

COMPARING AND CONTRASTING HEALTH BEHAVIOUR WITH ILLNESS BEHAVIOUR

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ABSTRACT

Health behaviour and illness behaviour are important areas of investigation in the field of medical sociology. Health behaviour is a kind of health related activity to maintain good health and prevent from potential health hazards whereas illness behaviour is passive or active response to felt or actual health problem. The strands of health behaviour are positive or negative health life styles and risk avoidance whereas the sub-concepts of illness behaviour are health-seeking behaviour, help-seeking behaviour, healthcare seeking or treatment seeking behaviour, the sick role behaviour, and life experiences of living with acute or chronic conditions. Understanding the similarities and differences among these strands or sub-concepts is necessary to use them in health research in their correct original sense.

Keywords: health behaviour, illness behaviour, health-seeking behaviour, help-seeking behaviour, medical sociology

INTRODUCTION

Health behaviour and illness behaviour are two major broader areas of investigation in medical sociology and other related disciplines. Although both are related to individuals' health and illness conditions but are different in their approaches to study peoples' response to their health and illness. Lay concepts of health and illness are very mundane. They lack the deep rooted behavioral aspects. For example people consider health as the state of human body without any perceived symptoms of disease or having malfunction of any part of it. This is why it is labeled as negative concept; however, there are many health problems that occur without developing obvious illness symptoms. People's attitudes and behaviour regarding malfunctioning of whole body or its any part are important to be understood but not encompassing complete scenario because health as a concept is more than just absence of disease. Therefore it is paramount to know what people think of and do for maintaining the normality of their bodies. Studying how people maintain and improve their health and prevent from suspected illness come into the scope of health behaviour (Cockerham, 2016).

People cannot always remain healthy and live with normal bodily functions. They become sick often and respond to that sickness, sometimes immediately after knowing the symptoms and sometimes delay in help seeking. Illness behaviour initiates when people identify the symptoms of any ill condition perceived to be dangerous for the normal functioning of the body. All the efforts are made to recover from perceived or diagnosed sickness. The complete manifestation of illness behaviour is observed when people become patient and accept the role of being sick. This sick role is assigned to them by the biomedical system where doctors as professional

healthcare providers begin the treatment process and confine the limits of normal social functions. But this does not happen always in smooth manner because many times especially in chronic ailment patients loose the sick role and manage their daily life routine activities. Hence it can be argued that illness behaviour is a broader umbrella concept that covers the treatment seeking process as well as illness experiences of the people living with acute or chronic conditions. The lived experiences of ill people are embedded in their cultural dynamics that influence the meaning making process associated to their health problems (Vivien and Noor, 2014).

It is fact that the concepts of health and illness behaviour emerged in the field of medical sociology but now they are being used in other allied disciplines also such as nursing, public health and social epidemiology. Novice researchers often confuse both the concepts of health behaviour and illness behaviour and use them interchangeably. Such confusion can be noticed from their writings on the subtopics of these main concepts. Therefore it is need of the time to give an elaborative account of the meaning, definitions, conceptual complexity and typology of the sub-concepts of health and illness behaviour. Thus the present article attempts to survey the classical as well as current literature on the use of concepts of health behaviour and illness behaviour and delineate the resulting conceptual analysis.

LITERATURE REVIEW

The Health Behavior

Defining Health Behaviour

The concept of health behaviour emerged in medical sociology in middle of the twentieth century in America. The most cited and popular definition of health behavior was given by Kasl and Cobb in 1966. They defined health behavior as “any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic stage” (Kasl & Kobb 1966 a: 246). Another definition of health behavior is given by Gochman (1997). He defined health behavior as “behavior patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement” (Gochman, 1997: 3). The health behaviors are further divided into two wings: health enhancing behaviors and health impairing behaviors: the former includes exercises, healthy food intake, safe sexual activity, whereas the later one is exhibited in the engagement of smoking, excessive use of alcohol, unprotected sexual behavior. The health impairing behaviors as clear from the name are harmful to health (Conner, 2001).

