1. INTRODUCTION
Disease is a biological and social phenomenon. It is, and has forever remained a very common experience of man. However, there is still no universally accepted definition of 'disease,' though attempts to define it have been many, and, with knowledge expanding rapidly, almost every day newer concepts emerge.

The latest edition of Oxford Dictionary has given the following meaning of the word 'disease':

"Unhealthy condition of body, mind, plant, or some part thereof, illness, sickness; particular kind of this with special symptoms or location".

The WHO definition of 'health' emphasises that health is not merely an absence of disease or infirmity, but a state of complete physical, mental and social well-being. Recently, the spiritual component has been added to the concept of 'positive health'. Thus, even if a person is free from disease or infirmity, he may not be enjoying positive health as defined by WHO.

The simplest possible definition of disease could include just any deviation from the normalcy of health. But then the questions arise: What is normalcy of health, and what constitutes deviation from it and how to measure this.

deviation? For example, a person may have high blood pressure, high levels of fats in blood, or, low levels of haemoglobin and yet not manifest any known signs and symptoms of any one of these deviations. At present, we have methods to determine these deviations and we know the normal values or range of these parameters. Thus, strictly speaking, all those persons who manifest such deviation should be regarded as 'diseased', even though they do not show any visible signs of diseases which are known to be associated with such deviations from the normalcy of health. This clearly shows that a disease may either be clinical (apparent), or subclinical (inapparent) and therefore latent.

Now the word 'disease' still lacking a definition, innumerable classifications have been proposed based either on mode of onset, or duration, or outcome or etiology, or even on the system in the body that is affected; and also on the mode of transmission, or pathology or even on the result of the treatment given and also on the basis of various other factors. These could be given in a short tabular form which is as follows:

- **Onset**
  - Acute
  - Subacute
  - Insidious

- **Duration** of chronic diseases.
Outcome | Fatal or nonfatal
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Enterology | Bacterial, Viral, Fungal etc.
The system involved | Diseases of the respiratory system.
Transmission | Air-borne or water-borne.
Pathology | Inflammatory, degenerative, neoplastic etc.
Treatment and its result | Curable or incurable
Various other factors and their role | Social diseases and their medical aspects.

Again, individuals differ in their nature. Some of them are more sensitive and form a particular attitude towards any inequilibrium created in their body, and even adopt a method to get rid of these imbalances. And the differences in their attitudes are manifold. However, these differences arise because of the differences in the perception of a problem. The perception of a particular problem generally leads to the formation of the 'attitude'. Further, 'attitudes' are generally the acts of an individual and are either related to the "neuromuscular system"\(^1\), or to the "tendency to act"\(^2\) or a "preparatory activity"\(^3\). Thus an attitude is a determining tendency or 'set', which

predisposes a person to behave in certain ways towards a specific object. It facilitates adjustment to person and situations, in an individual's environment. Being, a determining tendency, it can not be directly observed, but must be inferred with what success we can, from concrete responses, or, adjustments.

But more important in this respect, is that what has the traditional view to say about how attitudes are related to other psychological processes, how attitudes are formed, how they are measured, and, how they are manipulated. Merely defining attitudes as enduring, general, and learned, tells us little about how to measure, or, change them. In fact, defining attitudes in this way only implies that they are certain states which not only put on pressure from within an individual, and but which also exert some control over his overt behaviour. But as to how they exert this control is left imbiguous. Therefore, to solve these problems, attitudes are divided into three components —— affect, cognition, and behaviour. The affective component consists of a person's evaluation or liking of, or emotional response to, some object, or, person. The cognitive component has been conceptualised as a person's beliefs about, or, factual knowledge of, the object, or, person. The behavioural component involves the person's overt behaviour,
directed towards the object, or, person. If, attitudes are conceptualized in this way, we can see how techniques designed to change only a person's emotional reactions towards some object, or, person, would be attacking only one component of the attitude in question. Various studies regarding the construction of scales have been done, such as Wang (1932), Thurstone and Chave (1929), Likert (1932), Bird (1940), Edward (1941), and Kilpatricks (1948). Apart from these, Giddings, in his celebrated work Principle of Sociology (1896), used for the first time, the word 'attitude' from a sociological point of view. Later on, it was taken up by psychologist, and in 1903 particularly by J. Orth, of the Wurzburg School of Psychology. But the systematic use of the word 'attitude' is to be traced to the work of Thomas and Znaniecki (1918) in their monumental study of Polish Peasants. In fact, Allport (1935) gives the entire credit, for, instituting the concept of 'attitude', as a permanent and

central feature in sociological writing to Thomas and Znaniecki.¹

Now if we look into the different theories of 'attitudes', that is be it the Postural Response Theory or, Theory of Mental Set or other such general theories we find that all regard 'attitude' as a preparatory activity. And, as such, it involves anticipation, trial response, incompleted adjustment, and also a state of readiness. For this reason 'attitude' has been defined as an implicit response, or, a predisposition to act, towards, or, away, from individual, or social value.

