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A STUDY OF FACTORS INFLUENCE ILLNESS BEHAVIOUR AMONG ESUT UNDERGRADUATE STUDENTS

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ABSTRACT
The study was carried out to determine the factors influencing illness behaviour among ESUT undergraduate students. A total number of 107 participants comprising 57 females and 50 males between the age ranges of 18-27, mean age of 21.27 and standard deviation of 2.17 from the faculty of Education, Enugu state university of science and technology was used for the study. The sample was selected using simple random sampling technique. A 61 item questionnaire with a dichotomous response format of YES/NO designed to measure 8 factors of illness behaviour developed by Pilowsky & Spence (1983) was used for the study. The researcher made use of 3 factors out of the 8 factors on illness behaviour questionnaire (IBQ). Reason's are for convenience, to control fatigue effect and memory effect, and most importantly, to ensure that the participants do not bias their responses on a given item. A survey design was used while Chi square was applied as a statistics to analyse the data. The findings revealed that Irritability as a factor yielded a significant outcome of 12.80 at p<.001 level of significance, General hypochondriasis as a factor did not yield a significant outcome of 0.11 at p<.001 level of significance, and Affective inhibition as a factor did not yield a significant outcome of 0.004 at p<.001 level of significance. The findings were discussed in relation to literature review and suggestions were made.
Keywords: *Illness behaviour, factors, influence and undergraduate students.*

INTRODUCTION
Doctors are familiar with a variety of illness behaviours. They observe the illness behaviour during history taking and when formulating a treatment programme. Falling ill is a common experience for everyone. The process of becoming ill includes questions like: why am I sick? What is it? What can be done? What can I do myself? (Rankin 2013). The latter question refers to what is called 'illness behaviour'. Illness behaviour is diverse. It varies much between people. For a common cold one individual may continue with his daily routine as normally as possible, another may stay at home simply sleeping a few extra hours, and a third may consult a pharmacist or doctor or both. This is the case probably not because the common colds are so different, but because of the subjective aspects of both illness and the inclination to react (Mechanic & Volkart, 2015). Hence, it is not surprising that illness behaviour is not easily predictable from the complaints or illness itself. For individuals, however, illness behaviour does not change so much. Rather it seems that consulting seldom or often is connected more to the person than to his/her state of health.

Aspects of illness behaviour

A combination of two aspects is meant when speaking of illness behaviour: The cognition and emotions associated with feeling ill, and the actions one decides to take after the assessment of the cognition and emotions. Helman (2007) stresses the social context proposing: 'illness is the subjective response of the patient, and of those around him, to his being unwell; particularly how he, and they, interpret the origin and significance of this event; how it affects his behaviour, and his relationship with other people; and the various steps he takes to remedy the situation'. As reactions to illness seem to vary with certain characteristics of an individual, it is probably fruitful to study illness behaviour as *learned behaviour*.

The development of illness behaviour

Behaviour develops during the different stages of a person's life cycle. It is believed that the basis for illness behaviour is laid down in the early years. What is going on when small children show disturbed health? It is the caregivers who become alarmed. They can be alarmed by the child's changes in bodily appearance/temperature and bodily functions. Crying, refusing the breast milk or the bottle, and food for example, attract the caregiver's attention to the health of the child. The caregiver assumes physical (pain, constipation), emotional (fear) symptoms, or changes in the interpersonal relations ('did you miss mum?') (Mechanic & Volkart, 2015). One can hypothesize, that the caregiver's interpretation of the observed bodily appearance/temperature and bodily functions reflects his or her own experiences. Thus, some caregivers will show great confidence in nature's ability to heal. They will console the child and monitor the child's condition. Other caregivers react differently. They will be alarmed, not so much by the objective condition of the child but by their own thoughts. The young child feels and sees the confidence of the former caregiver and the fear of the latter. As a consequence, the child learns to react with confidence or fear. This simplified scenario exemplifies the inter-generational patterns of illness behaviour that are seen and reported by doctors.

The role of the family, the mother in particular, in the shaping of attitudes, beliefs, and illness behaviour is important. Illness behaviour as learned behaviour is part of the *socialization process.* Norms, attitudes, and beliefs learned early in life do not change greatly or easily once they are stabilized in the young adult (Dimatteo, 2004). Furthermore, attitudes and health beliefs, which are significant items in understanding illness behaviour, have been shown to be strongly correlated between children and their parents. This is consistent with the concept of *'family scripts*'. These scripts contain among others, the rules on how to behave. It is clear that illness behaviour develops in a process of social learning. Influences of culture and social class are dominant in this process. Among others it is the cultural influences that lead to differences in symptom-experience,

symptom-interpretation, naming of the symptoms, and, ultimately, illness behaviour. It seems that in our world, despite the enormous possibilities of transport and the amount and accessibility of information, cultural aspects, including religious aspects, of health and illness are still understudied (Pilowsky, 1986).

