HEALTH AND ILLNESS

Lecture 1

A PERSONAL VIEW OF HEALTH AND ILLNESS

Is there an Ideal Healthy state?

The idea of health (wellness) and illness vary from one individual to another and depends on a number of factors. The WHO has defined heath as *'the state of complete physical, mental and social well being and not merely the absence of disease or infirmity'* (WHO 1983, p.1). This perspective of health emphasises the necessity of individuals to identify and define their own health.

FACTORS WHICH AFFECT PEOPLE'S IDEAS OF HEALTH AND ILLNESS

1. GOOD HEALTH

Good Health as understood by the individual person. The art of measuring individuals' perceptions of their health is relatively embryonic. At the same time, conceptions of health and illness vary among different groups of people within the same society (for example, between people in different social strata) and between different societies, as well as in any single society over time (Morris 1975). As a result, in the analysis of inequalities in health analysts have been forced to rely on a medical model of health, which, in theory, can claim to have a number of standardised, and universal health measures

The Social Model of Health

Social scientists distinguish between the medical concept of disease, and subjective feelings and perceptions of disease, often labelled as illness or sickness by lay people. Illness and sickness, unlike disease, are not necessarily detected by biochemical indications.

Research shows that some people can be diseased according to biochemical indicators, without actually feeling sick or ill (e.g. high blood pressure), and others can feel ill without any biochemical evidence of being diseased (e.g. chronic back pain). Health and ill health are viewed by social scientists as a continuum along which individuals progress and regress.

The social model of health is best expressed with reference to the World Health Organisation's definition (stated in its charter) that health is not merely the absence of disease but a state of complete physical, psychological and social well being.

Social Well Being

Is it reasonable to include social well-being in a definition of health? Because human being rarely lives in complete isolation form one another the conduct of each individual affects others and this is extricably related to everything surrounding that person. It is impossible to be healthy in a 'sick' society, which does not provide the resources for

basic physical and emotional needs. For example, people obviously cannot be healthy if they cannot afford necessities for food, clothing and shelter, but nor can they be healthy in countries of extreme political oppression where basic human rights are denied. Women cannot be healthy when their contribution to society is undervalued, and neither can black nor white be healthy in a racist society where racism undermines human worth, self-esteem and social relationships. Unemployed people cannot be healthy in a society which only values people in paid employment, and it is very unlikely that anyone can be healthy if they live in area which lacks basic services and facilities such as health care, transport and recreation.

2. ATTITUDES TO HEALTH

Cultural Influence

Most of our opinions or views result from the mixing together of many experiences and opinions to which we are constantly exposed. In an area such as health and illness these may go right back to early child hood. Fitzpatrick (1984) describes the way people experience illness as being influenced by the culture of the society in which they live. Thus a person's reaction to illness and the action he/she takes to seek help is the result of the accepted ways of behaving within the social group of which that person is a part.

Self-Concept

Because we make personal judgements about our own state of health, it follows that our health is a vital part of the way in which we see ourselves – our 'self-concept'. Blaxter and Paterson (1982) sum it by pointing out that we live in our bodies and that our physical identity is part of ourselves. All disabilities and chronic illnesses challenge the self (Brooks & Matson, 1987; Bury, 1982; Corbin and Strauss, 1987; Schneider & Conrad, 1983; Charmaz, 1991 cited in Weitz, 1996). If labelling a condition an illness reflects the perceived undesirability of that condition, then labelling someone ill reflects the undesirability of that person. By definition, an ill person is one whose actions, ability or appearance do not meet the social norms, or expectations within a given culture regarding proper behaviour or appearance. Such a person will typical be considered less whole and less socially worthy than those deemed healthy.

Interpersonal Interaction

The interpersonal behaviour of a labelled person may be affected as people around them respond to them differently. This response, whether it is based on an attempt to ignore or help, can reaffirm the new self-image of the labelled person. *Do people talk to the blind person on the bus in the same way that they talk with other people?* Some people can become quite embarrassed when they suddenly discover that the person they were talking to at their table is paraplegic: *What had they been saying? Had they inadvertently said things, which may have shocked, or hurt?*

The response of so-called normal people to disability may be well-meaning but the result can often be to bring the behaviour of the person so labelled into conformity with people's expectations. There is some evidence, for example, of a 'halo' effect in the

classroom such that if a teacher is told that certain children are intelligent, even if they are only medium ability, the labelled children achieve better results than otherwise similar children.

Relevance of Secondary Deviance in Health Care
The notion of secondary deviance *(refers to the change in behaviour that occurs as consequence of labelling)* is of importance in health care in that certain labels carry with them public stereotypes that may change a patient's behaviour. Thus a diagnosed epileptic may refuse to climb stairs, go swimming or cross a busy road and may become depressed and withdrawn again because of the social meaning placed on the diagnostic label. In the end, these changes may have a greater effect on the patient's life than the biological dysfunction that was originally described.

