Chapter-II

REVIEW OF LITERATURE

This review of literature examines the studies which led to the formulation of the problem of present study. These studies deal with different aspects which influence the health care seeking behaviour of a persons. Before reviewing the studies a brief history of health psychology and its concern with health care seeking behaviour will be presented.

Any activity of psychology which relates to aspect of health, illness, the health care system or health policy may be considered to fall in the field of Health psychology. Health psychology deals with such question as: Can certain behaviour predispose to particular illnesses? Can health education programmes prevent illness? Health psychology was given recognition as a separate field of study in a convention held by American Psychological Association (A.P.A.) (1978). Health psychology subscribes to the view that both body and mind are important determinants of health and illness. Specifically, health psychologists assume that our beliefs attitudes and behaviour contribute significantly to the onset and prevention of disease (Engel, 1980). A very comprehensive definition of health psychology as a field is proposed by Joseph Matarazzo (1980):

"Health psychology is the aggregate of the specific educational, scientific and professional contribution of
the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiology and diagnostic correlates of health, illness and related dysfunction, and the analysis and improvement of the health care system and health policy formation".

The primary aim of health psychology is to determine important relationship between psychological variables and health. The psychological factors are learning, perception, cognition and social and emotional factors which determine to some extent the health-related behaviour of an individual.

When an individual get sick, a number of social, cultural, psychological and financial factors determine his or her decision about the health care seeking and recovery from illness. Suchman (1965), has described number of stages which intervene between the person's decision to consult a competent physician or do self-treatment. These stages are : (i) Symptom experience stage; (ii) assumption of sick role; (iii) medical care contact; (iv) dependent patient role; and (v) recovery.

In the first stage an individual perceives that something is seriously wrong with him, and decides that he is sick and enters the second stage. In the second stage, sick person adopts the sick role and is excused from his regular duties, initial contacts are often made by the sick
person with spouse or family and friends. Sick person leaves lay care system and enters the third stage in which he usually resumes his normal roles or goes to other physicians until he achieves the diagnosis he wants and comes into the next stage which is dependent patient role. This stage is fraught with problems. In this stage the patient must wrestle between his child like dependence upon the physician and the normal state of adult independence. This is also a stage in which physician and patient work together to commence recovery to normal physical state. Recovery is the last stage in which pain subsides and individual resumes his normal routine.

Many variables are involved in health care seeking. Some important demographic variables are age, socio-economic status, social support, rural-urban residence. The present study was undertaken to determine the variation in the time taken of patients to arrive at different stages of health care seeking and to find out how these variations are contingent upon some of the variables which are mentioned above. The relationship between physicians rating of painfulness of the symptoms and the patient time to report at hospital was also studied in relation to the selected demographic variables.

Age is one of the important elements in the understanding of the individual status in society. In the study of health, age indicates bodily strength and weakness. Tender and old age generally considered prone to disease as
they show weaknesses. The age of youth symbolises strength and valour, and a young person is not expected to be the victim of diseases, according to general perception of people. A number of studies have been conducted in which age is taken as independent variable.

Mechanic (1962) in his study found that best predictors of children's report of fear of getting hurt and attention to pain were the child's age and sex.

In an interesting study by Gonda (1962) a fairly large relationship was observed between persistent complaints of pain and the patient's age and family background. Both older people and those from large families were more likely to be persistent complainers.

Levenson et al. (1984) studied student attitudes toward health and illness. They found that adolescents attributed more importance to their health and showed a better personal health status, expressed more worry and concern about their personal health and about becoming sick.

Ihezue (1985) investigated the psycho-social characteristics of 142 depressive patients seen for the first time at a Nigerian psychiatric hospital. Findings show that whereas neurotic depression occurred more commonly in those aged less than 30 years. Psychotic depression was more often seen in those aged over 30 years.
Bausell (1986) compared public and professional perceptions of the salutary effects of 17 preventive behaviours via telephone interview with 1,254 adults (aged 18+ yr.) and 103 individuals in the field of public health (e.g. educators, government officials, journals editors). Results show that the public rated the majority of the behaviour as more important, than professional sample, although the exceptions were notable. Not smoking, wearing seat belts and drinking in moderation were all considered substantially less important by the public in promoting health and longevity.