The sick role

Parsons (1951), vision of the social aspects of being ill found wide recognition. By defining patients' and doctors' roles, the rules of the health care arena were also defined. Parsons' concept of the sick role was based on a functionalist view of society, which was seen as a system characterized by norms and rules that helped citizens to live their lives in harmony. Sickness was seen as deviance from the normal state, that is, a state of full health and functioning, needed to contribute to the development of society. Deviant behaviour was seen as threatening to the status quo, requiring rules for its containment. In this context, the concept of the sick role was formulated by Sigerist, (1989).

RIGHTS AND RESPONSIBILITIES OF THE SICK ROLE

The patient:

_ is free of the normal obligations of work and school
_ is not responsible for being ill
_ has the obligation to get well as soon as possible
_ has the obligation to seek medical help

The doctor:

_ should be clinically highly competent
_ should be emotionally neutral and objective
_ is given access to normally intimate areas

The concept of 'illness behaviour' can be traced to an essay by
Sigerist published in (1989) on the 'special position of the sick', and to Parsons' conceptualisation of the 'sick role' (Parsons 1951). Mechanic and Volkart (2015) coined the phrase 'illness behaviour' to describe, 'the way in which symptoms are perceived, evaluated, and acted upon by a person who recognises some pain, discomfort or other signs of organic malfunction'. Irritability is a common and impairing clinical presentation in children and adolescents. Irritability is a trait distributed continuously in youth, thereby fitting within the national institute of mental health research domain criteria initiative.

Today, hypochondriasis is considered a mental disorder, but in the 17th century it referred to a common somatic condition, with the name hypochondria, introduced by Hippocrates and literally meaning "below the cartilage," suggesting the

involvement of organs. This debilitating condition is the result of an inaccurate perception of the condition of body or mind despite the absence of an actual medical condition. An individual suffering from hypochondriasis is known as a hypochondriac. Hypochondriacs become unduly alarmed about any physical or psychological symptoms they detect, no matter how minor the symptom may be, and are convinced that they have, or are about to be diagnosed with, a serious illness (Angel & Angel, 2006). Often, hypochondriasis persists even after a physician has evaluated a person and reassured them that their concerns about symptoms do not have an underlying medical basis or, if there is a medical illness, their concerns are far in excess of what is appropriate for the level of disease. Many hypochondriacs focus on a particular symptom as the catalyst of their worrying, such as gastro-intestinal problems, palpitations, or muscle fatigue (Deacon & Abramowitz, 2008). Many individuals with hypochondriasis express doubt and disbelief in the doctors' diagnosis, and report that doctors' reassurance about an absence of a serious medical condition is unconvincing, or short-lasting. Additionally, many hypochondriacs experience elevated blood pressure, stress, and anxiety in the presence of doctors or while occupying a medical facility, a condition known as "white coat syndrome". Many hypochondriacs require constant reassurance, either from doctors, family, or friends, and the disorder can become a disabling torment for the individual with hypochondriasis, as well as his or her family and friends (Fallon, Harper & Landa, 2012). Some hypochondriacal individuals completely avoid any reminder of illness, whereas others frequently visit medical facilities, sometimes obsessively. Other victims of this disease will never speak about it. Sometimes hypochondriacal fears develop after reading an article or seeing a television program about a disease.

CAUSES OF HYPOCHONDRIASIS

Major disease outbreaks or predicted pandemics can also contribute to hypochondriasis. Overly protective caregivers and an excessive focus on minor health concerns have been implicated as a potential cause of hypochondriasis development. It is common for serious illnesses or deaths of family members or friends to trigger hypochondria in certain individuals (Harley,1999). Similarly, when approaching the age of a parent's premature death from disease, many otherwise healthy, happy individuals fall prey to hypochondriasis. These individuals believe they are suffering from the same disease that caused their parent's death, sometimes causing panic attacks with corresponding symptoms. Family studies of hypochondriasis do not show a genetic transmission of the disorder.

Amplification of Sensory Experience: people with hypochondriasis are highly sensitive to physical sensations. They are more likely than most people to pay close attention to sensations within their bodies (heart rate, minor noises in the

digestive tract, the amount or taste of saliva in the mouth, etc.), which magnifies their experience of these feelings. While many people fail to notice minor discomfort as they go about their regular activities, the individual with hypochondriasis pays constant attention to inner sensations and becomes alarmed when these sensations vary in any way (Harley, 1999). This heightened scrutiny may actually increase the intensity of the sensations, and the intensity of the experience fuels fears that the sensations signal an underlying illness. Once the fears are aroused, preoccupation with the symptom increases, further enhancing the intensity of sensations.

