Is there a Relationship between Tolerance and the Healthcare Seeking Behaviours of Jamaicans?

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Abstract

Tolerance plays an important role in one's opinion, behaviour, and choices. This research was piloted by 3 objectives:1) To investigate if there is a direct correlation between tolerance and attitude toward seeking health care, 2) To determine the tolerance levels of Jamaicans, and 3) To determine the type of health care preference of Jamaicans and why they seek that health care. A quantitative correlational research design was employed to examine the research topic. The population was selected using a convenience sampling (non-probability sampling). A questionnaire was developed using a web-based instrument consisting of 24 closed ended questions, of which 14 were items incorporated from the Distress Tolerance Scale by Simons & Gaher (2005). It was used to measure the tolerance level of the sampled respondents. A Likert scale was used to measure each question that ranged from strongly disagree to strongly agree. The researchers utilized social media platforms such as Whatsapp, Instagram, and Facebook to disseminate the link to the survey questions with details to Jamaican males and females 18 years and older across the 14 parishes of Jamaica. The period of data collection was between September 24, 2021 and November 22, 2021. The data was stored and retrieved from Google forms. IBM Statistical Packaging for Social Sciences (SPSS) Windows version 25.0 was then used to analyze the data collected, presenting them in the form of percentages, diagrammatic representations (pie and bar charts) and frequency tables. The findings have shown that 84.11% of the sampled respondents prefer traditional healthcare, whereas 15.89% prefer non-traditional health care. 4.0% have a low tolerance level, 36.2% have a moderate tolerance level, 52.2% tolerance level is high while 7.6% have a very high tolerance level. The findings revealed that

there is a relationship between the two aforementioned variables (χ^2 critical = 9.348< χ^2 calculated 14.251, df=3 with 5% (0.025), P=0.003). Based on the finding the χ^2 calculated (14.64) is more than the critical value 9.348. Therefore, we reject the null hypothesis which states there is no relationship between tolerance and healthcare seeking behaviours among Jamaicans. In conclusion, tolerance and health seeking behaviors are two variables that are closely linked. This plays an important role in a nation's health status, behaviour, choices and opinions about one's health which contributes to maintaining of good health.

Keywords: Tolerance, Health seeking behaviour, Health belief model, distress tolerance scale.

Introduction

"Health behaviours shape health and well-being in individuals and populations" (Short & Mollborn, (2015). Health is a comprehensive concept that encompasses all social and biological aspects of life (Latunji & Akinyemi, 2018). Healthcare seeking behaviour (HSB) has been defined as any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy (Latunji & Akinyemi, 2018). Latunji & Akinyemi (2018), proposed that "Health seeking behaviour is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health. Those observable actions and mental events that relate to health restoration, maintenance or improvement can be divided into three categories according to (Glanz et al., 2015). These include: 1) Preventative behaviours, 2) Behaviours taken with a perceived illness, and 3) Activities done while actually being sick.

Consequently, behaviours deemed inappropriate have been linked to a devastation of health outcomes increasing mortality and morbidity. One study found that respondents believe that provision of good service is the reason for their choice of healthcare (Nadiri & Hussain, 2016). Erslani (2014), defined tolerance as the ability to endure anything, be it physical, chemical, or psychological. It may include the ability to endure stressful situations, encumbrance, pain and or pressure without being harmed (Erslani, 2014). Researchers postulated that factors such as socio-demographic subjects such as age, marital status, level of education and socioeconomic status influences the health seeking behaviours of individuals (Latunji & Akinyemi, 2018). Despite these factors having such an impact, it was hypothesized that there is a relationship between tolerance and the health seeking behaviours among Jamaicans.

Hence, to establish the validity of this hypothesis, this study is piloted by 3 main objectives:

1. To investigate if there is a direct correlation to tolerance and attitude towards seeking healthcare,
2. To determine the tolerance level of Jamaicans,
3. To determine the type of healthcare preference of Jamaicans and why they seek that type of healthcare. The study was guided by "Health Belief Model" as a theoretical framework to determine if there is a relationship between health seeking behaviour and tolerance.

Conclusively, substantial suffering, premature mortality and medical costs can all be avoided by positive practicing models and theories in health seeking behaviours can dictate methods to prevent relapse and recommended practices, especially to those who present with multiple risk factors for chronic illnesses. Along with these models and theories proposed are a plethora of disciplinary influences that dominate the change seen in health seeking behaviours over time. However, it is important to note that these practices and theories are not independent of each other, but rather coexist.