Gelberg and Linn (1988) studied the social and physical health of homeless adults previously treated for mental health problems. They surveyed 529 homeless adults to determine the relationship between their previous use of mental health services and their physical health status, utilization of medical services, personal habits affecting health, experience of injury and victimization, and perceived needs. Ss with a previous psychiatric hospitalization were more likely to have experienced serious physical symptoms during the previous month than those who had used only out patient mental health services or who had never used mental health services. They reported more reasons for not obtaining needed medical care, were more likely to obtain food from garbage cans, and had the least adequate personal hygiene.
Haug, M.R. Wykle M.L. (1989) defining self care as treatment for perceived symptom, interviewed 728 Ss aged 45-94 years. Self care, rate was calculated as the percentage of experienced symptoms. They found self treatment without professional advice was slightly higher for persons whose symptoms were seen as less serious. Measures of self assessed health were related to self care for those having less severe symptoms, while lower faith in doctors as well as health were more closely related to the ailments perceived as more serious.

Farron and McCann (1989) examined relationship between hope, mental health and physical health in 76 adults (aged 60 years) who completed a questionnaire at two times, two years apart. Relationship between the variables examined were best explained by a theoretical model of hope, that viewed mental health as a mediating variable between physical health and hope. The model also proposes that social support, personal control and religious beliefs would have a direct impact on hope. This model was table over both times 1 and 2. Data suggest that hope in older adults is maintained through multiple path ways. Therefore interventions need to be holistic in nature and directed towards responding to these multiple needs.

Rakowski and Cryan (1990) using data from the 1984 supplement on Aging to the National Health Interview Survey investigated association among health perception,
and indices of functional health status in 13,726 persons aged 55+ year. They found greater functional impairment was associated with less favourable health perceptions. Although efficacy at taking care of health and perceived control over health showed lower strengths of association with functional impairment, results for subject aged 80+ years were similar in some ways to those for subject aged 55-64 years. However, there was evidence of stronger negative association with increasing functional limitation among Ss aged 55-64 yrs.

Bird and Podmore (1990) examined the understanding of 25 5- and 27 9-yr. Olds about health and 4 illnesses, using open ended probe interviews. Younger Ss were more likely to center on their current state of health as being completely healthy or ill, while older Ss could envisage a state of partial health; less centering was found in judgements of future health for both ages. Older Ss were more aware of strategies for preventing heart attacks and broken arms, although 33% thought there was no way to avoid chickenpox. Most subject gave strategies for avoiding colds as well as for staying healthy. Older Ss had greater awareness of objective and non-observable, physiological signs of some illness as well as of objective symptoms. Few Ss mentioned non-observable symptoms of any illness.

Corney (1990) explored variables associated with consultation and help seeking behaviour for minor illness
in 142-female and 52 male low or non attenders, and in 62 female and 28 male high attenders (aged 20-45 years). Attendance for both sexes was closely linked to physical illness, and the presence of physical symptoms was predictive of more frequent consultations. However the presence of psycho-social problems predicted consultation in females, but not in males. Females had more confidence and contacted more social agencies than males.

Worsley (1990) evaluated the importance of 33 aspects of health as rated by 677 people in Adelaide. They found generally women Ss in older age groups evaluated their health more highly than others. Findings suggest that health evaluation depend on illness experience and social roles.

Luther, A. Lincoln, N.B. (1998) compared stroke patients reports with service provider. Ss were 93 stroke patients (aged 48-95 yrs.) who had not been admitted to a hospital. Ss were visited 1 month after stroke and asked to report on whether they had received any hospital services. Some departments were contacted and asked if the patients were known to them and whether they had been seen. Result shows that Ss reported having little contact with hospital or social services. Findings also suggest that stroke patients and service providers report on rehabilitation services may not always agree. It is concluded that care should be taken when interpreting information on service provision.
Tordy, Rebecca, W. (1998) examined the role and impact of informal, interpersonal networks in health care decision making by investigating the lived experiences of 24 women aged (23-43 yrs.) in a mother's and toddler's play group as they discussed their own, their family member, and their friends, health experiences. Ss conversations revolved around such health related issues as pregnancy and delivery, physicians and hospitals, breast feeding, illnesses, accidents and diet and nutrition. The result shows exchanges of information and shared experiences with others are very important in decision making of people to seek health care.

