Patterns of help-seeking behaviour for toddlers from two contrasting socio-economic groups: new evidence on a neglected topic

Adrian Edwards and Roisin Pill


**Objective.** This descriptive study aimed to assess patterns in help-seeking behaviour for common childhood symptoms.

**Method.** Clinic attenders aged 9–18 months of two child health clinics on Tyneside, UK, one with substantial economic deprivation, were studied. Outcome measures were parental reporting of common symptoms, utilization of professional advice and general practitioner records of consultations.

**Results.** Children in the affluent area had had fewer general practitioner consultations (mean 7.3) than those in the poorer area (mean 15.1; 95% CI for difference 4.3–11.4). They were less likely to present with an episode of diarrhoea or cold but were as likely as the poorer group to present with fever. Behaviour problems were reported less frequently (23% versus 47%), but if present, this was far more likely to result in help seeking than in the poorer group (86% versus 33%; P < 0.05).

**Conclusions.** Variations in help-seeking behaviour between two economically contrasting groups were identified; this has implications for clinical understanding and service provision in primary care.

**Keyword.** Help-seeking behaviour.

**Introduction**

The general practice literature contains many descriptions of the contribution of acute minor illness to general practice workload, and the opportunities to modify patients’ help-seeking behaviour associated with these problems.¹ A social class gradient in utilization of care has been established² and incorporated into calculations of workload and adjustment of reimbursements accordingly.² Studies of ‘use in relation to need’ give mixed results as to whether help is sought more frequently by higher or lower social classes.³

Much of the literature is quite dated now, however, and despite the importance and impact of help-seeking behaviour on everyday practice there has been little ongoing research in this area. A search of recent literature specifically concerning children revealed consultation data only, with little attention to help-seeking behaviour. Recent experience suggests that norms of help-seeking behaviour may be changing with development of societal attitudes and expectations of health care,⁴ and for this reason we assessed whether important differences in help-seeking behaviour persist and may have evolved. A fuller understanding of these patterns is important both to clinicians and for planning future service provision.

We identified patterns of utilization of services for young children in two socio-economically distinct communities in Tyneside, one with marked economic deprivation, and the other more advantaged. We examined differences between these polar groups, but did not attempt to describe help-seeking behaviour for the general population of toddlers. In the UK parents often have a choice of taking their children either to general practice or Health Authority clinics for child health surveillance (CHS). Since the 1990 new Contract for general practitioners (GPs), the shift from Health Authority to general practice provision of CHS has increased.

We accessed the two groups of children via the Health Authority clinics in the areas, rather than by GP clinic,
to provide a wider representation of GPs in the study. Twenty-eight GPs cared for the 67 children in the study, 12 in the poorer Group 1 children, 16 in the more affluent Group 2. Health visitor records were not included in the study. This large number of GPs reduces the likelihood of bias from individual GPs’ behaviour, although it cannot eliminate the risk of bias from the group of GPs in the deprived area behaving differently to those in the more affluent area.

The study did not seek to examine differences between clinic attenders and non-attenders. Non-attenders at both clinics may be more disadvantaged and show different patterns of health and help-seeking behaviour. This is likely to be most evident in the disadvantaged area. It is not clear whether Health Authority clinic populations are representative of all children in general: it is likely that this varies with local availability of these clinics and general practice-based child health clinics. The study groups, however, would be expected to give a valid indication of differences in both illness and utilization of care, and hence 'use in relation to need' in these advantaged and disadvantaged groups.

Method

Two groups of child development clinic attenders were studied by means of a questionnaire given to mothers for completion. The questions were derived from the minor illness subsection of a larger questionnaire being used to assess children with 'failure to thrive'.

All attending children aged between 9 and 18 months were eligible for the study. Thirty-four mothers in the poorer Group 1 completed the questionnaire; these results were compared with those of 33 mothers from the more affluent Group 2. This constituted a 10% non-randomly selected sample of all those registered at the clinics, this being a comprehensive population list for each clinic. The consultation rate did not differ significantly according to family size. The rates for both groups exceed national figures from 1991 to 1992 (4.49 per person per year). The wider age range (0–4 weeks (February–April) in both clinics.

The questionnaire identified parental reporting of children’s minor illnesses and non-feeding behaviour problems (e.g. sleep problems, tantrums, etc.). The consequent utilization of professional help (by GP, health visitor, etc.) was explored. The questionnaire focused on specific minor illnesses and symptoms: colds, fever, ear infections, and diarrhoea. Symptoms were specified in the questionnaire, as follows:

- cold: a runny nose and at least mildly unwell;
- diarrhoea: motions more frequent and more fluid than usual for at least 1 day;
- fever: increase in body temperature and at least slightly unwell, lasting more than an hour.

