

Aetiology and Management of Abnormal Illness Behavior among Secondary School Students in Uasin Gishu District, Kenya

By Chege, Kimani.G., Philip.K. Rono – School of Arts and Social Sciences and Michael M. Ndurumo -School of Education, Moi University. P.O. Box 3900, 30100 Eldoret, Kenya

Abstract

For many years poor performance among students in boarding secondary schools has been attributed to many side-factors, overlooking possible causes such as abnormal illness behavior. The study sought to determine the causes, types, effects and the management of the same. The study also sought to investigate the relationship between gender, age, respondent's class, birth position in the family, respondent's type of parent and exhibition of the abnormal illness behaviors. The study adopted the descriptive and exploratory research design and the population comprised of all boys and girls boarding secondary schools in Uasin Gishu district, from which a four (4) schools were selected using stratified random sampling. A sample 320 students was selected using the stratified random sampling technique. A total of 16 teachers were selected purposively to give information concerning the effects and management of the abnormal illness behavior. A questionnaire was used to collect data and the analysis made use of the chi-square statistic. The findings revealed the following types of abnormal illness behaviors: hypochondriasis, hysteria, denial of disease, malingering and factitious illness. The results indicated that the presence of abnormal illness behavior heralds poor academic performance. Teachers used elementary counseling skills, punishment, threats of punishment, suspension and public ridicule to combat this problem.

Introduction

Illness behavior refers to the ways in which given symptoms may be differentially perceived, evaluated and acted (or not acted) upon. This includes all aspects of thinking, emotion and behavior related to the physical symptoms of disease, whether or not these are associated with objective evidence of physical or mental illness. Illness behavior does not imply that the behaviors are necessarily pathological (Corsini, 1994). It includes behaviors that are regarded as being entirely appropriate to any disorder that the subject may have and also those that are regarded as inappropriate because they seem to be either excessive or insufficient, or take an unusual form.

For individuals, illness behavior includes both traits, for example the lifelong tendency to have either a low or a high threshold for consulting doctors) and state (the behavior at a particular time). According to Williams (1993), there is evidence that such traits are acquired during childhood, by learning the patterns of illness behavior that are characteristic of the culture or family, and these may have considerable value as defense mechanisms in later life. The majority of consultations, particularly in general practice, are determined to a considerable extent by current social and psychological factors. Thus many of the behaviors related to illness are not directly determined by disease processes but by the psychological and social state of the patient.

Abnormal illness behavior refers to illness behaviors which are regarded as inappropriate. The most common are hypochondriasis, factitious illness, hysteria, malingering and denial of disease. Hypochondriasis is characterized by preoccupation with disease (either physical or mental). The term is used in several ways. Hypochondriacal personality traits

include a lifelong tendency to be over-concerned with health, food fads, and physical fitness, as well as fear of illness. Hypochondriacal symptoms can take the form of ruminations, delusions and over-valued ideas. In primary hypochondriasis; the characteristic feature is the presence of over-valued ideas about illness. The patient has rather vague but pervasive and persistent beliefs that he is suffering from an unidentified (usually a physical) disease, despite the fact that he is likely to have been intensively investigated by physicians on many occasions with negative results. Perhaps because patients with this disorder regard themselves as physically ill, they are reluctant to see counselors or psychiatrists. Hypochondriasis can be thought of as 'chronic somatization'. Similar presentations are called *Briquet's syndrome*. This is a chronic disorder – continuing for at least several years – starting before the age of thirty, characterized by multiple physical complaints in the absence of relevant abnormal physical findings. Dysmorphophobia is a more circumscribed condition which involves the belief that the body is deformed in some way; particularly the nose, but sometimes other parts of the body such as the face, breasts, and hair among others. The form of the belief is either an over-valued idea, which occurs most commonly in a setting of severe personality disorder; or a delusion, usually in the setting of schizophrenia (Clifford, 1995).