Distorted Interpretation of Symptoms: people with hypochondriasis are prone to make catastrophic misinterpretations of their physical symptoms. They are pessimistic about the state of their physical health, and overestimate their chances of falling ill. Hypochondriasis thus represents a cognitive bias; whereas most people assume they are healthy unless there is clear evidence of disease, the person with hypochondriasis assumes he or she is sick unless given a clean bill of health. Some studies indicate that people with hypochondriasis are more likely to have suffered frequent or serious illnesses as children, which may explain the development of a negative cognitive bias in interpreting physical sensations or symptoms.

SYMPTOMS OF HYPOCHONDRIASIS

In order to relieve the anxiety that arises from their thoughts, people with hypochondriasis may act on their fears by talking about their symptoms; by seeking information about feared diseases in books or on the Internet; or by *"doctor-shopping,"* going from one specialist to another for a consultation. Others may deal with their fears through avoidance, staying away from anything that might remind them of illness or death. Persons with hypochondriasis vary in their insight into their disorder. Some recognize themselves as "hypochondriacs," but suffer anxiety in spite of their recognition. Others are unable to see that their concerns are unreasonable or exaggerated (Kirmayer & Loper, 2006). Hypochondriasis is often accompanied by other psychological disorders. Bipolar disorder, clinical depression, obsessive-compulsive disorder (OCD), phobias, and somatization disorder are the most common accompanying conditions in people with hypochondriasis, as well as a generalized anxiety disorder diagnosis at some point in their life. Hypochondriacs are frustrated by their doctors' repeated failure to provide symptom relief.

Demographics

Hypochondriasis can appear at any age, although it frequently begins in early adulthood. Men and women appear to suffer equally from the disorder. *DSM-IV-TR 2000* notes that people from some cultures may appear to have fears of

illness that resemble hypochondriasis, but are in fact influenced by beliefs that are traditional in their culture.

Diagnosis

Hypochondriasis is most likely to be diagnosed when one of the doctors consulted by the patient considers the patient's preoccupation with physical symptoms and concerns excessive or problematic. After giving the patient a thorough physical examination to rule out a general medical condition, the doctor will usually give him or her psychological test that screens for anxiety or depression as well as hypochondriasis. If the results suggest a diagnosis of hypochondriasis, the patient should be referred for *psychotherapy* many patients with hypochondriasis abuse medications.

In order to receive a *DSM-IV-TR (2000)* diagnosis of hypochondriasis, a person must meet all six of the following criteria:

- The person must be preoccupied with the notion or fear of having a serious disease. This preoccupation is based on misinterpretation of physical symptoms or sensations.
- Appropriate medical evaluation and reassurance that there is no illness present do not eliminate the preoccupation.
- The belief or fear of illness must not be of delusional intensity. Delusional health fears are more likely to be bizarre in nature— for instance, the belief that one's skin emits a foul odour or that food is rotting in one's intestines. The preoccupations must not be limited to a concern about appearance; excessive concerns that focus solely on defects in appearance would receive a diagnosis of body dysmorphic disorder.
- The preoccupation must have lasted for at least six months.
- The person's preoccupation with illness must not simply be part of the presentation of another disorder, including generalized anxiety disorder , obsessive-compulsive disorder, panic disorder, separation anxiety, major depressive episode, or another somatoform disorder (APA,2000).

TREATMENTS OF HYPOCHONDRIASIS

Cognitive Therapy: The goal of cognitive therapy for hypochondriasis is to guide patients to the recognition that their chief problem is fear of illness, rather than vulnerability to illness. Patients are asked to monitor worries and to evaluate how realistic and reasonable they are. Therapists encourage patients to consider alternative explanations for the physical signs they normally interpret as disease symptoms (Aiken & Mechanic, 1998o. For instance, a patient may be told to focus intently on a specific physical sensation and monitor increases in anxiety. Another behavioral assignment might ask the patient to suppress urges to talk about health-related worries with family members, and then observe their anxiety level.

Behavioral Stress Management: This second form of therapy focuses on the notion that stress contributes to excessive worry about health. Patients were asked to identify stressors in their lives and taught stress management techniques to help them cope with these stressors. The researchers taught the patients relaxation techniques and problem-solving skills, and the patients practiced these techniques in and out of sessions.

Exposure and response prevention: This therapy begins by asking patients to make a list of their hypochondriacal behaviours, such as checking body sensations, seeking reassurance from physicians or friends, and avoiding reminders of illness. Behavioral assignments are then developed. Patients who frequently monitor their physical sensations or seek reassurance are asked not to do so, and to allow themselves to experience the anxiety that accompanies suppression of these behaviors. Patients practice exposing themselves to anxiety until it becomes manageable, gradually reducing hypochondriacal behaviors in the process. Most research indicates that cognitive behavioural therapy (CBT) is an effective treatment for hypochondriasis (Theodore, 2009).

