersonal difficulty. People are often able to initiate a personal interaction with the physician more easily than with someone with whom the contact is less structured and the role less defined. Interaction with the physician can usually be initiated with little difficulty and does not usually require complex and subtle cues and responses necessary in social relationships. In other words, social skills on the part of the patient are not as necessary in interaction with physicians as in other social situations.

Interpersonal difficulties are also frequent precipitating events of anxiety, depression, and grief, and these are probably accompanied by physiological states that may precipitate an illness or exacerbate a symptom (see Chapters 4, 6, and 14).

Finally, it should be remembered that somatic symptoms themselves are emotional stressors, and the stress they generate may finally push the illness behavior toward help-seeking behavior.

Role of Previous Experience ("Priming Factors")

Previous personal experiences as a patient with illness and health care may strongly influence subsequent help-seeking behavior. Positive memories of a hospital experience, such as uneventful recovery from an appendectomy, make it easier to initiate contact with a doctor the next time. On the other hand, exposure to negative experiences, such as complications arising from medical treatment, prolonged recovery, and exposure to impersonal and brusque behavior on the part of health-care personnel may discourage or delay future contacts with the setting. Even when a patient with negative past experiences does contact the physician, he is likely to do so with negative expectations, and this may result in a self-fulfilling prophecy.

Exposure to the *experiences of relatives or friends* with medical systems in the community may also have its effects, shaping the expectations that the person might bring to the system when he becomes ill. Similarly, such exposure may influence attitudes toward a particular illness or set of symptoms.

> A woman was convinced that she had cancer of the breast when she developed pains in her joints. This conviction persisted in the face of her doctor's repeated reassurances that she had arthritis. As it turns out, a friend had suffered bone pain from spread of breast cancer to the bone. The conviction was strong enough to make her delay return visits to the doctor for fear that she would have to undergo mutilating breast surgery as had her friend.

In these ways, direct or indirect personal exposure to illness and health-care systems affects help-seeking attitudes and behavior. Additionally, it may "prime" a patient for psychological complications such as depression based on unfounded or fantasized expectations. Similarly, educational programs, reading medical books or magazine articles, watching television programs about medical matters, and the like may also set the stage for unfounded fears, although it is our impression that their impact is somewhat weaker than the personal exposures discussed above.

Community attitudes toward health care provide an explicit and implicit background against which an individual contemplates the possibility of seeking care. We have observed that when a hospital that originally had been used for chronic and terminally ill patients was converted to a modern, acute-care, general hospital, many patients admitted to that hospital as long as ten years later expressed uneasiness because of the lingering reputation of the hospital as "a place to die." Community and peer-group myths and superstitions also influence the type of help that is sought, for example, physician or hospital emergency room.

TAXONOMY OF MEDICAL HELP-SEEKING BEHAVIOR

McWhinney (1972) proposed a taxonomy of medical help-seeking behavior that he calls *patient behavior,* using the doctor–patient contact

as the reference point. This classificatory scheme is useful in assessing clinical situations. It consists of five mutually exclusive categories as immediate precipitating causes of the doctor–patient contact.

Limit of Tolerance. The patient initiates contact with the doctor because the discomfort, pain, or disability has become intolerable. A subcategory is limit of tolerance for unhappiness.

Limit of Anxiety. The patient initiates contact with the doctor because of anxiety concerning the implications of the symptom. The symptom itself may be quite tolerable, but the implications are not. An example is bloody urine.

Problems of Living Presenting as a Symptom (Heterothetic Presentation).* The patient initiates contact with a physician ostensibly because of symptoms that are minor (exceed the limit of neither tolerance nor anxiety) but in the context of disturbing emotional difficulties that constitute the underlying but unrecognized motive for the help-seeking action. An example is a woman who, at the time of painful interpersonal conflict with her boss, comes to the doctor complaining of back pain that she has had occasionally for many years.

Here, the underlying reason for the doctor–patient contact is an *attempt to establish a supportive interpersonal relationship* and find *relief from the emotional distress.* Many patients who present with vague and long-standing symptoms (20 years in vignette 3 above) and many patients who experience unexplained delay in recovering from illness will often on further inquiry be found to have some major emotional problems.

Conversely, some patients who present with *emotional problems* to mental health personnel or nonmedical counselors may turn out to be suffering from *serious medical disorders,* and it is important that the *medical condition* of the patient be checked before assuming that the symptoms are indeed psychological in origin.

The next two categories are doctor–patient contacts that are not help-seeking in the usual medical sense.

Administrative. These doctor–patient contacts are for administrative reasons only, whether or not the patient is ill, for example, insurance examination.

*Heterothetic means "putting forward other things."

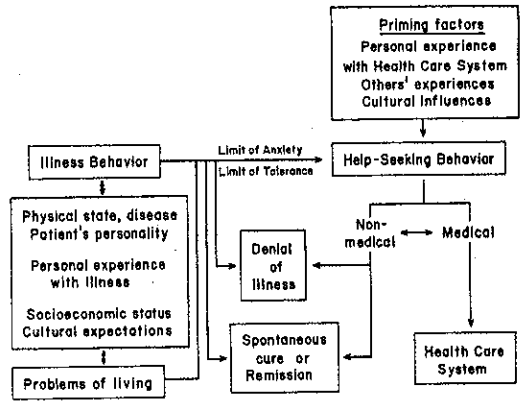

Figure 1. Help-seeking behavior.