Types of Health Behaviour

Alonzo (1993) pointed out four different subthemes or dimensions of health behaviour. First one is Preventive Health Behaviour that is to keep oneself away from health hazards and prevent from possible ailment. This includes actions like immunization, exercise, intake of healthy foods and avoid smoking. The second type is Detective Health Behaviour. This kind of health behaviour is manifested when individuals engage in active medical screening to detect or identify the real or potential risk of getting caught by any disease. Usually the detection is carried out before perceiving symptoms of any disease or in other words at the asymptomatic stage. Many hospitals or voluntary health organizations develop programmes of detection of possible risk factors by engaging certain target populations into their mass screening programmes. The third dimension

of health behaviour is health promotion. The Health Promotion Behaviour is to undertake certain healthy activities and adopt healthy life styles to maintain and promote existing health conditions. The health promotion can also be achieved through preventive health behaviour. The fourth and final subtype of health behaviour as proposed by Alonzo (1993) is Health Protective Behaviour. The author argues that the health protection occurs at macro societal level where the environmental factors have to be accounted for protecting people from any suspected health problems.

Theoretical Explanations of Health Behaviour

The health behaviour has been explained theoretically both from macro sociological as well as micro sociological perspectives. The macro factors are social-structural, cultural, economic, political and environmental contributors that influence individual's health behaviour. Whereas micro factors are personal socio-psychological triggers that determine personal choices of people that they make from their social life in terms of engaging in health behaviour. This is a kind of structure and agency debate brought to understand the health behaviour in more holistic way. Drawing upon Max Weber, Pierre Bourdieu and Anthony Giddens, William Cockerham (2005) formulated the theory of 'health life styles' by combining both macro as well as micro factors to explain the health behaviour of individuals in the society.

Since the coining of the concept much attention has been given to micro level socio-psychological attributes of health behaviour. The widely recognized works in this regards are Health Beliefs Model (HBM), Theory of Reasoned Action (TRA) or Theory of Planned Behaviour (TPB), and Health Locus of Control (HLC).

Health Belief Model was first developed in America in 1950s by a team of social psychologists including Godfrey Hochbaum, Stephen Kegels and Irwin Rosenstock to know the reasons of failure of mass chest screening programme of the government to control tuberculosis in the country (Hochbaum, 1958). The most influential contribution to the development and improvement of the model was from a public health expert M.H. Becker in 1974 and finally in 1984. Since 1980s the model has been frequently used as a theoretical framework in the fields of medical sociology, public health, nursing, social epidemiology and other related disciplines. The model explains main three aspects related to health behaviour: individual perceptions, modifying factors and likelihood of action. Individual perceptions further cover the perceived susceptibility of a disease and its perceived seriousness or severity. The modifying factors can be demographic, socio-psychological and structural forces that motivate individuals to take actions. The actions are manifested in the shape of preventing or protecting health behaviour (Becker, 1974).

TPB was almost based on TRA (Rodhan, 2010). Attitudes, subjective norms and perceived behavioural control are the main components of both the theories. Ajzen and Fishbein (1970 and 1980) proposed this framework initially in 1970s and further furnished it in 1980. According to both TPB and TRA individuals' intentions are crucial to develop certain attitudes that trigger whether the expected behaviour would take place or not. Attitudes can be positive or negative based on the beliefs people have about the outcomes of specific actions. Subjective norms are associated with belief holder's expectations about other important people who influence their behaviour or actions. Perceived behavioural control determines the value attached to the positive or negative outcome of the actions. If a person thinks he or she can have control over some ac-

tions to do certain tasks or engage in behaviour it will decide whether that particular action will be performed or not. This theoretical framework has widely applied to health behaviour studies.

Health Locus of Control (HLC) theory was developed by Julian B. Rotter (1966). This theory argues that health behaviour outcomes are the result of the level of personal control people have over their behaviour or actions. The locus of control is further divided into external or internal. Internal locus of control justifies that the good or bad health outcomes are consequences of peoples' belief about the ability they have to protect or prevent themselves from health problems. Whereas the external locus of control is lack of power people can hold over external influences on good or bad health. They think that these external social influences are beyond their control. Peoples' engagement in healthy behaviour can be predicted through this theory.

Besides socio-psychological models and theories that focus only on cognitive level analysis of health behaviour, there are also macro influences that determine peoples' chances of adopting health behaviour. Some of the macro level societal factors that influence people's health behaviour are availability of protective or harmful consumer productions, physical characteristics of products, social structure and policies, and media and cultural messages (Cohen, Scribner, Farely, 2000).

From the above definitions, different types, and theoretical frameworks it can safely be said that the health behavior is a kind of health related behavior of healthy people who want to maintain their health and avoid from illness. They engage in different screenings, immunizations, and routine check-ups to ensure the well and normal functioning of their bodies. Here it is important to note that health behavior is to protect oneself from possible illnesses and never means to recover from any already prevailing diseases or illnesses.