Who is Most at Risk of Hypochondriasis?

These factors increase the risk of developing hypochondriasis:

- Family history of hypochondriasis
- Recent stressful event (for example, the death of a close friend or relative)
- Serious childhood illness
- Mental disorders, such as anxiety, obsessive-compulsive disorder, personality disorders, and depression.

Treatment Options: People with hypochondriasis may also benefit from psychotherapy. Studies show group therapy, behavior modification, and cognitive therapy work particularly well. Health care provider may recommend limiting reading medical books and websites.

Nutrition: No scientific studies have examined the effect of nutrition on hypochondriasis. However, people with hypochondriasis who also have anxiety or depression may benefit from avoiding alcohol and caffeine.

According to Litman, (2017) and Theodore, (2009), following these nutritional tips may also help reduce risks and symptoms:

- Eliminate all suspected food allergens, including dairy (milk, cheese, eggs, and ice cream), wheat (gluten), soy, corn, preservatives, and chemical food additives. Your health care provider may want to test you for food allergies.

- Eat foods high in B-vitamins and iron, such as whole grains (if no allergy), dark leafy greens (such as spinach and kale), and sea vegetables.
- Eat antioxidant foods, including fruits (such as blueberries, cherries, and tomatoes), and vegetables (such as squash and bell pepper).
- Avoid refined foods, such as white breads, pastas, and sugar.
- Eat small, frequent meals throughout the day. This helps stabilize blood sugar (which can improve mood) and improve digestion (which may reduce awareness of normal body sensations as food passes through the intestines).
- Use healthy oils for cooking, such as olive oil or coconut oil.
- Reduce significantly or eliminate trans-fatty acids, found in commercially-baked goods, such as cookies, crackers, cakes, and donuts. These fats are also found in French fries, onion rings, processed foods, and margarine.
- Avoid coffee and other stimulants, alcohol, and tobacco.
- Drink 6 to 8 glasses of filtered water daily.
- Exercise moderately, for 30 minutes daily, 5 days a week.

No herbs are specifically used to treat hypochondriasis, but certain herbs used to relieve stress or anxiety may help a person with hypochondriasis become less preoccupied with disease (which tends to worsen during stressful times). Other herbs may help lessen symptoms of hypochondriasis. Because many herbs interact with prescription antidepressants and anxiety medications, make sure your doctor is aware of all medications, herbs, and supplements you take.

Acupuncture: Several studies indicate that acupuncture may be useful in treating hypochondriasis. Acupuncturists believe the procedure balances the flow of energy in the body. This balancing effect may be particularly helpful for people who have distorted perceptions of normal body sensations. Acupuncture may be useful for:

- Relieving on-going fear and apprehension
- Reducing symptoms of emotional stress
- Lessening stress and pain
- Regulating sleep patterns
- Improving energy

Massage: Some health care providers believe that regular visits to a massage therapist (which include techniques to relieve stress) may help reduce symptoms of hypochondriasis.

Following Up: Try to maintain a healthy relationship with your primary health care provider. Your health care provider will want to schedule regular appointments to monitor your symptoms.

Components of hypochondriasis: Hypochondriasis is characterized by four main domains of dysfunction:
i. preoccupation and misinterpretation (cognitive component);
ii. fear/anxiety (affective component);
iii. hyper-vigilance to bodily symptoms (attention component); and
iv. Avoidance and repetitive behaviors (behavioral component) Anderson, 1995).
Based on the background above, the researchers tend to investigate if these factors would significantly influence illness behavior among ESUT undergraduate students.

The following experiences motivated us to embark on this study; the researchers have often observed some individuals who usually have poor interpersonal relationship with their care givers, parents, siblings and even those that came to sympathize with them when they are ill. Such poor interpersonal behaviour includes but not limited to non-adherence to recommended treatment regimen, hissing, keeping quiet and being angry whenever their state of health is asked after. The researchers also observed some individuals who are excessively concerned about their health and are always eager to seek the services of health professionals or more doctors whenever there is a change in their body's physiology so that they will be re-assured that there is absolutely nothing for them to worry about. And lastly, the researchers observed also that some individuals who because of their cultural background, beliefs and values would prefer to keep their illness to themselves.

THEORETICAL FRAMEWORK

Micro-sociological Models of Illness Behaviour

The progression of micro-sociological models has been toward probabilistic and comprehensive models of behaviour at a local level. The structure of the sick role provides the starting point for discussion.