The main points to be found in above studies are:
1. Adolescents give more importance to their health.
2. Subjects (patient who were suffering from less serious disease were slightly more predisposed toward self treatment.
3. Younger subjects were more likely to center on their current state of health while older subjects could envisage a state of partial health.
4. Less centering was found in judgement of future health in both older and younger subject.
5. Physical health problem increased with age and women reported higher number of physical health problems in old age as compared to men.
6. Female contacted the hospital immediately and sought health care more quickly in comparison to men.

7. Exchange of information and shared experiences with others are very important in decision making of people to seek health care.

It is believed that health status differs from class to class. Those who belong to upper class have a higher life span and less mortality than those who belong to lower class.

Affliction to disease is also subject to economic status. Certain diseases are common among the people of upper class and other diseases are more prevalent among the people of lower classes, for example C.H.D., Hypertension, Diabetes have high incidence among upper class people, whereas other classes have low incidence of these diseases. Diseases of skin, eye, ear, diarrhoea and dysentry have high incidence in the lower classes. This can be ascribed to the poor physical environment in which they live. Families in lower socio-economic status is bigger in size while the upper class families are small sized. As far the utilization of medical care is concerned, individual in the lower social classes are expected to make less use of the hospital facilities, consult the doctors less often, and are less likely to utilize preventive health services.

Cannell (1963) found reporting was significantly poorer for low income and low-education persons than for
high income and high education persons. But the finding was quite amazing in study by Charles (1964) as he found lower class persons are more likely to be concerned about illness than those of higher status, and thus are more likely to report conditions they do not have.

In 1970, a study by the Center for Health Administration Studies of the University of Chicago, it was found that those with family income of less than $2000, said 126 percent of their total family income and those between $2,000-4,000 gave 9 percent of their total income for health services. The comparable proportion of income paid for health services by those with family incomes of more than $7,500 was 3.5 percent. Thus, despite large federal programmes such as Medic-aid, the cost of medical care are a disproportionate burden on the poor. This indicate that the use of service is more, depends on the income and socio-economic status (SES).

In a study conducted in 1971 by U.S. National Center for Health Statistics, it was found that persons having family income of 60 dollar per month had the highest visit rate per year. This is due mostly to the fact that lowest income group has a disproportionately large number of persons.

In a study conducted in United Kingdom the patients decision to use care or not was directly related to socio-economic status. It was found that higher income
persons utilizing the services of physicians to a greater extent than lower income persons. In U.K. the decision to seek medical help or not, is totally dependent on and related with socio-economic status; especially it was found persons of lower (SES) are less likely to utilize medical facilities.

Aday (1972) finds in her study that the poor continue to use fewer services relative to their medical need than do those in higher socio-economic circumstances.

Dulton Diana (1986) used data from a survey of 3058, family members about how patient used medical care? It was found that low income practices clientele, and high charges, were the most significant deterrent to use medical care. Moreover distance, limited hours, had disproportionate impact on the poors' medical care.

In Indian setting study by Shukla (1989) found that C.H.D. were related to deficiency of money problem, problem of daughters marriage, family conflict and unemployment of son that indicates socio-economic status is somehow related to person's health care seeking.

Dubow, E.F, Lovko, K.R. and Kousch, D.F. (1990) surveyed between 33% and 50% of the 1,384 junior and high school students and they found subject with lower socio-economic status (SES) appeared to be at higher risk regardless of demographic characteristics. Also, Ss were generally unaware of existing professional agencies and were reluctant to seek help.
In a recent large study in Italy Hospital Massachussets conducted by Vines and Magno in 1993, it was found that patient with lowest income and at lowest educational level had an increased relative risk of delay in securing hospital care for a number of medical or surgical conditions.

Kephart George, Thomas and David, R. (1998) in a recent study examined socio-economic differences in the use of physician services in Nova Scotia, Canada. The study was based on survey data from the 1990. Nova Scotia Nutrition Survey, containing information on SES, linked to Physician claims data, socio-economic differences in use of physician services were estimated, adjusted for age, sex and region of residence among a sample of 2,198 adults (aged 18-74 yrs). Results showed large socio-economic differences in the use of physician services with use inversely related to both household income and education.