No Illness. This includes all visits for preventive purposes, as well as routine physical examinations, for example, antenatal care.

In this scheme of classification, all patients who present with symptoms should be classified as belonging in one of the first three categories. If the visit cannot be categorized as due to either limit of anxiety or limit of tolerance, the physician should consider the possibility that he is dealing with *problems of living presenting as a symptom.* This type of presentation is often motivated by an unrecognized wish to hide the true nature of suffering. It is therefore necessary for the physician to inquire about personal problems and psychosocial aspects of the patient's life since the patient will not himself put them forward.

Patient behavior is often a result of complex interpersonal interactions between the patient and his immediate environment (Figure 1). There are instances when the patient comes to the doctor not by choice but because he is forced by others. This is especially true in the case of mental disorders. For example, a schizophrenic patient may be brought to a doctor only because others cannot tolerate his bizarre behavior. Although McWhinney's classification system of patient behavior is intended primarily for individual patients, we can use the same scheme to classify patient behavior instigated by others, for example, limit of tolerance—family, limit of anxiety—employer, or problems of living—family.

Example 1. The patient comes to the doctor because his wife is concerned about his weight loss and change in behavior (social withdrawal), although the patient himself feels that he is just tired because

of overwork. He comes only because his wife insisted. Here, the behavioral classification would be limit of anxiety—wife; the patient's clinical diagnosis may be depressive syndrome (see Chapter 6).

Example 2. The patient, a 7-year-old boy, is brought in by the parents because of frequent fights at school and minor accidents. Further inquiry reveals that these problems started a year ago when the father lost his job after an industrial accident. This, in turn, had led to financial difficulties and frequent fights between the parents. Behavioral classification: problems of living on the part of parents. Clinical diagnosis (child): transient situational reaction of childhood related to problems of living.

Reference to such a behavioral classification in parallel with medical diagnosis will help the physician identify the reasons for initiating the medical contact and alert him to the implicit as well as explicit expectations of both patient and family.

SUMMARY

What one does in the presence of symptoms (illness behavior) is determined not only by the nature of the symptom(s) but also by demographic factors, presence or absence of stress, and, most important, previous experience with or exposure to similar symptoms or the health-care system or both (priming experiences).

Help-seeking behavior occurs when a person does something to get help for his symptom or distress. This may be medical (seeing a doctor) or nonmedical (talking with a friend, attending a prayer meeting). In medical help-seeking behavior, the immediate reason for the patient–doctor contact may be the patient's (or the family's) having reached the limit of tolerance for the symptoms or for the associated anxiety. On the other hand, the patient (family) may be emotionally distressed and more in need of *interpersonal support* than elimination of a benign symptom; this would be an example of problems of living presenting as a physical symptom.

IMPLICATIONS

For the Patient

The presence of a symptom may not by itself constitute a sufficient condition for seeking medical help. The interpretation of the symptom by the patient in the light of his own unique background and personal

experience, together with the prevailing community expectations, determines the action. Many patients engage in nonmedical help-seeking behavior before consulting a physician. Contact with the physician represents, for many patients, a last resort—having reached the limit of anxiety or tolerance concerning the symptom. It may also be an indication of problems of living about which the patient is unaware.

For the Physician

Patients are different. What they do in the hospital or consulting room is determined by a number of factors that are not directly involved in the disease process and its associated symptoms. *Demographic data* concerning the patient are important in enabling the physician to understand the patient's behavior in the context of the normative attitudes and expectations of his cultural and social groups. Information concerning the patient's *previous medical experiences* and his exposure to similar symptoms and to the health-care system (doctors, hospitals) may also be essential for understanding the patient and for effective communication with him. It is often necessary to clarify misunderstandings and misconceptions carried over by the patient from priming experiences before the patient can attend to the words and recommendations of the doctor. Recognition of problems of living presenting as a symptom will enable the physician to avoid unnecessary laboratory tests and medical procedures and to provide more effective support, such as simple listening and follow-up or referral to a psychiatrist. Remember that problems of living may not be apparent unless the patient is queried about his life situation. For example, it turned out that the woman in vignette 3 was undergoing menopause and had recently separated from her husband. It was these difficulties that had motivated her seeking help in the form of a request for surgery on her varicose veins. The operation, which was unnecessary, was postponed by her doctor, and she was referred for counseling and followed at regular intervals by the physician. In six months, she had resolved the difficulties with her husband, and her (initially urgent) request for operation was dropped.

For the Community and the Health-Care System

The underutilization of health-care services by lower socioeconomic classes calls for community efforts to increase their accessibility and acceptability, especially the preventive and educational facilities. Since cultural and ethnic factors play a role in help-seeking behavior, hospitals should, if possible, have members of various cultural and ethnic groups

available to assist in communication between the health-care personnel and patients in need of their services. Nonmedical personnel (e.g., clergy, teachers) should be educated to be alert to the possible presence of medical disorders and to facilitate medical help-seeking behavior when it is indicated.

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RECOMMENDED READING

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Zborowski M: *People in Pain.* San Francisco, Jossey-Bass, 1969. An easily readable, sometimes dramatic presentation of the ethnic differences in how people behave in the presence of pain. The author studied "Old Americans," Italian, Jewish, and Irish Americans who were being treated for pain in a Veterans Administration Hospital in New York City. Somewhat stereotyped and oversimplified.