The sick role

Parsons offers one of the earliest formulations of the socio-psychology of illness behaviour as part of his explanation of social systems (Parsons 1951). Illness, according to Parsons, disrupts normal life function and relationships and is therefore behaviourally deviant. Illness is not a biological or psychological condition, or an unstructured event. It is a social role, the 'sick role', characterised by duties and obligations of the parties to the doctor-patient relationship, and it is shaped by the society to which the parties belong. The sick role is characterised by the following conceptual rules:

1. The sick person is exempt from the normal social roles that the person takes for the duration of the illness. This exemption is legitimised by society as represented by the physician. Normal role performance and responsibilities are

suspended so that the ill person can 'get well'. The strength of the exemption varies directly with the severity of the illness.

2. Sick persons are not responsible for their illnesses. The illness is beyond personal control. A curative process outside the person is required to restore wellness.

3. The sick person has the duty to try to get well. Sickness is societally undesirable and thus society places the obligation to get well on the patient, with the help of the doctor, of course.

4. The sick person must seek competent technical help and co-operate with that caregiver (Cockerham 2001)

The doctor is invested with the function of social control in the sick role system. Physicians reinforce the societal goal of wellness, adjudge the legitimacy of illness for the patient, and provide deviance mitigation (Cockerham 2001) Finally, Rier (2010) discussed the suspension of patient involvement and patient power in the decision-making process during episodes of intensive care, emphasising the physician's dominant role. There have been many misconceptions of the sick role concept over the years.

Critique of the sick role

Although Parson's Sick role as described in 1951 in the social system has been severely criticised for its inapplicability to chronic illness, a portion of the theory is still a relevant and necessary factor in terms of understanding and treating chronic illness today. One of the most evident and persisting health disparities in the United States is the dissimilarity in morbidity and mobility rates between men and women. Cockerham (2012), explained that "females report more illness and disability. They may be sick more often but usually live longer. The division of labour especially contributes to men's higher rates of morbidity and mortality as the most dangerous jobs in the United States are performed by men. Thus men have "Higher accident rates due to an increased exposure to dangerous activities (Cokerham 2012). Parsons was one of the first to acknowledge sickness a socially constructed phenomenon and define it, in part, as the inability to work and fulfil expected roles. Illness behaviour can be defined as the activity undertaken by a person who feels ill for the purpose of defining that illness and seeking relief from it (Cocherham 2012). Demographics affect individual's perception of personal health, to some extent regardless of disease or physical symptoms. A number of authors have discussed Parsons' assumption of the correctness of asymmetric power in the sick role relationship (Hahn 2001). Parsons' configuration assumes that the power to manage an illness resides with

the caregiver. Another criticism of Parson's original model concerns its failure adequately to explain variation in illness behaviour for patients with the same illness who differ in social, cultural, ethnic and economic backgrounds. Several authors have discussed the socio-cultural variations present in illness behaviour. Mechanic (1964) discussed the gender and age differences in children in their approach to illness. Male children and older children are more stoical than girls or younger children. Similar differences in attitudes regarding the approach to illness appear among adults. Theodore (2009) states that women seek care more often than men and they exhibit more symptoms. Men go to doctors for more acute illnesses and are more positive about treatment outcomes. The researchers believe that any ailing individual should be properly cared for in other to hasten their recuperation. Conversely, any ailing individual who is over-pampered might pretend to still be ill even after he or she has recovered due to some secondary gains he derives from the parents, care-giver or guardian. Nevertheless, any ailing individual should be cared for, but the care should not be too much because every human being irrespective of gender, culture, age or religious affiliation etc, desires to be pampered.

Psychodynamic Theories of Hypochondriasis:

First lay by Freud in the late 19th century. This theory focuses on the role of (unconscious) guilt over sexual and hostile wishes, fantasies, and feelings that must be disguised to avoid overwhelming fear of punishment, bodily damage (castration), and death. Since medical reassurance results in immediate relief followed by the longer-term return of anxiety, avoidance behaviours are important maintaining factors and a major focus for treatment. Their case reports indicate that treatments focused on elimination of reassurance (response prevention) and facilitation of self-directed exposure and cognitive change (cognitive reappraisal) are successful in the reduction of discomfort and attenuation of the urge to seek reassurance, Freud, (1920). Some repressed childhood negative experiences like loosing a loved one (to death through a terminal disease like kidney failure, diabetes etc), falling a victim of rape can reappear in the consciousness of an adult person and hence make the individual manifest hypochondrical characteristics.