The main conclusions that can be drawn regarding relationship of SES with the care seeking are:

1. Health seeking behaviour differed according to subjects' socio-economic status.

2. Subjects of lower socio-economic status appeared to be at higher risk.

3. Subjects of lower socio-economic status evaluated their health more highly than others.
4. Lower class persons are more likely to be concerned about their illness than those of higher status.

6. Reporting was significantly poorer for low income persons in comparison to high income persons.

6. Poor class seek fewer medical help in comparison to other classes (Middle upper class).

7. Poor class persons delay in approaching to hospital than Middle and upper classes.

When a person decides to seek medical help there are so many psychological factor which are associated with this decision to seek medical help, social support is one of them, social support comes from family members such as spouse, partner, children friends and professional caregivers.

Cassell (1976) one who has social support will be the healthier one. In other words more social support helps to produce better patient adjustment.

Berkman and Syme (1979) indicated in their study individuals with high levels of social support are less likely to develop serious illnesses and therefore less likely to seek care.

House, J.S. Robbins, C. (1982) people particularly males with a larger number of "social connection" live longer than people with fewer contact.

Wallston, B.S. Alagna, S.W. (1983) suggests a relationship between social support and prospects of
recovery. People who are already ill seem to recover more quickly if they have high level of social support.

Blake and Robert (1991) examined psycho-social correlates of morbidity and functional status in 44 adults with chronic lung disease. They found in their study that low social support predicted higher rates of physician visits.

Olsen Ole, Iverson, Lars (1991) in a cross-sectional study of 1,500 occupationally active males (aged 16-74 yrs.), the hypothesized aged dependencies were studied with health operationalized as psychological well-being and social support divided into support from wife children family and friends. The prevalence of support from the wife increased with age, whereas her impact on health was only significantly positive in the age range 30-49 yrs. Support from family and friends was most prevalent among the youngest, but it had a positive impact on health both among the young and old.

Cramer and Duncan (1991) investigated the relationship between psychological distress and social support along with other health relevant variables in 2050 women and 1,873 men who also retained the self completion questionnaire in the 1984-85. British health and life style survey psychological distress was measured with the General Health Questionnaire (G.H.Q.) stepwise regression analyses indicated that the quality of family supported accounted
for a significant increase of 0.2-1.0% of the variance in the G.H.Q. for women and 0.8-1.9% for men. The correlation between family support and distress was reduced from 13 to .04 for women and from .15 to .10 for men.

Tarvin and Gloria (1995), found that the involvement and support of the family are vital in stroke rehabilitation. Stroke can have a devastating effect on family relationships. The primary goal of rehabilitation is to help the stroke survivor and family to maximize their resources and capabilities to address the reality of stroke survivorship. This goal is achieved through the combined efforts of the stroke survivor, the family, and the treatment team.

Fukunishi, J. Aoki, T. (1997) examined correlations of social support with rated mood states, including depression, during the chronic poststroke period for 47 patients with cerebrovascular disease and 47 healthy controls. After the structural clinical interview for diagnostic and statistical manual of Mental Disorders-III Revised (DMS-III-R), 4 psychological measures, the Zung self-depression scale, the Hamilton Depression Scale, profile of mood states, and social support scale were administered. The patients with cerebrovascular disease exhibited significantly more psychiatric disorders, including depression and had poorer social support than healthy controls. The severity of depression was
significantly related to poor social support and particularly to the presence of social support rather than just the perception of poor social support.

Stephen, M. Ann, P. (1997) conducted a study of 57 later-life married couples (aged 55 yrs. and older) who were attempting to adjust to the changes that a stroke had brought to their lives. Results clearly demonstrate that marital partners who are experiencing a period of significant adjustment communicate reciprocally with each other in a variety of ways during episodes of emotional distress and also used supportive communications.

Dimmer and Debra (1998) presents the case of a old woman who was admitted to an inpatient rehabilitation hospital with right hemiplegia dysphagia and Broca's aphasia after suffering a left hemisphere stroke. The subject expressed a desire to return home after her discharge from the rehabilitation hospital, but in the absence of adequate family support, the treatment team recommended a nursing home as a better choice for continued care.