Literature Review

This study seeks to examine if there is a relationship between tolerance and health seeking behaviours among Jamaicans. According to Latunji & Akinyemi (2018), inappropriate health seeking behaviours have led to an increase in morbidity and mortality rates. The authors define appropriate health seeking behaviours as consultations with qualified medical personnel and health care facilities such as clinics, primary health care and general hospitals whereas inappropriate health seeking behaviours are those that involve care from traditional healers, patent medicine vendors or doing nothing at all. The study found that marital status, age, socioeconomic status, family size is among the factors that influence health seeking behaviours of many persons (Latunji & Akinyemi, 2018). It was also discovered that the performance of formal health care systems can influence health seeking behaviours. These include: accessibility to facilities, availability of drugs, quality of care, attitude of health care workers and affordability of medical expenses. Of the 246 sampled respondents, 62.2% accounted for visits being sought at hospitals and clinics which was deduced to be the most common healthcare pursued. 33.3% visited chemists and traditional healers (Latunji & Akinyemi, 2018).

Good delivery service was considered one of the most important factors affecting healthcare seeking behaviour and represented 34.5% of the participants. Availability accounted for 7.1% whilst 20.5% accounted for affordability of healthcare (Latunji & Akinyemi, 2018). Muriithi (2013), conducted a study in Kenya to discover the determinants of health seeking behaviour. His study revealed that most people preferred to seek care at alternative health facilities rather than those in close proximity to them such as government owned institutions (Muriithi, 2013). It was found that many individuals who sought health care at government facilities had or faced no difficulties with the availability of drugs. Lack of adequate health information was identified as a determinant that was closely associated with variation and utilization of certain types of healthcare (Muriithi, 2013). "Healthcare seeking behaviour has been suggested as a mediator of healthcare utilization" (Clewley et al., 2018).

A study conducted about the facilitators and the barriers of health care seeking behaviours among Filipino migrants revealed that participants reported that clean, peaceful surroundings contribute to good health and were reported as facilitators of health seeking behaviours. In this study, the majority of the responses, which accounted for 485 participants, reported that lack of personal items, time, and long working hours as barriers to health care seeking behaviours (Maneze et al., 2015). Other than the many factors that have an influence on an individual's decision to seek health care, tolerance is considered another key factor of impact (Maneze et al., 2015). According to Brown et al 2005 & Leyro et al 2010, distress tolerance reflects an individual's

perceived or actual ability to withstand negative effects. "Persons with low levels of distress tolerance may be particularly prone to pursuits of negative reinforcements to avoid or reduce distressing states." (Leyro et al., 2010).

A study conducted by Nadiri & Hussain (2016) explores services of healthcare facilities that may cause a person to be more tolerant while seeking healthcare. His research revealed that the quality of services offered at health care facilities has an impact on the tolerance of patients who visit hospitals in North Cyprus (Nadiri & Hussain, 2016). "It has been established that healthcare seeking behaviour has a strong influence on health status, morbidity and mortality of a society" (Usman et al., 2020).

The health belief model is a social psychological health behaviour change model that was developed to help predict health related behaviours particularly as it regards the uptake of health services. This model hypothesizes six constructs that predict health behaviours. These include: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (McArthur et al., 2018). An individual's perception about their likelihood to contract or not contract a disease, how severe this condition can affect them and how they can benefit from treatment may impact their tolerance to seek assistance at health facilities. Being knowledgeable and having the ability to effectively utilize healthy behaviours can encourage or discourage one to seek healthcare.

Theoretical framework

The study is anchored from the theoretical support of the Health Belief Model. The Health Belief Model (HBM) was developed in the 1950's by social psychologists Hochbaum, Rosenstock and others. The Health Belief Model is a theoretical model that can be used to guide health promotion and disease prevention programs. It is used to explain and predict individual changes in health behaviours. It is one of the most widely used models for understanding health behaviours (Seyed Mohammad Mehdi et al., 2014). The Health Belief Model (HBM) posits that seven constructs predict health behaviour: risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy, and cues to action and modifying factors.

The Health Belief Model
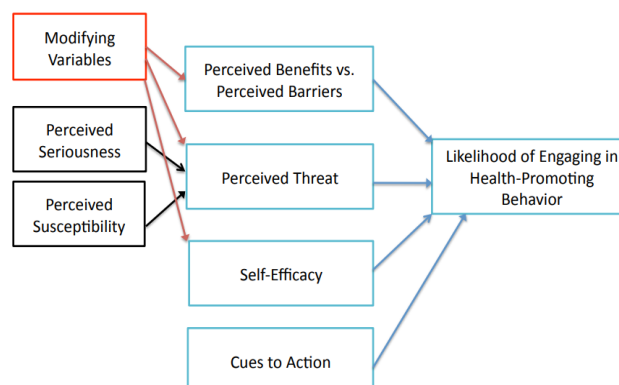
Source: ("File: The Health Belief Model.pdf - Wikimedia Commons", 2021)

Figure 1.The Health belief Model and its Constructs

Perceived susceptibility: If persons believe they are susceptible to contracting a disease, or any health condition their tolerance level may be heightened to accommodate preventative measures such as regular exercise, controlling their diet and frequent visits to the doctor. On the other hand, if persons believe that they are not susceptible, they will not seek medical attention promptly, or they may be less tolerable to commit to preventative measures that may be perceived as invasive.