The Common Sense Self-Regulation Model

Leventhal (2001) seeks to explain that individual illness perceptions influence coping responses to an illness. This perspective explains that clients construct their own illness representations to help them make sense of their illness experience. It is these representations that form a basis for appropriate or inappropriate coping responses (Leventhal, 2001). Using the model of Levanthal, less emotional distress predicted more frequent health behaviours and more-positive mental health scores; whereas those women who perceived their

fibromyalgia to have more serious consequences and as less controllable, were more likely to have higher scores on the Fibromyalgia Impact Questionnaire. For some individuals the most distressing part of the illness were the negative responses from family members, the workplace, and their physicians, who questioning the legitimacy of their illness behaviour because of the dynamic symptoms of CFS (Leventhal, 2001). Denial of opportunity to move into the sick role leads to "*doctor hopping,*" placing clients in problematic relationships in which they must "work out" solutions alone. Although assuming sick role dependency may be adaptive in acute illness, Professional Responses to Illness behaviour and roles healthcare professionals generally expect those entering the acute hospital setting to conform to sick role behaviours. Most people entering the hospital for the first time are quickly socialized and expected to cooperate with treatment, to recover, and to return to their normal roles. Provider expectations and client responses are in line with social expectations and fit with the traditional medical model of illness as acute and curable. When clients are compliant and cooperative, healthcare professionals communicate to them that they are "good patients" (Lorber, 2000). When clients are less cooperative, the staff may consider them problematic. Multiple contacts with the health care system result in loss of the "blind faith" that the individual once had in that system.

Pilowsky (1986) supports the notion that patients who present with illness behaviours that are not congruent with the physical illness exhibit "abnormal" illness behaviour. Displaying extreme behaviour over the result of a minor health issue, for instance, an ingrown toenail may be termed abnormal illness behaviour. Abnormal illness behaviours would include excessive or inadequate response to symptoms, including but not limited to hypochondriasis, somatization, and denial of illness (Kirmayer & Loper, 2006). Above all, the micro-sociological theory of illness behaviour as championed by Parson's 1951 views illness as deviant behaviour. He conceptualized the duties and obligation of the patient and the doctor so that the society will live in harmony. Illness according to Parsons (1951) disrupts normal life function and relationships and is therefore behaviourally deviant. Illness according to Parsons is not a biological or psychological condition or an unstructured event. It is a social role, the "sick role", characterized by duties and obligations of the parties to the doctor-patient relationship.

The sick is characterised by the following conceptual rules;

The patient;

i. Is free of the normal obligations of work and school
ii. Is not responsible for being ill
iii. Has the obligation to get well as soon as possible
iv. Has the obligation to seek medical help.

The doctor;

i. Should be clinically highly competent
ii. Should be emotionally neutral and objective
iii. Is given access to normally intimate areas.

The sick role does not account for the considerable variability in behaviour among sick persons. Variations occur not only by age, gender and ethnicity, but also by the certainty and severity of prognosis (chances of recovery from a disease) Barsky & Ahern, 2004).

The sick role is applicable in describing patient experience with acute illness only and is less appropriate in describing persons with chronic illnesses who may not have easily recognizable symptoms and may not get well no matter how much they want to and how faithful they are following the physicians' instructions. The sick role does not adequately account for the variety of settings in which physicians and patients interact; it is most applicable to a physician-patient relationship that occurs in the physicians' office. The sick role is more applicable to middle class patients and middle class values than it is for persons in lower socioeconomic groups. Not everyone can follow this pathway. The doctor should always be clinically highly competent so that illness which is perceived by Parson as a deviant behaviour could be eradicated so that the society will always be in harmony (Avia & Ruiz, 2005).The doctor should always be emotionally neutral otherwise referred to as maintaining professional distance so that his emotions will not bias his services. The patient on their own part should endeavour to confide to the doctor everything about their illness so that the doctor will prescribe the appropriate medications, furthermore, the doctor should always guaranty the patient maximum confidentiality which will make the patient to be always willing and determined to allow them an access to their normal intimate areas. The role of the patient could be influenced by the psychoanalytic structure of personality. In times of illness, the conscious motivation is to recover from illness, though there might be unconscious motivation to receive 'secondary gains' by a lack of recovery and continued exemption from the rigours of everyday life.

According to Freudian psychoanalytic theory (1920), we have basically three structures of personality and each of them has a principle it operates upon. The three structures of personality and the principle it operates upon are:

i. The id – pleasure principle
ii. The ego – realistic principle
iii. The super-ego – moral principle