The Illness Behavior

Illness behavior is different from health behavior in a way that it is the behavior of those who feel themselves to be ill and need the medical help (Cockerham, 2016). Devid Mechanic and Edmund H. Volkart (1960) were the first and pioneering scholars who proposed the concept of illness behavior in 1960 to understand the behavioral aspect of sickness. They defined illness behavior as "the ways in which given symptoms may be differently perceived, evaluated, and acted (or not acted) upon by different kinds of persons" (Mechanic and Volkart, 1960: 87). Later on in 1986 David Mechanic brought some changes in the conceptualization of the term and defined it as "Illness behavior refers to the varying ways individuals respond to bodily indications, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions and utilize various sources of informal and formal care" (Mechanic, 1986). Jonathan Gabe, Mike Bury and Mary Ann Elston (2004) in their book *Key concepts in medical sociology* have given a short definition of illness behavior as "Illness behaviour refers to the way in which people define and interpret their symptoms and the actions they take in seeking help" (page. 63). From the point of view of given definitions of illness behavior J.T. Young (2004) considers it socially constructed and socio-cultural in nature. Therefore, it can be maintained that illness behavior is people's response to symptoms of a disease in the context of their socio-cultural life. This response can manifest itself in the form of identification of symptoms, self-care, lay referral system, going to traditional as well as spiritual healers, seeking medical help from competent health care provider (formal or/and informal and public or/and private), and adherence to prescriptions.

The major subtypes or strands of illness behaviour are the sick role behaviour, health-seeking behaviour, help-seeking behaviour, healthcare seeking behaviour, treatment seeking behaviour, and illness experiences.

The Sick-role Behavior

The concept of sick role was proposed by an American Sociologist Talcott Parsons in his famous book 'the social system' which published in 1951. According to Parsons a person when become ill has to accept and adopt the role of being sick. By adopting this kind of role he must seek competent help from physicians to recover from that sickness. During the sick role, he should cooperate with the physician and oblige to medical advice. During illness person's sick role has got to have priority over other social roles and he is relieved from other responsibilities to just focus on getting well soon to play his normal social roles in routine life. From this approach sickness/ illness is considered to be the deviant aspect of social life that affects normal functioning of society (Parsons, 1951).

The sick role has been considered as the part of illness behavior by some researchers in the field of medical sociology (Cockerham, 1998; Mechanic, 1960 and 1995). However, Kasl and Cobb (1966 b.) had mentioned Parsons' sick role as a behavior and as a separate concept different from that of illness behavior particularly in terms of ill person's consideration of himself to be ill in contrast to illness behavior where a person feels himself to be ill, but the purpose of both behaviors (illness as well as sick role behaviors) is same: to recover from sickness/ illness, (page. 531). Nevertheless, simply to describe and distinguish the two concepts, it can be argued that the sick role has dimensions of being a legitimate role sanctioned by the formal health care system whereas the illness behavior is one step behind it. After adopting the sick role, an ill person certainly manifests the illness behavior but during the illness behavior it is not necessary for a person to accept the legitimate role of being sick.

The Health-seeking Behavior

Noel J. Chrisman (1977) defined health seeking behavior as "the steps taken by an individual who perceives a need for help as he or she attempts to solve a health problem" (page. 353). MacKian, Bedri & Lovel (2004) citing Tipping, G and Segall, M (1995) has defined health seeking behavior as "a process which occurs as response to illness" (page. 138). Anwar, Green & Norris (2012) describe health seeking behavior to be "concerned with how people monitor and respond to symptoms and symptom change over the course of an illness, and how it affects the behavior, remedial actions taken and response to treatment" (page. 508). Borrowing from Kasl and Cobb's (1966 a) definitions of illness behavior the health seeking behavior has been defined as "any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy" (Ward, Mertens & Thomas, 1997). The process of seeking health mostly occur when a person is ill, therefore, health seeking behavior has been considered the part (or sub-topic) of illness behavior rather than the health behavior (Grundy & Annear, 2010; Anwar, Green & Norris, 2012; Ward, Mertens & Thomas, 1997; and Chrisman, 1977).