Hysterical symptoms on the other hand are unconscious simulations of the signs of disease, which involves disruption of normal functions, particularly those of the nervous system, which are usually under voluntary control. The most common is the inability to stand and walk, fits, anaesthesia, paralysis, tremor, amnesia and dysphonia. An important difference between hypochondriacal and hysterical symptoms is that patients with the former present with verbal complaints but the latter have primarily a non-verbal presentation. Transient hysterical symptoms are common in childhood but first onset become less common with increasing age. When appearing first over the age of forty, they are particularly suggestive of a neurological disorder, such as disseminated sclerosis. Hysteria is a syndrome characterized by the presence of hysterical symptoms in the absence of any other demonstrable physical or psychiatric disorder. It should be possible to demonstrate that the symptoms have some adaptive value for the individual. For example, anxiety is relieved when the development of a symptom removes a student from conflict. A student who feared he might fail his exams developed a paralysis of his arm, which prevented him from completing his course and sitting the exam. The primary cause of this symptom would be anxiety about failure, and the symptom effectively relieved this. This relief of anxiety is therefore referred to as the primary gain of his illness. Because of their value, hysterical symptoms often result in a surprising lack of distress and the individual may pay little more than lip service to the wish to overcome his disability. Subsequent use of the symptom to manipulate others, for example to be inappropriately cared for and financially supported, is called secondary gain: this is of course by no means confined to hysteria, and indeed may be a consequence of any physical or mental disorder. Mass hysteria involves the epidemic spread of hysterical symptoms usually amongst adolescents and young adults who are in close proximity. There are generally several accounts of outbreaks, for example in schools or at 'pop' concerts sometimes masquerading as some new or mysterious disease. One interesting facet is the widespread vulnerability of the general population to the development of the hysterical symptoms by suggestion, given 'favourable' conditions; they are by no means limited to a few 'weak' or abnormal personalities.

Malingering closely resembles hysterical symptoms except that in the former the subject is both conscious that he is simulating the symptoms of disease and also of the purpose (the nature of the gain), for example this may be to get some time off or a break from school or to avoid responsibility for some disciplinary action. In practice it can be extremely difficult to differentiate between them. Often they overlap, as in the case of an individual who gradually acquires insight then consciously maintains his symptom in order to 'save face.'

Benjamin (1996) notes that some individuals produce the physical signs of disease, in order to deceive medical practitioners, by self-injury or other subterfuge (factitious means artificial). They may present with many different signs, including rashes – ‘*dermatitis artefacta*’; infections, for example of the urinary tract or septic arthritis, due to the introduction of infected material; or lapses of consciousness due to the injection of insulin. Usually the individuals are aware of the deception but may have little or no insight into the motives for their behavior. In this respect they differ from malingerers. Their motives in general are to maintain themselves in the role of invulnerability, from which they derive comfort and care; they either fail to receive these normal human requirements from the more usual sources, or they are dependent personalities with excessive needs. Munchausen syndrome is a form of factitious illness, which is sometimes referred to as ‘hospital addiction’, and usually tends to present as an emergency. The individual may give a polished history, which can include a false name and past medical history. Such individuals rarely want to see counselors or psychiatrists.

Purpose of the study:

The purpose of the study was to determine the types of abnormal illness behaviors exhibited by secondary school students who are boarders, the aetiology of these illness behaviors, the effects of the abnormal illness behaviors and the methods adopted by the teachers and administration in dealing with these abnormal illness behaviors. The study also sought to investigate the relationship between gender, age, respondent’s class, birth position in the family, respondent’s type of parent and exhibition of the abnormal illness behaviors as well as the time or season in the school term during which incidences of these abnormal illness behaviors are common.

Data and methods.

Population and sample:

The population of the study comprised all the secondary school students in Uasin Gishu district who attend boarding schools. These students are in different classes, both boys and girls and they come from homes with different types of parents and parenting styles. The students who are of different ages also occupy different birth positions in the family. The population also comprised all the boarding secondary schools in uasin gishu district. From these, four schools were sampled purposively, two of which were girls’ while the other two were boys’. A sample of 320 students were selected from the four schools using the stratified random sampling. The strata were based on gender, age, class, respondent’s type of parent and birth position. A sample of sixteen teachers were selected purposively, four from each school on the basis of their participation in the management of the abnormal illness behaviors.