From the above listed principles, it is worthy of note that during illness, those set of individuals whose conscious motivation is to recover are under the influence of

their ego and super-ego while those set of people whose unconscious motivation is to receive 'secondary gains' by a lack of recovery and continued exemption from the rigours of everyday life are under the influence of their id. The sick role does not take into account gender differences in patients. But credence should be given to Theodore (2009) who states that women seek care more often than men and they exhibit more symptoms. Men go to doctors for more acute illnesses and are more positive about treatment outcomes. It is worthy of note also that the fact that women seek care more than men do not make them more fragile than men rather it is because women are more self-protective of their health. And that men are more positive about treatment outcomes is just being influenced by their mere resolve to prove masculinity. I find it difficult to understand why some individual feel so reluctant to consider their wellbeing first before any other things. There is a saying that health is wealth yet some people find it hard to adhere to this wise saying. Conclusively, any individual who manifests irritability, general hypochondriasis, or affective inhibition is manifesting abnormal illness behaviour. Illness behaviour is a learned behaviour, so when it comes to controlling a child's abnormal illness behaviour parent's has a role to play to alleviate the anomaly. Children as we know learn by imitation, observation and modelling of their significant other's. I have witnessed an incident were my childhood friend lost his life to ordinary tetanus that he got from a nail that pierced his right foot when we were playing football in the neighbourhood. This unfortunate event could have been averted if the boy wasn't reluctant to tell his parents what had happened. The question now starring in the face is, why didn't he tell the parents what happened to him? It was at last that it became obvious to us that the parents paid little or no attention to the wellbeing of their children. Therefore for this friend of mine, informing his parents would neither contribute little nor nothing to his recuperation The point here is that the parent especially the mother while inculcating in their children normal illness behaviour should endeavour to live an exemplary illness behaviour worthy of emulation because life has no duplicate.

The way parents react to their children's health complaints may later influence the child's illness behaviour and how they cope with illness. One's learning, socialization, and past experience as defined by their social and cultural background, mediate illness behaviour. Past experience of observing one's parents being stoic, going to work when they were ill, avoiding medical help, all influence their children's future responses. If children see that "hard work" and not giving in to illness pays off with rewards, they will assimilate those experiences and mirror them in their own lives. Why people feel so reluctant to disclose their health status when they are ill is quite discouraging. I don't know why some people are still living their lives based on the opinions of other's. How someone who is suffering from a particular illness could prefers to bottle up their health status because of perceived fear of reason's best known to them. It's indeed a sign

of not being much self-protective of their ill health. Left for me, if we are aware of how quickly people forget the dead, we will not be living our lives to impress people. Individuals should always be free and open to discuss their health status to other's in times of ill health because a problem shared is half solved. The purpose of the study was to determine whether there will be a significant influence of irritability as a factor in illness behaviour. To determine whether there will be a significant influence of general hypochondriasis as a factor in illness behaviour. And also to determine whether there will be a significant influence of affective inhibition as a factor in illness behaviour. It was hypothesized as follows:

1. That there will be no significant influence of Irritability as a factor in illness behaviour.
2. That there will be no significant influence of General hypochondriasis as a factor in influence illness behaviour.
3. That there will be no significant influence of Affective inhibition as a factor in influence illness behaviour

METHOD

Participants

A total number of 107 participants comprising 57 females and 50 males between the age ranges of 18-27 with mean age of 21.27 and standard deviation of 2.17 from the faculty of Education, Enugu State University of Science and Technology (ESUT) was used for this study, The sample were selected using simple random sampling technique.

Instrument

A 61- item questionnaire designed to measure 8 factors of illness behaviour developed by Pilowsky & Spence (1983) with a dichotomous response format of Yes/No was used. The researcher made use of 3 factors on (IBQ) and they are: scale B which measures irritability, scale C which measures general hypochondriasis and scale F which measures affective inhibition. The reasons are for convenience, to control fatigue effect and memory effect and to ensure that the participants' response is not biased. The IBQ was adapted for use in Nigeria after several years of research at re-standardizing it in other to enhance its suitability and relevance for Nigerians.

Psychometrics properties

Pilowsky and Spence (1983) provided the original psychometric properties for Australian samples validated by Ugwu, (1998) with reliability and validity index of 0.52 and .78 respectively.

Procedure

Enugu State University of Science and Technology comprises of ten faculties.
I adhered to the principle of probabilistic sampling technique which involves giving each sample an equal chance of being selected. The benefit of it is that the sample will be a true representative of the parent population and the findings from the sample can be extrapolated to the parent population the probabilistic sampling technique we used was simple random sampling technique because it is an unbiased sampling technique. One of the ways of achieving simple random sampling technique is hand drawing; and it involves writing out the names of all the faculties on a shit of paper, fold and put all of them in a polythene bag, thereafter shook the polythene bag very well and put hand inside and select one out of the ten faculties written down on small shits of paper inside the polythene bag. After adopting the hand drawing technique, faculty of Education in Agbani was picked. The permission and cooperation of the Dean and the students of faculty of Education were solicited and obtained. Participants do not receive any financial and monetary reward for participation in the study. With the help of three research assistants from Psychology department, a total of 140 copies of the questionnaire were distributed accordingly to the males and females. All the 140 copies of the questionnaire were distributed across the targeted population within a period of three weeks. Thus, 33 out of the number distributed were wrongly filled and were discarded and 107 that were correctly filled were scored and analysed in other to test the hypotheses.