To avoid problems of recall and sequencing over time only the most recent episode of each specific symptom was explored. These symptoms could have been either distinct illness episodes or coincident. A larger number of illness episodes or greater time span would be likely to result in greater inaccuracy.

Information about the frequency of consultations to general practice and the prescription of drugs was drawn from the GP records for each individual child. Consultations were classified also according to the primary symptom or problem documented in the GP record. 'Physical' symptom consultations were defined as those with colds, ear infections, diarrhoea, asthma or fever as the primary documented problem. The GP-derived information was used to validate certain elements of the parental questionnaire (e.g. recall of symptom presentation and prescription of medication). We did not attempt, however, to gauge whether the report of ‘behavioural’ or physical problems represented valid and reliable documentation of illness—rather the emphasis was on accepting parental perception of that illness, and exploring the consequent help-seeking behaviour.

Statistical analysis with Epi Info 6 used chi-square and t-tests to examine differences between the groups of children.

Results

The answers to 34 questionnaires from the poorer Group 1 and 33 from the more affluent Group 2 were available for analysis. Adequate completion of individual questions varied from 85 to 100%. Children in Group 1 were older (14.2 months versus 12.4 months in Group 2; \( P < 0.05 \)) and from larger families (mean number of siblings 1.44 versus 0.63 in Group 2; \( P < 0.05 \)). Group 1 showed, as expected, considerably more economic disadvantage with only 9% home-ownership, 32% car-ownership, and 74% unemployment, compared with Group 2 in which there was 85% home-ownership, 79% car-ownership and 15% unemployment. With these clear socio-economic differences confirmed, the minor illness and symptom pattern was examined.

Consultation rates

Consultation rates and GP prescribing for the two groups of children are shown in Table 1. A difference between the groups as large as this is unlikely to be explained simply by the age differences (2 months), and thus reflects a true difference in utilization of GP services. The consultation rate did not differ significantly according to family size. The rates for both groups exceed national figures from 1991 to 1992 (4.49 per person per year). The wider age range (0–4
Help-seeking behaviour

TABLE 1 Differences in GP records

<table>
<thead>
<tr>
<th>Statistical</th>
<th>95% CI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>Group 2</td>
</tr>
<tr>
<td>No. of GP</td>
<td></td>
</tr>
<tr>
<td>consultations recorded (mean)</td>
<td>15.1</td>
</tr>
<tr>
<td>No. of GP</td>
<td></td>
</tr>
<tr>
<td>prescriptions recorded (mean)</td>
<td>13.3</td>
</tr>
</tbody>
</table>

* Confidence interval for difference.

years) of the national figures largely explains their lower rates, as within this age group new episode rates are highest in the first 2 years.8

Behaviour problems

Table 2 shows differences in reported behaviour problems and help-seeking behaviour between Groups 1 and 2. The difference for behaviour problems was not statistically significant, but the difference in utilization of professional help (e.g. from GP or health visitor) was significant: those in the more affluent Group 2 were much more likely to seek help. All seven reported behaviour problems in Group 2 related to sleep problems. Amongst the 15 children in Group 1, 10 were reported to have sleep problems, seven problems with tantrums, and one described as aggressive (one with all three).

Parents reported that the health visitor was the usual source of advice for behaviour problems (9 out of 11 from parental questionnaires). Implied confirmation of this came from the finding that only one child was noted in GP records to have had consultations for a behavioural problem. Despite this there was still a striking difference in use of GP services within the more affluent Group 2, according to the presence or absence of reported behaviour problems (Table 3). Children reported to have behavioural problems were presenting more frequently with other ‘physical’ complaints (colds, ear infections, diarrhoea, asthma and fever).

The difference between Groups 1 and 2 did not seem to be a result of the older age-group in Group 1, as similar proportions were shown when examining only those children aged 1 year or less. Behaviour problems were less common in families with two children (3 out of 22) than either one-child families (12 out of 24) or larger families (7 out of 18; P < 0.05).

Infections

Excluding those who reported never having suffered from the relevant symptoms, the proportions who sought advice (from any professional) during their last illness episodes are shown in Table 4.