Research design:

The study adopted the descriptive and exploratory research design. According to Kothari (1990) descriptive research studies are concerned with the description of characteristics of an individual or a group. Exploratory studies on the other hand are concerned with the formulation of problems for more precise investigations or for developing working hypotheses from an operational point of view. The aim of this study was to investigate the relationship between gender, age, respondent’s class, birth position in the family, respondent’s type of parent and exhibition of the abnormal illness behaviors. The questionnaire was used to obtain data for the study. The data obtained was analyzed using both descriptive and inferential statistics where the chi-square statistic was computed to test the research hypotheses at .05 level of significance.

Results and discussion

Types of abnormal illness behaviors:

On administering the questionnaires to the respondents, a total of 113 girls (35.3%) were found to be hypochondriacs, 64 boys (20%) were hypochondriacs while the remainder did not respond positively to the items detailing the symptoms of hypochondriasis. These included the following: whether the respondent was preoccupied with physical or mental disease, over concern for health, and food fads. A majority of the 113 hypochondriac girls (79) said that they have persistent beliefs that they are suffering from an unidentified physical disease despite medical diagnosis proving absence of disease. This is referred to as primary hypochondriasis. A total of 11.7% of the girls who were hypochondriac were also dysmorphophobic, they sometimes believed that their bodies were deformed in some way, particularly the nose, breasts, hair and face.

The study also found out that malingering was common among students in boarding schools. The abnormal illness was exhibited by 159 girls (49.7%) while their male counterparts who were or had ever been malingerers were 109 (34.1%). When these two groups of students were asked whether they had ever faked an illness in order to avoid attending school or punishment or an exam, they all responded with a yes.

The responses from the study subjects indicated all the symptoms of factitious illness. The students were asked whether they have ever applied chemical substances on their skin to produce rashes in order to deceive the school nurse and 48 girls said yes while 9 boys responded with a yes and therefore they have suffered from *dermatitis artefacta*. A total of 41 boys admitted that during clinical examination they have put the thermometer in hot tea to depict the presence of a fever. No female student had ever done this. This behavior is referred to as *pyrexia*. A small number of girl students (6) said that they had introduced infected material into the urinary tract in order to induce disease. The *Munchausen syndrome* is common among female students than their male counterparts. The respondents were asked whether they were addicted to sanatoriums, clinics and hospitals to the point of creating a story and history about serious disease. It is surprising to note that a total of 104 female students and 78 male students exhibited this syndrome.

The study found out that an abnormal illness behavior known, as hysteria was also prevalent among last-born students than any other group. A total of 51 female students and 32 male students said that they had been sick often to the point of being unable to stand or walk even in the absence of a real physical illness. This is referred to as *astasia-abasia*. The same students admitted that they sometimes experienced fits and tremors. Some male students said that they sometimes felt that their hand used for writing was paralyzed before an exam. This has adoptive value since it is used to alleviate the anxiety associated with exams since if the hand is paralyzed, the student would be booked for a special exam later on. *Mass hysteria* was common among male students than females. When asked whether many students had ever experienced or suffered from some mysterious disease, 137 boys said yes while 58 female students said no. This could indicate that groupthink and peer influence is strong in boys' schools than in girls and hence the presence of mass hysteria.

The study also found out that a total of 21 (6.56%) female students always denied disease while male students who had the same problem were 97 (30.31). This was an equally serious abnormal illness behavior because its consequences can be fatal if the individual has an illness that need proper medical examination and management.

Abnormal illness behavior as a function of gender, age, class, birth position and type of parent and parenting styles:

Abnormal illness behavior as a function of the respondent's class:

The new students (form ones) are expected to be high in exhibition of the abnormal illness behavior compared to the continuing students and this is attributed to the new environment away from home.

Table 1 Cross-tabulation of degree of exhibition of abnormal illness and the respondents' class.