Health care seeking behaviour

Health care seeking behavior is the term mostly used as alternate of health seeking behavior but with slight difference. The health care seeking behavior involves decision making about utilizing or not utilizing public or private, formal or informal healthcare services, or only availing the option of indigenous home remedies (Tipping and Segall, 1995 and Tipping, 2000). Utilization of healthcare services is the end point of health care seeking behavior at which the ill person goes for to utilize health care services provided usually by the formal health care system (MacKian et al., 2004). In other words it can be said health care seeking behavior is associated with the utilization of health services for any health problem. There is no much wide difference between healthcare seeking and treatment seeking. However as the word treatment is more concerned with consulting professionally trained health professionals such as physicians, specialist, and nurses providing medical care to patients having certain health problems. In other words it can be said that health care seeking is broader concept than treatment seeking.

Help-seeking behaviour for a health problem

Some researchers have used the term 'help seeking behavior' instead of health seeking behavior when they mean the same process of responses to illness while discussing the concept of illness behavior (Kasl and Cobb, 1966 a; Mechanic, 1960, 1978, 1995; Cockerham, 1998; Freund & McGuire, 1995; Pescosolido, 1992; Nettleton, 2006; Right and Perry, 2010). Others have used both the concepts for similar meanings by using the connector 'or' and putting parenthesis for one of them (Green et al. 2014). Help seeking behavior has been conceived a multistage process and generally been defined as an individual's efforts to obtain required assistance to solve a problem (Waltz, Sreickland and Lenz, 2005 cited in Cornally and McCarthy, 2011). Analyzing the concept of help seeking behavior based on the review of various studies and models Cornally and McCarthy (2011) have defined help seeking behavior in the context of being a health oriented behavior as "problem focused, planned behavior, involving interpersonal interaction with a selected health-care professional" (page. 286). They go ahead and distinguish the help seeking behavior from that of health seeking in terms of the characteristics and attributes of both the concepts. They have described three main characteristics of help seeking behavior: there must be a problem for that the help is required, there must be a person who is in need of help, and there must be someone else from the help is obtained (Cornally and McCarthy (2011). Health seeking behavior becomes help seeking behavior when all three characteristics are present in it but it is not always like that. Help seeking behavior occur when a person cannot solve the health problem alone whereas the health seeking behavior can take place even when a person tries to solve the health problem by himself/herself without getting help from others; such as, using home remedies to treat a health problem.

Theoretical Explanations of Illness Behaviour

Theories related to different strands of illness behaviour explain what people do, where they go for help, how they seek medical or non-medical help, how they manage acute as well as chronic conditions, why they use health services, and how they develop health beliefs and form illness perceptions.

David Mechanic and Edmund Volkart initiated the theoretical work on illness behaviour in 1960s and later on Mechanic (1978) formulated a general theory of help-seeking for a health problem (Cockerham, 2016). According to general theory of help seeking, ten most important factors play key role in the process of decision making whether an ill person will seek or not seek medical or non-medical help for a health problem. These factors include (1) symptoms recognition, (2) perception of symptoms as serious or not serious, (3) disturbance of daily life due to symptoms, (4) the relative occurrence of symptoms, (5) ability to tolerate the symptoms, (6) level of awareness based on available information, (7) denial circumstances, (8), other needs and illness responses, (9) interpretation of symptoms, and (10) structure of health system and affordability of ill persons (Cockerham, 1998).

How people experience illness at various stages has been explained by Suchman (1965). According to stages of illness experience model an ill person pass through five stages and make chronological decisions for moving from one stage to next stage. The first stage is related to experience of symptoms. Here the person feels something wrong with body or any part of it. He or she then enters into the second stage where he or she accepts the sick role. This sick role can be confirmed by a doctor or a member his or her family, community or social group at any level. The third stage starts with the process of seeking medical care. Contact with health care provider is necessary at this stage. At the fourth stage the medical treatment is accepted and patient role is performed. Adherence to medical care is indispensable at this stage. The final stage is that of recovery and rehabilitation. After recovery the person starts his/ her normal life activities. Sometimes the recovery is slow and even life long, in that case the chronic illness experiences take place and the person manages to cope up with such conditions.

The most influential theoretical model on the use of health services as part of illness behaviour is Behavioural Model of Health Services Use proposed by Ronald Anderson in 1960s. The model later on fully developed in 1995. In 2008 Anderson presented review of the model sketching it through five developmental stages. This model explains the use of health services for health problems by incorporating three main components: predisposing factors, enabling factors, and need factor. These factors are situated in and interplay with contextual characteristics as well as individual characteristics (Anderson, 2008).