For each of these symptoms help was sought from the GP in over 88% of episodes. The remainder was made up by the child health clinic, hospital or health visitor. Twelve per cent reported seeking help from more than one professional source. With the majority in both groups attending only the GP for advice, the large difference in consultation rates between the groups described earlier does not appear attributable to help seeking from another source (e.g. health visitor).
The significance attached to fever by both extensive self-management of problems before seeking perceived then they were very likely to present, both groups compared with other symptoms of infection or health visitor, but if a behaviour problem was they were more likely to manage an episode of diarrhoea or a cold themselves, and not present to doctor on frequent attenders to explore (and modify) their help-seeking behaviour for different problems, and this has implications for primary care services. Parents may assess illness episodes in their children through behavioural changes: the more frequent reporting of behaviour problems in the poorer Group 1 could be explained by more physical illness episodes in that group. Hannay, however, identified a ‘symptom iceberg’ for presentation of childhood behavioural problems (though the study included all ages of children), with 60% not presenting, 20% using informal resources, and 20% presenting for professional advice. These findings are similar to Group 1, suggesting that parents have been reporting more consistent problems than just the temporary changes that would be observed with illness episodes. In this study labelling a child’s behaviour as a ‘problem’ by Group 1 was not necessarily translated into action, but (the affluent) Group 2 appeared much more willing to seek help.

Early research identified socio-economic differences in help-seeking behaviour patterns, but little work has been undertaken recently to increase this understanding. This study suggests that important differences persist. Further research is needed to clarify current variations between socio-economic groups. This would assist planning of service provision, and adjustments for deprivation indices. Further evidence of unmet need, especially so in poorer areas, would be relevant to discussions regarding, for example, the allocation of health visitor resources to such areas.

Practitioners can make use of this data by focusing on frequent attenders to explore (and modify) their help-seeking behaviour. Childhood ‘behavioural problems’ may be likely but often not considered in consultations: the apparent behaviour and the reasons for it can also be usefully explored.

Acknowledgements
The Parkin Project, Newcastle upon Tyne, is studying the effects of an intervention programme for children

Data consistency
Consultation data from diarrhoeal illness showed internal consistency when comparing parental answers and GP records. The numbers who reported not presenting with the last diarrhoeal illness (7 and 12 in Groups 1 and 2 respectively) were the same as the numbers with no recorded prescriptions for diarrhoea in GP records, and similar to the numbers with no recorded consultations (6 and 11). Although the parental answers only relate to the last illness episode the consistency of the answers suggests accurate recall.

Data on the number of recorded ear infections treated with antibiotics was also used to assess validity of parental reports (Table 5). This shows a trend towards more prescriptions noted for more episodes recalled by parents, and also suggests a degree of validity in the data.

Table 5 GP records and parental recall of number of ear infections requiring treatment

<table>
<thead>
<tr>
<th>Episodes requiring treatment (parental recall)</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP recorded prescriptions (mean)</td>
<td>0.7</td>
<td>1.6</td>
<td>1.0</td>
<td>2.3</td>
<td>2.0</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Discussion
This study explored the help-seeking behaviour relating to common childhood problems in two very different communities. The differences between the two social groups may have been maximized by studying an age group which presents most frequently of all ages to general practice, but the implications for workload and clinical management are significant. The methodology did not permit a comparison of the frequency of symptoms between the groups, but within each group some understanding of the likelihood of seeking professional advice for a given problem was possible.

In the poorer Group 1 a perceived behaviour problem was less likely to be presented to professionals in primary care, but a diarrhoeal illness or cold was more likely to result in consultation. Utilization of services by the more affluent Group 2 was quite the opposite: they were more likely to manage an episode of diarrhoea or a cold themselves, and not present to doctor or health visitor, but if a behaviour problem was perceived they were very likely to present, both with this and with apparently ‘organic’ problems too.

These results are consistent with descriptions of extensive self-management of problems before seeking help. The significance attached to fever by both groups compared with other symptoms of infection is also consistent with evidence of cultural beliefs about aetiology affecting management.

The curious finding that behaviour problems were described less commonly in families with two children than in larger or smaller families suggests that some problems have more to do with perceptions than a ‘true diagnostic label’. The observed differences in utilization of primary care, both for this and for ‘organic’ symptoms, may derive more from illness behaviour than actual morbidity. Whether or not the label of behavioural or physical problems would be confirmed by a professional, however, the evidence is that parents have perceived a difficulty in their particular circumstances at that time. They have translated this into a variety of responses, with a spectrum of help-seeking behaviour for different problems, and this has implications for primary care services.

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with Failure to Thrive. Part of its assessment includes gathering information on common illnesses, and this methodology was replicated in this study. We are grateful also for the assistance given to this study by North Tyneside Health Visitors, GPs and Dr Neela Shabde, Consultant Community Paediatrician, and contribution to the analysis and report from Professor NCH Stott.

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