Degree of illness bhv. exhibition	Form 1	Form 2	Form 3	Form 4	Total
High/regular	3	11	19	4	37
Moderate	2	7	11	1	21
Little/no exhibition	21	66	3	2	92
Total	26	84	33	7	320

Chi-square observed at .05 level of significance was 67.38 while the chi-square critical at .05 level of significance, 6 df 12.592 was hence our null hypothesis stands rejected. There was a significant relationship between the respondents' class and the degree of exhibition of the abnormal illness behavior. The form four students are more likely to be hysterical due to inadequate preparation for the mock or final exams while form ones would be malingerers due to the new threatening environment.

Abnormal illness behavior as a function of gender:

The study sought to test the null hypothesis Ho2: there is no significant difference between male and female students in boarding secondary schools in the exhibition of abnormal illness behavior among students. The study accepted this hypothesis since the χ^2 observed was 1.807, which was less than the χ^2 critical (2, 0.05) of 5.991. It was established that both male and female students demonstrate or exhibit these illnesses alike, the difference being the types of illnesses, the degree and the motives. This implies that efforts to manage this phenomenon should target both male and female students.

Table 2: Cross-tabulation of degree of exhibition of abnormal illness and the respondents' gender.

Degree of illness bhv. exhibition	First born	Middle born	Last born	Total
High/regular	3	11	103	117
Moderate	19	7	37	63
Little/no exhibition	95	38	7	140
Total	117	56	147	320

A total 147 (45.9%) of the respondents were last borns, 117 (36.6%) were first borns while 56 (17.5%) were middle borns. The hypothesis Ho3: there is no significant relationship between the respondents' birth position and involvement or exhibition of abnormal illness behavior was tested and a χ^2 observed was 41.93 which was greater than the χ^2 critical (4, 0.05) of 9.488 and hence our hypothesis stands rejected. These findings of the chi-square showed that there is a significant difference in the degree of exhibition of abnormal illness behavior among the students by their birth positions. The last borns were high in the followed by middle borns. The first borns were low in the same and this is consistent with the psychological argument that first borns are always in control of the situations around them and they are highly responsible. Teachers and other people who provide help to such students should obtain personal student information to assist them to focus on the last borns who are in need of these help more than the other groups.

The relationship between abnormal illness behavior and the respondent's age:

The study also sought to establish whether there was a difference in the degree of exhibition of the abnormal illness behavior between students of different ages. Consequently the null hypothesis Ho4: there is no significant difference between secondary school students of different ages in the exhibition of abnormal illness behaviors was tested using the chi-square statistic. The χ^2 observed was 2.471 which was less than the χ^2 critical (2, 0.05) of 5.991 and on the basis of this, the null hypothesis was accepted implying that young and old students alike exhibit the abnormal illness behaviors. This is because there are other important factors that matter in the exhibition of the abnormal illness behaviors, for example the birth position and gender.

The relationship between abnormal illness behavior and the type of parent or parenting style:

The study found out that the students who came from single parent families were high in the exhibition of the abnormal illness behaviors than those who came from families or homes with both parents. The students who were brought up by single mothers were almost definitely masters of the abnormal illness behaviors. Those who had come from homes where the parents were strictly autocratic in their parenting style were frequently exhibited malingering and hysteria than any other group. Chi-square observed at .05 level of significance was 17.291 while the chi-square critical at .05 level of significance, 4 df was 9.488 hence our null hypothesis, Ho5: there is no significant relationship between the parenting style and exhibition of the abnormal illness behaviors among secondary school students, stands rejected. The students who had were brought up by single mothers or other guardians (especially grandmothers) tended to participate or exhibit these abnormal illness behaviors more than their counterparts who were brought up by single fathers or both parents. This was indicated by the results of hypothesis testing. Hypothesis Ho6: the type of parent has no significant effect on the respondents' involvement or exhibition of the abnormal illness behaviors was rejected since χ^2 observed of 51.63 which was greater than χ^2 critical (6, 0.05) of 12.592. Therefore teachers' counseling efforts should be guided by information about the respondent's type of parent and parenting style.