Design/statistics

Survey research design was adopted and Chi Square was adopted as a statistics to analyse the data based on frequency of responses for each item.

RESULTS

Table 1: Summary table of X^2 on hypothesis 1 which states that there will be no significant influence of irritability as a factor in illness behaviour

N	df	Response		X^2	p
107	1	72 or 67.29%	35 or 32.71%	12.80	<.001

Based on statistical calculations on table 1, the x^2 calculated value of 12.80 is found to be greater than the x^2 critical value of 10.83 at $p<.001$ level of significance, thus, the null hypothesis which states that there will be no significant influence of irritability as a factor in illness behaviour is hereby rejected. Indicating there is a significant influence of irritability as a factor in illness behaviour.

Table 2: Summary table of X^2 on hypothesis II which states that there will be no significant influence of general hypochondriasis as a factor in influence illness behaviour.

N	df	Response		x^2	p
107	1	56 or 52.33%	51 or 47.67%	0.22	<.001

Based on statistical calculations on table II, the x^2 calculated value of 0.22 is found to be lesser than the x^2 critical value of 10.83 at p<.001 level of significance, thus, the null hypothesis which states that there will be no significant influence of general hypochondriasis as a factor in illness behaviour is hereby accepted.
Indicating, there is no significant influence of general hypochondriasis as a factor in influence illness behaviour.

Table 3: Summary table of x^2 on hypothesis III which states that there will be no significant influence of affective inhibition as a factor in illness behaviour.

N	Df	Response		x^2	p
107	1	53 or 49.53%	54 or 50.47%	0.004	<.001

Based on statistical calculations on table III, the x^2 calculated value of 0.004 is found to be lesser than the x^2 critical value of 10.83 at p<.001 level of significance, the null hypothesis which states that there will be no significant influence of affective inhibition as a factor in illness behaviour is hereby accepted.
Indicating, there is no significant influence of affective inhibition as a factor in illness behaviour.

Summary of the Results

Out of the three hypotheses tested which are; Irritability, General Hypochondriasis and Affective Inhibition, it is only Irritability that is significantly influencing illness behaviour among ESUT undergraduate students, at p<.001 level of significance.

DISCUSSION

The study was carried out to determine factors influencing illness behaviour among ESUT undergraduate students. The factors are: irritability, general hypochondriasis and affective inhibition. The first hypothesis which states that; there will be no significant influence of irritability as a factor in illness behaviour was rejected which implies that irritability as factor significantly influenced illness behaviour among ESUT undergraduate students. Based on my findings, my respondents, was of the opinion that it is highly influenced by their values, beliefs, culture, and religious affiliation which is in agreement with the principle

of behaviourism. The second hypothesis which states that; there will be significant influence of General Hypochondriasis as a factor in illness behaviour was accepted which implies that General Hypochondriasis as a factor did not significantly influenced illness behaviour among ESUT undergraduate students. Based on my findings, my respondents was of the view that since every iron must pass through the blacksmith test, it is needless for them to be excessively concerned of their health. Although it is paramount for one to be careful of his health, and practise good personal hygiene, it should not be done excessively. They were of the opinion that they learnt it from their significant others- parents and guardian which is in agreement with the principle of behaviourism. The third hypothesis which states that; there will be significant influence of Affective Inhibition as a factor in illness behaviour was accepted which implies that Affective Inhibition as a factor did not significantly influenced illness behaviour among ESUT undergraduate students. Based on my on findings, my respondents was of the opinion that life has no duplicate and as a result they are always willing to tell others about their illness so that they will know the next line of action. They were also of the opinion that they learnt it from their significant others- parents and guardian which is in agreement with the principle of behaviourism. When it comes to controlling a child's abnormal illness behaviour parents has a role to play in other to alleviate the anomaly. Children as we know learn through imitation, observation and modelling of their significant others. As a result, children who are not well socialized, tend to manifest abnormal illness behaviour in adulthood. One's learning, socialization, and past experience, as defined by their social and cultural background, mediate illness behaviour. Past experience of observing one's parent being stoic, going to work, when they were ill, avoiding medical help, all influence their children's future responses. If children see that "hard work" and not giving in to illness pays off with rewards, they will assimilate those experiences and mirror them in their own lives.

SUMMARY AND CONCLUSION

According to Watson (1919) the father of behaviourism, every behavior that is learned can also be unlearned. Illness behaviour as we have seen in this research work is a learned behaviour and as such it can also be unlearned. Parents and guardians should always endeavour to live normal illness behaviour worthy of emulation so that when their children or wards grow up, it shall imbibe in them.

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