SOCIAL FACTORS IN ILLNESS BEHAVIOR

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The field of public health has long been aware of the greater resistance to modern medical science and technology among the lower socioeconomic and ethnic minority groups. The nature and underlying causes of this resistance, however, are in general not precisely formulated. The present paper attempts to study the nature of such resistance by analyzing variations in reactions to modern medical care in terms of two major social factors: (1) the structure of the social group to which the individual belongs; and (2) the health orientation or value system to which he adheres.

HYPOTHESES

The aspect of social structure to be studied involves the degree to which the individual belongs to a highly integrated, ethnocentric and socially cohesive group. It is hypothesized that the more the social structure within which the individual is embedded can be characterized as *parochial* (ethnocentric, traditional, closed, shared, affectional), as opposed to *cosmopolitan* (progressive, open, individualistic, instrumental), the more difficulty will he have in accepting and adjusting to the modern medical care system.

To study health orientation, individuals are compared according to the extent of their belief in, and acceptance of, modern scientific medicine. It is hypothesized that the more the individual's health orientation partakes of a *popular* character (subjective, informal, personal, lay), as opposed to a *scientific* point of view (objective, formal, impersonal, professional), the more difficulty will he have in accepting and adjusting to the modern medical care system.

Finally, it is hypothesized that social organization will be related to health orientation, with members of cosmopolitan groups more likely to share a scientific health orientation, and members of parochial groups more likely to adhere to a popular health orientation. Thus, both social organization and health orientation reinforce each other, with the cosmopolitan-scientific group being most congruent with the structure and practice of modern medicine, and the parochial-popular group being least congruent.

The analysis of medical behavior will be directed toward a single specific episode of illness. This episode has been divided into five separate stages, representing major transition points of medical care.[1] The specific hypotheses concerning medical care behavior during these various stages of illness are based upon the expectation that cosmopolitan groups are more likely to take "rational," impersonal, individualistic action in the face of illness; parochial groups are more likely to behave in an emotional, dependent, conservative and less "rational" manner. Thus, it is hypothesized that, at the different stages of illness, the more parochial the groups to which the individual belongs and the more nonscientific his health orientation, the more likely would he be to exhibit behavior such as the following:

1. Symptom Experience Stage
   (a) Delay the recognition of symptoms.
   (b) Underestimate seriousness of symptoms.
   (c) Turn to others for interpretation of symptoms.
   (d) Emphasize importance of pain and incapacity.
   (e) Worry about interference with normal functioning.
   (f) Accent "popular" disease etiology.

2. Assumption of Sick Role Stage
   (a) Discuss symptoms with others.
   (b) Avoid factual information.
   (c) Seek repeated approval of others to relinquish obligations.
   (d) Demand affection and support.
   (e) Try self-medication and home remedies.
   (f) Display greater ambivalence in action.

3. Medical Care Contact Stage
   (a) Delay seeking medical care.
   (b) Ask others to initiate medical contact.
   (c) Lack knowledge of available facilities.

(d) Shop around for group-approved physician.
(e) Stress symptom alleviation rather than cure.
(f) Be suspicious of physician's diagnosis.

4. Dependent-Patient Role Stage
   (a) Have difficulty in assuming sick role.
   (b) Make a poor adjustment to sick role.
   (c) Depend upon others for help.
   (d) Resist unfamiliar therapies.
   (e) Break appointments.
   (f) Neglect medications.

5. Recovery or Rehabilitation Stage
   (a) Be quick to relinquish sick role.
   (b) Resist long-term rehabilitation.
   (c) Have difficulty in assuming invalid role.
   (d) Require constant reassurance on progress.
   (e) Deny continued illness.
   (f) Neglect rehabilitative measures.

The following analysis will not test each of these specific hypotheses, but will describe the general reactions of the sample of illness cases during each stage, and compare them according to the cosmopolitan or parochial nature of their social group memberships and the scientific or popular nature of their orientation toward illness and medical care.[2]

METHOD

The cases of illness analyzed in the present report were obtained from a large-scale community survey on health status and medical care.[3] *All* individuals in this sample who had experienced a relatively serious illness in the past two months were revisited for a follow-up interview dealing with this specific illness episode. The criteria for selecting these cases were: any illness occurring during the past two months that either (1) required hospitalization for one or more days, or (2) required three or more physician visits and incapacitated the individual for five or more consecutive days. Using the above criteria, a sample of 137 cases was obtained, which may be viewed as representative of all such illness cases within the community. It might be predicted that any differences observed for these major illnesses would be even more pronounced for minor ailments, where the response to the condition would more likely be governed by social, rather than medical, factors.

TABLE I. RELATIONSHIP BETWEEN SOCIAL STRUCTURE AND HEALTH ORIENTATION

Social Structure	*Illness Cases*	*Population Sample*
	Per Cent of Each Group Holding Popular Health Orientation	
Parochial	37 (35)*	42 (612)
Mixed	25 (58)	21 (712)
Cosmopolitan	8 (30)	12 (558)

* Number of cases in each group upon which percentages are based is given in parentheses.