Thus if we analyse 'attitude' in the above mentioned way then 'attitude' will be found to have the following characteristics:

1) A specific reference
2) A clear focus
3) A form
4) Affective properties
5) A subject - object relationship
6) A relatively enduring status of readiness
7) Be as numerous and varies as the stimuli and finally
8) General and widely extended attitude must differ from traits

Now, Allport suggests four conditions of attitude formation, which Stagner describes as integration, differentiation, trauma, and adoption. But how to explain the operation of these four conditions? Again, we use a Stagner illustration which he actually borrowed from Davis Study on the development of 163 communist leaders in Russia. Stagner writes:

"Some .......... developed gradually to a communist position as a result of continued persecution, experiences with the representative of Czarist order, and so on "integration." Others were converted suddenly as a result of unusual, shocking or painful experiences "Trauma". A third group shows in the development a preliminary stage of vague discontent and interest in various forms of unorthodox ideas, which ultimately become concrete and specific communist activity "differentiation". Finally there seems to be considerable evidence that some of them simply followed suggestion or example of friends, teachers or parents "adoption."\(^2\)

The acquisition of attitude by adoption is clearly indicated by both observation and careful investigation. Sociologists have demonstrated the influence of the group,

either as an institution or even as a whole community, in shaping the beliefs and attitudes of individuals. While discussing social behaviour, Durkheim (1858-1917) regarded social factors as significant elements of behaviour and beliefs, shared by the members of a group, that is collectively, and expressing the way in which the group conceives itself, and its relation with the object which affect it. It becomes clear therefore that individuals in a group have, in the course of time, come to establish particular ways of thinking about things and people, inside and outside of a particular group, and, they have also developed ways of acting towards each other, and the people outside. Although the members of a group may not always think or act alike, they do share similar conceptions about appropriate attitudes.

Two significant social factors, that are thought to govern social actions, are, values, and norms. Values refer to collective beliefs, and, are conceived of at a relatively abstract level. Norms, on the other hand, though difficult to distinguish from values, at a certain level of abstraction, are, more concrete ways of feeling, thinking, and acting, that reflect a set of beliefs.

The sociologist's perspective suggests, therefore, that if we are trying to understand the collective behaviour of human beings, we must not treat them as domestic, or, isolated individuals. To do so, it would mean deliberately ignoring the fact of culture, the set of learnt beliefs, values, and symbols, that individuals must to some extent share, if any social life is to be viable. A person forming an attitude, reflects the culture of his own social world. Together, such attitudes constitute social action, and thus can be traced to social structure and all this helps to understand individual behaviour. Generally, values and norms generate a social structure, which in turn helps in the formation of an individual's attitudes. Attitudes and values are related to each other. One does not exist without the others. Sometimes an individual may even adopt the attitudes of others, or, of the group, and make them his own. In that case his own attitudes derive from the attitudes of others. Thus minus these attitudes, adopted from others he may have none of his own. In the language of frame of reference, an individual has attitudes, because there are no norms by which to judge their relevance. Attitudes are always directed towards values — objects, persons, situations etc. And in this regard, the role of family is emphasized, because sociologically and psychologically, it is a common place, that parents

project on their children, their own interests, preferences, prejudices, ambitions, and the like. The child identifies himself rather closely with his parents, and looks upon them as models, long before he even has the opportunity to identify himself with people outside the family. His area of psychological participation is highly constructed, so that he is much slower in learning to play the roles of others, beyond the family matrix. In this period, he readily accepts the standards of value and behaviour which dominate his life, and so his power of his discrimination and critical judgement have little opportunity to develop.

The family, like the larger community anteceding it, defines for the child, expected roles, which he must play in various situations. In this definitions of a situation, as Thomas calls it, "The child's attitudes are formed". Indeed, the whole life policy, and the personality of the individual, are significantly conditioned, by the definition within the family. Thomas makes this clear when he writes:

"Preliminary to any self determined act of behaviour there is always a state of examination and deliberation which we may call the definition of the situation ...... The child

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is always born into a group of people among whom all the
general types of situation which may arise have already
been defined and corresponding rules of conduct developed,
and where he has not the slightest chance of making his de­
finitions and following his wishes without interference."¹

Psychoanalysts, and sociologists, have argued for a
long time, that family interactions are some of the earliest
and most potent influences, on attitudes and behaviour. They
believe, for instance, that many people, with radical poli­
tical beliefs, express in their behaviour an attitude of
hostility towards family authority, especially the authority
of the father, or, an attitude of resentment against parental
rejection. Apart from W.I. Thomas' analysis, there are many
more, like those of Lasswell, Fromm, Krout, Stagner, and of
Newcomb and Svehla, who are also of the same opinion. Thus,
attitudes are formed and directed, by the social background,
in which the individual is living.