Stigma
Illness and disability affect not only relationships with friends and family but also less intimate relationships. The ideal of illness causing an individual to be held in low regard by others is often referred to as ***stigmatisation***. A wide range of illnesses such as AIDS, psoriasis, diabetes and deafness has been shown to be stigmatising (Scambler, 1984). Such stigmatisation may affect an individual from within or without. The degree to which illnesses are stigmatised varies, and mental disability is usually a greater stigma than physical illness (Furnham & Pendred, 1983).

Different Groups

Various qualitative and quantitative interview studies and postal questionnaire surveys have reported that lay people perceive health in a variety of way. For example, perceptions range from health as: the absence of disease (consistent with the medical model); a strength (e.g. feeling strong, getting on well); being able to maintain normal role functioning (e.g. to carry out normal routines); being fit (e.g. exercise); being able to cope with crises and stress; having healthy habits and vitality, being socially active; hygiene, good living conditions and personal development; and a state of good mental and physical equilibrium.

Even though we are of a particular culture, within that particular culture we may belong to a variety of groups: **Social class**, **Gender** and **Age group**.

Many of the definitions centre on health as the ability to function in one's normal social roles. Studies have also shown that perceptions of health vary as a function of socio-demographic factors. For example people in higher **socio-economic groups** appear to be more likely to define their health in positive terms, while people in lower socio-economic groups more likely to define health negatively, as outside their control. A study by Pill & Scott (1982) of working class mothers revealed that they had a broad view of health in that they regarded it as the 'absence of illness', which lacked any positive aspect such as 'feeling full of energy' or 'being really fit'.

*Does **Gender** affect attitudes to health and illness?* This is more difficult to answer, but there is evidence that the idea of health as 'positive fitness' is seen more often in men than in women (Stacey, 1988). Also Blaxter (1990) identifies a gender difference with men having a more positive notion of health as being 'fit, and women having a more negative notion as not being ill and being able to carry out everyday tasks. A possible controversial explanation for this is that because from puberty women experience menstruation with its often accompanying pain, nausea and other problems, and then from time to time exchange those problems for pregnancy, childbirth, lactation, health may be seen as being free from health discomfort, rather than a positive state of 'feeling healthy'.

*Does **Age** make a difference in attitudes to health and illness?* A study by Williams (1983) indicated that there are. His study particularly noted that the over sixties saw health as the absence of disease, which is relatively neutral state lacking any positive claims of health.

The current literature mirrors the shift away from the disease model of health, and there is interest in incorporating health, fitness and well-being in measurement scales of health status and health-related quality of life.

3. ATTITUDES TO ILLNESS

Illness as a Social Construction

Social scientists view health and disease as socially constructed entities. Health and disease are not states of objective reality waiting to be uncovered and investigated. Rather, they are actively produced and negotiated by ordinary people. This process becomes most apparent when doctors and their patients disagree about the significance or meaning of symptoms. For example, someone can feel ill but after investigations nothing medically wrong can be found. The subjective experience of feeling ill is not always matched by an objective diagnosis of disease. When this happens, doctors and health professionals may label such sufferers '*malingerers*' denying the validity of subjective illness. This can have important consequences for example a sick certificate may be withheld if a doctor is not convinced that someone's reported illness is genuine.

It is also possible to experience no symptoms or signs of disease but to be labelled sick as a result of examination or screening. Hypertension and precancerous changes to cell structures are two examples where screening may identify a disease even though the person concerned feels perfectly healthy. The central point is that subjective perceptions cannot be overruled, or invalidated by scientific medicine.

Cornwell (1984) suggests that people are therefore aware of both professional and lay systems of belief and can use either when asked to talk about health and illness. In encounters with professionals, people use scientific medicine terms, however in more informal settings, people use more holistic and social concepts to explain their illness.

Personal Responsibility

This sort of feeling ties in with evidence that individuals feel a responsibility for their health and for anything that detracts from it (Herzlich, 1973). According to the sociological model, illness is a moral status referring to conditions or behaviours deemed undesirable by powerful social groups. This may not be a logical attitude since we cannot avoid exposure to infecting organisms such as influenza or cold viruses if we mix with other people at all.

Group Differences

In some other societies the patient may be held responsible: for example, the illness might be a punishment for some past crime or transgression, ***thus group differences come into play about illness as they do in ideas about health.***

The search for explanations is often a painful one, set as it is in the context of a ***culture*** that continues at least partially to believe that individuals deserve their illnesses. Nevertheless, some individuals do manage to avoid allocating blame to themselves. For example, one person with HIV disease stated in an interview: *"Nobody deserves it [HIV disease]. I have friends that say 'well, hey if we weren't gay, we wouldn't get this disease.' That's ... I mean, I don't want to hear that from anybody. Because no germ has mercy on anybody, no matter who they are – gay, straight, babies, adults"* (Weitz, 1991:68 cited in Weitz, 1996).

The denial of responsibility is always somewhat arbitrary and it is quite possible to 'blame' patients for having disease. Cigarette smokers who present with lung cancer or ischaemic heart disease could be held partly responsible for their predicament if they knew beforehand of the dangers of smoking and still continued.