Fukunishi, I. Akimoto, M. (1998) examined coping with stress including social support, dealing with illness, and mood states, in a sample of 600 patients (aged 28-72 yrs.), who underwent primary health-care screening. Ss were not yet diagnosed as having glucose tolerance abnormality and considered themselves healthy, before the examination.
The result suggests that poor utilization of social support is associated with the onset of glucose tolerance abnormality. The main conclusions to be drawn about the importance of

1. Subjects of lower social support don't want to go home as hospital, nursing home as a better choice for continued care.
2. Tangible social support and adequate health insurance were all positively associated with adequacy of care.
3. Support from family and friends is most prevalent among the youngest, but it had a positive impact on health both among the young and old.
4. People of "social connection" live longer than people with fewer contact.

It can be supposed that rural people are much inclined towards magico-religious and supernatural causes of disease, whereas most of the urban people regard such causes of disease unusual and primitive and their method of treatment as irrational and non-scientific. Generally rural people hesitate to consult the modern physician because in their opinion the physician do not understand their feelings, and thus cannot treat their diseases. The modern physicians according to the people have no cure. If we compared urban people to rural people we find that urban people are to some extent aware of the cause and treatment of the diseases. They are also the more frequent visitor to the health centre than the rural people. Rural area patient
are more inclined toward the traditional view of diseases and their treatment, while an urban area patient do not manifest traditional view and as such by and large they practice modern way of treatment.

Sharpiro and Ross (1984), describes rural-urban differences in health care utilization between 1971 and 1977, using a sub-sample of 3,628 elderly subjects. Result show that despite disparities in income and in the distribution of physician resources, the volume and pattern of ambulatory care use by rural and urban elderly did not differ greatly. On the other hand they found higher hospital admission rate was consistently greater among rural than urban Ss. The variation in hospital utilization persisted when health status and other variable were taken into account, suggesting at least 3 possible explanation: rural poverty may make home care a less viable option and may contribute to limited social support; travel distances and transportation problems may encourage impatient treatment; and the greater availability of hospital beds and their low occupancy may encourage admissions.

Ojha (1986) studied the attitudes of 300 rural and 200 urban male subjects in India about hospitals medicine and the causes and treatment of major common illness, such as tuberculosis epilepsy, small pox, typhoid and dysentry. Two attitude scales and a belief questionnaire were prepared for subjects from urban and rural areas and high and low castes. For rural subjects God was the most important cause
of disease. Malnutrition and dirty environment were also acknowledged as important factors in causing dysentry, but germ theory was not much accepted by urban or rural subjects. A positive attitude toward medical treatment was usual but less likely for small pox and typhoid. Attitude toward hospitals were not so positive. Ss were not averse to "modern" beliefs if these had been adequately communicated.

Venugopal and Chandrasekaran (1987) studied 822 psychiatric patients, 187 persons classified as depressive neurotics were evaluated demographically and clinically. More subjects were from rural than urban areas and there were more married females than males. The prevalence of depressive neurosis was highest in the age range of 20-29 years male and 30-39 years females. There were more illiterates among the females than the males. Males had more psychological symptoms than females, but there were no significant sex differences in somatic or neurogetative symptoms.

Swartz et al. (1989) did rural/urban comparison in psychosomatics. They found in their study that somatization is associated with rural residence, less education lower socio-economic class and particular ethnicities. It was also found that somatization was associated with age variation between 45-64 years and being separated and divorced of less educated.
Gift and Zastowny (1990) hypothesized that the differences in mental health services use between males and females would be more pronounced in rural than in non-rural areas. They collected data of 255 rural and 462 non-rural clients of a community mental health center. They found that for treated incidence the ratio of males to females was significantly lower in a rural than in a non-rural setting.

Schlebusch and Ruggieri (1996) explored health beliefs among 50 black patient age (21-71 yrs) in South Africa who required highly specialized medical treatment. Ss were attending a university affiliated specialized teaching hospitals out-patient clinic for "high tech" medical or surgical procedures. Results show significant differences between the health beliefs of rural and urbanized subjects. Health belief related to health behaviour were influenced by several other variables including the interaction between socio-economic, cultural, environmental and other factors.

The main point found in above studies are given below:
1. Higher hospital admission rate was consistently greater among rural than urban.
2. In rural subjects God was the most important cause of disease.
3. Male had more psychological symptoms than females in both areas.

4. In rural area woman, health belief, social support adequate health insurance are all positively associated with adequate health care.