FINDINGS

Before describing the specific responses of the sick individual, a brief examination will be made of the general relationship of social structure to medical orientation for our present sample. As can be seen from Table 1, this relationship is verified, and parallels quite closely the relationship found for the entire population.

The following summary presents the main differences observed for each of the five stages into which the illness episode has been divided. Although it was not possible in the present exploratory study to test systematically the full range of hypothesized differences, those aspects that were investigated seem to support the validity of the hypotheses.

Stage 1. The Symptom Experience

A scientific point of view appears more likely than a nonscientific or popular one to result in the individual's taking his symptoms "very seriously" (25 per cent versus ten per cent) and viewing them with "high" concern (60 per cent versus 34 per cent), despite the greater incapacity resulting from the symptoms reported by the nonscientific group (56 per cent versus 36 per cent). An obvious interpretation of these differences is that knowledge of disease combined with a positive attitude toward medical care and a lack of dependency upon others during illness (the specific indices comprising the health orientation score) increases one's awareness of the significance of symptoms and their potential danger.

This finding, therefore, would tend to support the general prediction that individuals with a popular or nonscientific health orientation would be more likely to underestimate the seriousness of their symptoms and to "deny" the presence of illness. At the same time, their reports of greater incapacity would indicate their higher concern with symptoms

as an interference with normal functioning. It would appear that for the scientifically oriented, symptoms have more meaning in terms of possible disease whereas, for the popular oriented, such symptoms are more likely to have significance insofar as they prevent the individual from carrying on his regular activities. In this respect, the scientifically oriented are more likely to be in accord with the professional medical care system, which also places greater emphasis upon symptoms as indicators of a disease state rather than as disruptive to normal living.

Similar differences do not appear, however, in relation to cosmopolitanism-parochialism. Although the cosmopolitan groups are somewhat more likely to view the symptoms as indictive of illness (77 per cent versus 65 per cent), they are no more likely than parochials to take them seriously (14 per cent versus 18 per cent), or to feel concerned about them (48 per cent versus 52 per cent). It would appear that insofar as symptom reaction is concerned, it is the scientific or popular orientation of the individual rather than the social structure of the group to which he belongs that influences his response to illness.

Stage 2. Assumption of the Sick Role

Social structure and health orientation both appear to affect pre-medical care "lay" discussion. The individual who belongs to a close-knit parochial group is four times as likely as a cosmopolitan group member to have discussed his symptoms with several members of his group (40 per cent versus ten per cent). This finding supports the hypothesis concerning the greater significance of close interpersonal relationships among parochial groups.

It is possible that discussion of one's symptoms with others serves different functions for parochial and cosmopolitan group members. The former are probably more likely to seek sympathy and support—a form of "provisional validation" of their illness—whereas the latter are more likely to seek information and advice. Such discussion is therefore more likely to delay medical care among the parochial group members and hasten it for cosmopolitan group members.

The information-gathering function of discussion is indicated by the higher frequency of discussion reported by the scientifically health-oriented as compared to the popular health-oriented. The former group is more than twice as likely to have discussed their symptoms with several other people (36 per cent versus 15 per cent). Although the individual with a popular health orientation might be expected to be more dependent upon the interpretation of his symptoms by non-

professional friends and family, it would seem that actual discussion of one's symptoms is more likely to be reserved for fact-finding than for diagnosis and advice as to treatment.

Stage 3. Medical Care Contact

Members of cosmopolitan as compared to parochial groups and those with a scientific as compared to a popular health orientation are equally likely to think about and to contact a doctor upon experiencing symptoms, but those individuals with a popular or nonscientific health orientation are more likely to have delayed more than one week before doing so (13 per cent versus eight per cent). This finding provides additional support to the general proposition concerning the greater congruence of outlook between the scientifically health-oriented and professional medical care.

It must be remembered that the illness cases included in this study were fairly serious and that the symptoms were probably not easily ignored. In the case of minor ailments, where "folk" or home remedies might be tried, it is possible that even more delay would have been seen in the popular health-oriented and parochial group members.

Stage 4. The Dependent-Patient Role

The cosmopolitan and scientific groups are more likely to report that their families took care of them than are the parochial and popular groups—45 per cent (cosmopolitan) versus 30 per cent (parochial) and 44 per cent (scientific) versus 23 per cent (popular), respectively. However, the scientific health-oriented group is also much less likely than the popular health-oriented group to have felt dependent upon others during their illness (28 per cent versus 47 per cent).

This higher independence of the scientific group probably reflects their greater willingness to make decisions concerning medical care without seeking the approval of others. In utilizing medical care, the scientific group is also somewhat more likely to express the feeling that their doctor was able to help them "a great deal" (65 per cent versus 56 per cent), a feeling more likely to be shared by the parochial group member as compared to the cosmopolitan group member (70 per cent versus 52 per cent).