Cornwell (1984) found that the ***sexual division*** of labour both inside and outside the home as being involved in the way that people experience illness. In her study, men and women had very different responses to feeling unwell and this was seen as being closely related to how easy it was for the sick person to avoid work, considering paid employment as the major employment of men. Paid employment, more usually the employment of men, is often more avoidable than the constant demands made on a wife and mother who is frequently expected to take total responsibility for caring for a family. ***In a household in which domestic labour is not decided on a gender basis this would not apply.***

Illness Behaviour

Illness behaviour is concerned with those social factors, which affect definitions of health and illness and which influence, among other things, the demands people make for medical care. The term was first coined by Mechanic (1962) who defined illness behaviour as 'the way in which symptoms may be differentially perceived, evaluated and acted upon by different kinds of persons'. In other words, illness behaviour is about the social factors, which influence the way individuals view signs and symptoms, and the

kinds of action engaged in to deal with them. Individuals may recognise signs and symptoms as a medical problem, but may or may not choose to ignore them, or they may or may not deal with the problem without seeking formal medical care. What are the social factors, which influence the use of medical services?

A number of British studies have identified some broad characteristics of people (cited in Bond & Bond, 2000). Common social factors were found to be associated with the use of services; for example age, gender, marital status and education are all associated with health services utilisation.

Illness Behaviour: ***Age and Gender relevance to seek medical advice***
We know that middle-aged women visit their general practitioner more often than younger women, and more often than younger and middle-aged men (McCormick et al, 1990). Elliott-Binns (1973) found that when men were ill they were most likely to be initially comforted and reassured by their wives than to be immediately advised by them to seek medical advice. Men were more likely to suggest straight away that wives should seek a medical opinion. This has the implication that only when longer-term illness of a breadwinner threatens economic stability hat the need for recovery becomes urgent.

Illness Behaviour: ***Social Class relevance to seek medical advice***
Working-class people make less use of the dental services than their middle-class counterparts (Gray et al, 1970).

Illness Behaviour: ***Seeking medical advice to gain credibility to relieve guilt feelings about unmet responsibilities***
Although people may feel unwell they may not be socially accepted as being ill, for example, by their employers, unless a doctor 'legitimates' the illness. In Western society only the doctor has the social authority to legitimate illness and admit the person to what Parsons described as 'the sick role'. According to Parsons, in accepting the sick role the patient gains two benefits (Parsons, 1951 cited in Armstrong, 1994). These are:

- ***The patient is temporarily excused his or her normal role***. Gaining a sickness certificate from the doctor is the obvious way in which the expectation is met. Merely visiting the doctor however confers some legitimacy on a claim to be sick. Whereas 'feeling unwell' might be treated sceptically by friends and colleagues, a visit to the doctor may be sufficient to gain credibility.

- ***The patient is not responsible for his or her illness***. Not being held responsible for the illness can relieve the patient of a considerable burden.

On the other hand if patients are held responsible for their health this may encourage them to take preventive measures. The above studies have shown that the use of medical services is associated with certain social characteristics; in other words, they tell us which kind of person is most likely to use the different services. However they throw little light on ***why*** it is that people do or do not use the various health services. This has implications for policy makers. It is only by establishing these reasons and explaining

the differences that policy decisions can be influenced in an attempt to alter the utilisation of services by groups 'at risk' from health problems. It is increasingly suggested that the days in which governments could improve the nation's health without the active involvement of the people, e.g. in sanitation, in providing clean water, etc., are now passed. Prevention it is argued now rests with individuals who must change unhealthy behaviours patterns if they are to avoid ill health.

4. STAYING WELL

Personal Responsibility to take positive steps to reach and maintain a good level of health.

- Have you experienced the feeling of changing to a healthier lifestyle because you were hit by what colleagues are saying or because of their decisions to change themselves?

Even if you are well informed and made a logical decision actively to build up your own health levels you may find that other factors have to be considered such as **money, time** and even the **energy** to change to healthier habits.

This business of deciding what health and illness are, or what they mean to different people, and what action an individual should or might take to promote good health, is obviously very complicated. It is made even more complicated for nurses because their responsibilities include health education generally, and helping individual patients to recover and maintain the maximum health possible for them.

Summary and Conclusion

Health is a dynamic state that continually changes as an individual and family interacts with their internal and external environments. Health in itself is not negative or positive, but a reflection of the individual's physical, emotional, intellectual, social, developmental, and spiritual well-being. Health is viewed as being on a relative continuum, with wellness and illness on opposite poles. An individual's ability to adapt to the environment determines the position on this continuum.

Disease refers to a medical concept of pathology, which is indicated by a group of signs and symptoms, is clinically defined by the medical profession.

In contrast, ***Illness*** is defined by the person who had the signs and symptoms and refers primarily to a person's subjective experience of 'health' and 'ill-health'. Illness is an imbalance that occurs when an individual is unsuccessful in adapting to changes in the environment. The most positive state of health is the maximum level of adaptation at any given time and place. Many variables affect the level of health, including genetics, age,

life-style, perception of health and illness, health promotion activities, values, beliefs and culture.

Based on these definitions of health and illness, the nurse's role is one of identifying the adaptive and ineffective responses to illness, and helping to create an environment that enables the individual patients to adapt to the highest level of health possible for them.

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