Predisposing factors influence person to believe in certain way so that behaviour could occur. In Anderson's model predisposing factors are demographic, socio-cultural, health beliefs, and environmental. It is to note here that these factors can be personal as well as social in nature. Enabling factors are conditions that make it possible or impossible to use health services. These could be financial barriers, economic opportunities, organizational structure, and healing systems. The health insurance schemes have vital role in determining one's behaviour to use health services. The need factors as third and final component of the model explains the perceived and experienced symptoms of the health problem. If a person consider symptoms as serious and feels need to recover from them may bring this person to decide to use health services. The need factors are embedded into one's wider socio-cultural contexts and inner personality triggers.

Illness behaviour in the shape of health-seeking behavior and/or help-seeking behaviour for any health problems have received considerable attention in social science literature (Anwar, Green & Norris, 2012). They have been widely used as a tool to assess the utilization of health services provided by both formal and informal health care systems. The major focus of such studies has remained on the decision making process at individual level to respond to different health problems. The socio-structural factors have not been explored fully to link health seeking

behaviour to overall social system. The studies have depicted that health choices based on rational or spontaneous decisions to seek or not to seek care lie in the individual's approach and immediate thinking regarding interpretation of symptoms of that particular health problem or illness episode (MacKian et al., 2004).

Inconsistency in treatment seeking from a single or specific health care provision channel is evident in the literature. This is mainly because of dissatisfaction with the care provided and perceived urgency in recovery. Initiating from trying home remedies to seek advice from traditional healer, from seeking care at local quacks and unqualified people to consult with qualified formal health care providers, the patients keep wandering from one place to another (Pirani et al., 2015).

Priorities and preferences are also important dimensions of health oriented behaviours. Plethora of studies show that people give preferences to private health care providers over that of public sector due to many factors such as, satisfaction with care provision, diagnosis duration, infrastructure of health care facilities, health care staff behavior, waiting time, health education provision and so on (Long and Li, 2015).

Literature shows that people opt for traditional and complementary & alternative medicine sometimes coupled with spiritual healing side by side the conventional allopathic treatment not only in developing countries but also in medically advanced countries (Ramaduari, Sharf and Ramasubramanian, 2016). Women are more inclined to use alternative treatments than men (Bishop and Lewith, 2010) and same is the case with old age people (Lorenc et al., 2009).

A good number of studies depict the relationship between individuals' knowledge and their health seeking behaviour (Grundy and Annear, 2010). Knowing about the symptoms, healing options, viable facilities, etiology of diseases, and probable outcomes influences people's choices for care seeking. There, in this connection, is plethora of researches on knowledge, attitude and behaviour (KAP) regarding help seeking for particular illnesses. Such studies are good at providing individual and household level information about health seeking but lack in terms of linking health seeking behaviour with larger societal forces (MacKian et al., 2004 and Poortaghai et al., 2015).

Researchers have also explored and explained the gender aspect of health and illness behaviours. They have compared men and women's choice of health service providers and health facilities for their certain health problems (Orisaremi, 2014). They considered gender as influential on patterns of seeking care from different medical as well as non-medical sources.

Peoples' health related help-seeking has been studied in relation to different illnesses. These illnesses range from non-communicable to communicable and infectious health problems and from acute sickness to chronic conditions; such as on cancer, Diabetes mellitus, HIV/AIDS, common childhood illnesses, maternal health issues, and on many other illnesses. Many of these studies and several others have mainly focused on individual cognitive factors that determine the decision making process of help seeking for various illnesses.

CONCLUSION

Understanding the nature of concepts 'health behaviour' and 'illness behaviour' makes them lucid and comprehensible for new researchers in the field of medical sociology. The experienced researchers have used their strands interchangeably in their respective fields of studies. Scholars from the discipline of Nursing and Public Health have frequently used the term 'health-seeking behaviour' whereas medical sociologists are more inclined towards using the term 'help-seeking behaviour' when they all mean to respond to health problems. It is actually the nature of the response from the person that determines whether it is health-seeking or help-seeking. It is pretty clear that peoples' health behaviour show their routine activities related to their health life styles that ultimately determine how they prevent from potential health threats and maintain their current status of health. Health behaviours are healthy activities people engage in to avoid from falling ill. In contrast illness behaviour is manifested when a person feels sick or actually becomes ill and seeks help from medical or nonmedical sources recover from that unhealthy condition. The focus of such behaviour ranges from self-care to consulting with health care providers, from experiencing illness to its management, from getting early recovery of acute health problems to sometimes living with life-long chronic conditions such as cancer. Therefore, the future researchers must make themselves clear about the domain of inquiry whether they pull strands from health behaviour or illness behaviour based on their prior academic background and theoretical orientations.

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