Both the parochial group member and the individual with a popular or nonscientific health orientation are more likely to state that they felt depressed during their illness than are the cosmopolitan group member and the individual with a scientific health orientation—70

per cent (parochial) versus 61 per cent (cosmopolitan) and 75 per cent popular) versus 48 per cent (scientific), respectively. This finding would indicate that the greater independence of the cosmopolitan group member and the more informed and favorable attitude concerning medical care of the scientifically oriented individual is reflected in a higher degree of assurance and optimism during illness.

Medical referrals during illness are also more than twice as likely to occur if the individual has a scientific health orientation (38 per cent versus 16 per cent). On the other hand, a popular health orientation and membership in a parochial social structure are more likely to result in the individual's leaving his physician on his own and seeking medical care elsewhere—31 per cent (popular) versus 25 per cent (scientific) and 46 per cent (parochial) versus 20 per cent (cosmopolitan), respectively. These results indicate that cosmopolitan groups and individuals with a scientific health orientation are more likely to engage in medical behavior conducive to continuity of care than are parochial groups and individuals with a popular or nonscientific health orientation. Once more, it is seen that cosmopolitanism and a scientific health orientation are more likely to result in medical behavior more in keeping with the goals and methods of modern medicine.

Stage 5. Recovery or Rehabilitation

Although social structure and health orientation do not appear to be related to enjoyment of convalescence, members of parochial groups are much more likely than members of cosmopolitan groups to have worried about whether or not they would recover during the illness (60 per cent versus 34 per cent), and to continue to express such concern during their convalescence (37 per cent versus 13 per cent). However, it is the cosmopolite who expresses greater worry over resuming his usual activities following illness (61 per cent versus 46 per cent). Thus, it would appear that members of parochial groups are relatively more concerned about the physical aspects of illness and possible incapacitation than about being able to continue their normal role obligations.

A scientific orientation toward health and medical care appears to be more conducive to concern about the recovery of one's health (36 per cent versus 25 per cent); a popular or nonscientific orientation seems to produce more worry concerning the ability to resume one's usual social activities (71 per cent versus 52 per cent). The difference between a scientific and popular health orientation probably reflects

the greater involvement of the scientifically oriented individual with the progress of his medical treatment, in contrast to the popularly oriented individual who is more likely to view illness and medical care in terms of its social rather than its medical consequences.

Ethnic and Socioeconomic Factors

An analysis of ethnicity and social class membership reveals that members of the lower socioeconomic and ethnic minority groups are much more likely than upper-class majority groups to have a parochial form of social organization, and to adhere to a popular or nonscientific health orientation.[4] The relationship of social structure and health orientation to responses to illness and medical care, however, exists independently of ethnic or social class factors. Thus, the differences reported in illness behavior between the cosmopolitan-scientific and parochial-popular groups are not caused by either ethnicity or social class. Within the different ethnic and socioeconomic groups, the observed social structure and health orientation variations in attitudes and behavior regarding medical care continue to exist, when controlled on ethnicity and social class. In general a cumulative effect results, with the greatest contrast occurring between the lower-class minority groups scoring high on parochialism and nonscientific health orientation, and the upper-class majority groups scoring high on cosmopolitanism and scientific health orientation.

DISCUSSION

Depending upon whether one is dealing with a cosmopolitan-scientific group or a parochial-popular grouup, two disparate approaches by the medical profession are called for. The strong group identification and cohesion of the parochial-popular group provides a natural avenue of entry for medical care programs that can be organized in such a way that they receive the group's approval as being appropriate, acceptable and desirable. To secure this approval, it is essential that the medical program become a part of the popular health culture of the group. If such group approval can be obtained, individual members are likely to go along with the program, regardless of personal resistance.

On the other hand, the independent, individualistic nature of the members of the cosmopolitan-scientific groups demands that the medical program be formulated along "rational" lines and that it be ex-

plained to the individual. Cooperation should be forthcoming insofar as the program makes sense to the individual in terms of intelligent health action. These programs need to be individual rather than group-centered and to be based upon "scientific" evidence of effectiveness.

The recognition by organized medical care of the cause of the conflict between professionally determined needs for care and the felt needs of the lay public may help to point the way toward methods of eliminating frustrations experienced by both sides in this conflict.

REFERENCES

[1]A more detailed description of these stages is given *in* Suchman, E. A., Stages of Illness and Medical Care, *Journal of Health and Human Behavior,* 6, 114–128, Fall, 1965.

[2] *See* Appendix for questions used in constructing Social Group Organization Index and Health Orientation Index.

[3] *See* Appendix for description of sample design for Washington Heights Master Sample Survey, 1960–61.

[4] *See* Suchman, E. A., Ethnic and Social Factors in Medical Care Orientation, in this volume.

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