The relationship between exhibition of abnormal illness behavior and the time period during the term:

Most of the teachers (13) opined that the abnormal illness behaviors were very common towards the end of the term, when exams were about to begin and whenever the school failed to give students an off during the term.

Aetiology of the abnormal illness behaviors

A majority of the teachers (91%) attributed the abnormal illness behavior to anxiety about failure among the learners especially during exam time. This was particularly among the below average students. However, some teachers (10) believed that the students used the abnormal illness behaviors as a method of manipulating others, seeking attention and care from others, and for a few students, it was a means of seeking financial support. According to some teachers (65.62%), students would malingering in the middle of the school term in order to get permission to proceed home for treatment and in the process get financial support for upkeep. All the guidance and counseling masters in the schools (4) that participated in the study agreed that some abnormal illness behaviors were used for purposes of escape conditioning from the 'unpleasant conditions' in school. This was evident among the form one students who were new in these schools. Other teachers (43.9%) opined that these abnormal illness behaviors were used as for dissociation and conversion defense mechanisms which are common among adolescents and young adults.

Effects of the abnormal illness behaviors

When asked to give the effects of the abnormal illness behaviors, a total of 11 teachers mentioned that these behaviors lead to poor academic performance among the students. Their position is not any different from that of scholars who carried out similar inquiries in the western world. As Benjamin (1996) argues, learners' academic performance has been seen to nose-dive immediately after symptoms of abnormal illness behaviors were observed in them. This could be attributed to the fact that the students who are involved in these behaviors spend a lot of time seeking medication or deeply absorbed in the mechanics of the abnormal illness behaviors. This finding was validated by the chi-square result obtained after testing the hypothesis: there is no significant relationship between student involvement in the abnormal illness behaviors and their academic performance. The χ^2 observed was 18.375 which was greater than the χ^2 critical (4, 0.05) of 9.488 hence our null hypothesis was rejected. Most teachers (92.85%) said that indiscipline and irresponsibility among the students was as a consequence of involvement in these abnormal illness behaviors though they did not expound on this. Absenteeism and conflict with teachers were also cited as effects of these behaviors in boarding schools though the former was more common among female students than their male counterparts. A few teachers (18.75%) believed that involvement in the abnormal illness behaviors could precipitate high student turnover from the secondary schools.

Management of the abnormal illness behaviors

The study sought to find out the methods or techniques used by teachers in managing these behaviors. When teachers were asked to mention whether they looked for evidence of both physical and mental disorders in the students, 15 of them said they did while one did not respond to the item. This is a good position since it helps distinguish between genuine cases of illness and those of abnormal illness behaviors. The following methods were mentioned as being the main ones used to deal with these problems: counseling or behavioral therapy in

helping the students to give up the inappropriate behaviors and replace them with normal ones and the use of structured rehabilitation programmes (62.5%). This has potential for success as opined by Williams (1993). According to him, rehabilitation programs have succeeded in the management of abnormal illnesses especially on individuals with hysterical symptoms.

A few teachers (2) mentioned that they used cognitive therapy to change the students' inappropriate attitudes and perceptions towards the self. Some teachers (25%) preferred to suspend the students as a way of discouraging them from involvement in these behaviors while others (43.75%) simply ignored these behaviors, especially hysteria and malingering. This might be effective in the management of the abnormal illness behaviors since it denies the student the attention that is required for the propagation of the abnormal illness behaviors. Threat of punishment or suspension was also used to discourage students from engaging in these behaviors. Only one teacher mentioned that she had referred a female student to a psychiatrist for medical attention.

Conclusion

The study has shown that the abnormal illness behaviors of different types are in our boarding secondary schools and for sure they have far-reaching effects, especially in academic performance. A multi-dimensional attack is required in dealing with this problem. The study recommends that in order for these abnormal illness behaviors to be managed effectively and brought to an end, the entire family should be actively involved in the process of management. The parents should ignore such behaviors and give their children no room at home when they are supposed to be in school.

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