And as for as the attitudes of patients towards diseases
are concerned, these too are formed, according to the social
environment, under which the patients are living. The patients
and their diseases can only be understood in totality, because

¹. Thomas, W.I., (1923). "The unadjusted girl", Little Brown,
Boston : 42.
they are social beings, and hence they and their problems, can be understood, only in relation to their social environment. This too means then that the phenomenon of any specimen of human culture and the individual response to it, are all learnt and transmitted from generation to generation, through beliefs, values, and symbols which individuals must to some extent share in their social life. And therefore, patients too, coming to a hospital or visiting their general practitioner, bring with them the culture of their own social world.

There can therefore, be little question, that assumptions about the naturalness, and rightness of certain beliefs, thoughts, and actions, that is the social structure, are very significant, in understanding why, individuals behave as they do.

Illness behaviour is influenced by beliefs a patient has concerning the symptoms, and what he should do about them. A visit to a doctor is a piece of social action, and, as such, must be comprehended in terms of social influences.

Looked at from the point of view of the actor, a visit to the doctor could have many different meanings, and so could his symptoms. Research has shown, how different social groups may vary, in the way they interpret the signs and symptoms, that the scientifically trained doctors would regard
as serious indicators of disease. Research has also suggested, that individuals, do not necessarily go to the doctor, primarily to seek help with their symptoms (Zola, 1963). To the actor or patient the meaning of his symptoms, and, of a visit to the doctor may vary, both idiosyncratically, or, in socially patterned ways, and it is unlikely, therefore, that we will manage to understand, why people go to doctors, or, as is statistically more frequent, do not go, without taking the actor or patient's subjective perspective into account. A sufficient explanation of any social behaviour, must take into account the fact, that it is an individual's behaviour, who takes decision to behave in a particular way. Research on illness behaviour shows that a socialological approach to help-seeking, taking account of the subjective element in social action, can greatly widen our understanding of what patients want from doctors. Thus, the attitude of patients towards diseases, can be understood and abundantly too, through their cultural background.

For, due to different cultural backgrounds, people form different attitudes. These attitudes, lead or compel individuals, to act according to a given situation. These actions are influenced by age, sex, marital status, religion,

FIG. NO. 1: The Postulated Relationship between Symptoms and Illness Behaviour
ethnic and economic factors. The present study tries to discuss the attitude of patients towards diseases, with particular reference to symptoms experience, assumption of the sick role, the medical care contact stage, the dependent patient role, and, recovery and rehabilitation.

Literature is scarce on the problem dealt with in this study because it is a virgin area, where neither sociologists, nor medical men have stepped out for. References therefore, that this study makes are but only indirectly related to the problem. In fact in an elegant and extensive review of the available literature, Kasl and Cobb (1966) have developed a scheme which tries to understand, under what conditions individuals will and will not, take their symptoms to the doctors. The scheme is given in Figure No. I.

The scheme which is presented schematically in the figure No. I, focusses on the circumstances, that will lead an individual to perceive a symptom as a threat, and those, that will lead him to visit the doctor, as a way of reducing that threat. The idea is that if the individual sees the symptoms as a threat, and perceives that a visit to a doctor is likely to reduce it, he will seek medical aid. In other

words, the individual must first become aware of symptoms as a problem, and must then choose a visit to the doctor, as the appropriate action. A whole range of factors, influence the way, in which he defines the value of visiting the doctor. Thus, social and cultural factors, influence both the definition of symptoms as a threat, and the value, attached to a particular action. Age, sex, marital status, society, religion and ethnic background can all influence the perception of a problem. As a matter of fact, early studies about attitude of patients towards diseases, or, studies of illness behaviour, have been extensively reviewed by Mechnic (1968)\textsuperscript{1}, as well as, by Kasl and Cobb (1966)\textsuperscript{2}. They have tried to identify particular groups of individuals, who were under-utilizers of Medical Services, and, who were found to be more likely to tolerate the symptoms of disease. They had definitions of symptoms, that were different from those of the medical profession and were likely to consult their friends, and relations, or, practitioners of fringe medicine. They were frightened about going to the doctor, and felt that little could be done about their condition, or, were too busy to make a consultation. Investigators found, that these intervening variables, which mediated between the presence of symptoms, and, the consulting of a

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doctor about them, were often patterned, according to social and cultural groups (Koose, 1954). For example the ability to tolerate pain which Beecher suggested could vary according to the significance of the wound, has been found to vary across cultures and ethnic groups.

In order to emphasize how a particular cultural backgrounds make the experience of a particular ailment different, Melzack (1973) cites examples of child birth experiences of mothers from Western Culture, and also those of from South American Culture. He writes:

"In Western Culture, for example, child birth is considered by many to be one of the worst pains a human being can undergo. Yet anthropologists (Kroeber, 1948) have observed cultures throughout the world which practise couvade, in which the women show virtually, no distress during child birth. In some of these cultures a woman who is going to give birth continues to work in the field until the child is about to be born. Her husband then gets into bed and groans as though he were in great pain while she bears the child. In more extreme cases the husband stays in bed with the baby to recover from the terrible ordeal and the mother almost immediately returns to attend to the crops."¹

In another study Zborowski (1952) suggests that the ethnic origin of an individual, influences the perception and interpretations of his symptoms. Americans of Italian origin were found to be concerned immediately about pain experience, while Jewish Americans focus upon the symptomatic meaning of pain, its significance for their health and welfare. Old stocks Americans also showed future oriented anxiety about pain, but were more optimistic about its outcome than Jews. Zola (1966) also confirmed this hypothesis. Other studies also establish that there is this difference in attitudes to disease because of the difference in individual background; these studies include those of Saunders (1954), Rogler, and Hollingshead (1965).

To quote Park:

"The attitude of people to health and sickness may vary in different social classes, which may account for differences in distribution of disease in the social classes. There are people who regard that illness is a punishment and there are others who regard that illness is due to natural causes. There are people who diagnose illness themselves and there are others who seek early medical aid. The attitude of people therefore varies in different social classes."

Yet another study emphasizes social factors as the basis of forming attitudes towards diseases and thus Freidson (1961) pinpoints for this the lay referral system, which varies between social groups, but through which, individuals seek advice about their symptoms from friends and relatives. Similarly, McKinley (1973) has described the way this is done by expectant mothers in Aberdeen. Here he suggests that the more extensive the social network a person is involved in (that is, the extent to which day-to-day activities are typically carried on with reference to a wide and interlocking circle of friends and relatives), the less likelihood there is, that pregnant mother would be a high utilizer of antenatal care. In short their cognition of a symptom as a problem, and the patterns of appropriate action to deal with such symptoms, are socially constructed, and maintained, in much the same way as, are patterns of courtships.

The importance of past medical care for explaining the perceived value of action, is demonstrated in a study, of the last year of the life of 785 people, who died in the U.K., in 1969 (Cartwright, Hockey, and Anderson, 1973). The investigator found, that many individuals had not sought medical aid, for many of the symptoms they had, prior to their death. One reason, for not consulting the doctor might have been, that symptoms were felt to be relatively
trivial. But this was by no means the complete explanation. In fact the explanation for peoples' failure to consult a doctor lay very often in a realistic assessment of the degree to which doctors could help.

Another important variable Kasl and Cobb consider is the role of psychological distress. Blackwell (1963) also emphasizes that psychological distress factors are responsible for the delay in seeking treatment for cancer. Rosen Stock (1967) too stresses, that the psychological distress factor is an important factor, in the formation of attitudes towards diseases.

These studies apart, and all done outside India, very few have been attempted in this country, and when listed include Bhakoo (1976), Ramakrishna (1971), Kakar (1977), Vijai Kumar (1977 and 1981), Hiramani and Bhatia (1978) and Park (1980).

Therefore surveying the available literature in the field of medical sociology, with special reference to attitudes towards diseases, we can readily see, that most of the authors had studied the attitude of patients towards
diseases by considering specifically the cultural, social and ethnic variables, in order to understand the real meaning of the problem. But the present research is different from the above mentioned researches for the following reasons:

1. The present study is sociologically oriented, and therefore provides a very fresh perspective.

2. The problem has been studied by specifically considering independant variables, like symptom experience, assumption of the sick role; medical care contact stage and dependant patient role, also, recovery and rehabilitation, by the help of the dependant variables like sex, education, religion, profession and finally the urban and rural status of the patient.

3. The present research is also special in the sense that the two groups, urban and rural, will be compared, and the difference in their attitude towards diseases will be determined.

4. Finally, this study attempts an in-depth understanding of the independant variables referred to above in both
urban and rural areas; it also discusses the impact of dependant variables.

And, therefore, the present research may be considered a worthwhile contribution in the field of medical sociology.