Perceived severity: Conceding that a health condition is perceived as a serious and fatal condition, people will be more likely to endure unfavorable conditions to get the necessary help they think they need. Contrary to this, if people downplay the seriousness of a health condition, they may not tolerate any unfavourable conditions.

Perceived benefits: A person may enquire "will the use of condom, being faithful to my partner or abstaining from sex really helps me to prevent getting infected with HIV?" If the person is assured that practicing 'safe sex' actually works, they will be more likely to practice them (Katatsky, 1977). Conversely, if one has any reason to doubt that practicing 'safe sex' is effective in preventing HIV infection, then one may be less likely to practice them. This may be caused by hearing about others who get infected despite the fact. Perceived barriers: Where there are too many inconveniences involved in performing positive healthcare seeking behaviours, Jamaicans may not like performing them. Maneze (2015) postulated that, Cultural beliefs and practices could be a barrier to health-seeking behaviour. Also, (Glanz 2015) posits that, the rapid emergence of new communication technologies such as E-health and new models of use for older technologies, also provide new opportunities and dilemmas in healthcare seeking behaviour. As a result, these perceived barriers may affect their tolerance level and discourage individuals from practicing different medical regimens or health promotion.

Perception of self-efficacy: It should be noted that one's belief in their ability to actually implement the required preventive or curative action as needed can influence their tolerance towards a health seeking behaviour. If they believe that they are capable, the more their self-efficacy and the more they are likely to succeed. Whereas, a person doubts their ability to implement any health seeking behaviour as needed, they will be less likely to practice them. Lack of knowledge and experience in different health seeking behaviours can diminish a person's self-efficacy. Cues to action: Cues to action are needed at the right time to encourage the person to exercise healthy behaviours. Frequent health campaign adverts on radio, television and billboards in the community could be powerful cues to action to increase tolerance level and promote healthy behaviours.

Modifying factors: Modifying factors include demographic, biographic and economic factors that can enhance or diminish the likelihood of Jamaicans seeking healthcare or the type of healthcare sought. Factors that can enhance or decrease tolerance are economic status, gender and even religion.

Method and Materials

A quantitative correlational research design was employed to examine if there is a relationship between tolerance and health seeking behaviours among Jamaicans. The population was selected

using a convenience sampling (non-probability sampling). Using Jamaica's estimated population size as of 2019, 2,734,092 ("STATIN", 2021), at a 95% confidence level and a 3% margin of error, the calculated sample size is 1,068 participants given the formula:

Sample size $= (Z\ score)^2 \times Std\ Dev \times 1\text{-}StdDev)/ (margin\ of\ error)^2$

$= (1.96)^2 \times 0.5\ (1\text{-}0.5)/ (0.03)^2$

$= 0.9604/9$

$= 1067.11$

The period of data collection was between September 24, 2021 and November 22, 2021. The sampled population included both males and females 18 years and older, who reside in all 14 parishes across Jamaica. A research team was formed and assigned to all the parishes across the island.

A survey was developed using a web based standardized data instrument consisting of 24 closed ended questions, of which 14 were items incorporated from the Distress Tolerance Scale by Simons and Gaher (2005). This scale is an instrument that is specifically aimed at measuring the perceived capacity to tolerate distress from a multidimensional framework (Leyro et al, 2010). It was used to measure the tolerance level of the sampled respondents. Each item was answered on a Likert scale that ranged from strongly disagree to strongly agree (Leyro et al, 2010).

To ensure confidentiality and anonymity, participants were not required to share any personal identifiers such as their names or email addresses. Participants were informed that upon submission of the survey, consent was given to utilize the data collected. The researchers utilized platforms such as Whatsapp, Instagram and Facebook to disseminate the link to the survey questions with details as well as face to face interactions. The inclusion-exclusion criterion was being a Jamaican and living in Jamaica at the time of the survey. The survey was design to excluded people who are non-Jamaicans and not living in Jamaica at the time of the survey.

The data was stored and retrieved from Google forms. IBM Statistical Packaging for Social Sciences (SPSS) was used to analyze the data collected. The data was then presented in form of percentages, diagrammatic representation (pie and bar charts) and frequency tables. Pearson's correlation was calculated using SPSS to determine the relationship between the aforementioned variables, tolerance (independent variable) and health care seeking behaviours (dependent variable).

Distress Tolerance Scale

The instrument consists of 14 items. These include: Feeling distress or upset is unbearable to me, When I feel distressed or upset, all I can think about is how bad I feel, I can't handle feeling distressed or upset, My feelings of distress are so intense that they completely take over, There's nothing worse than feeling distressed or upset, I can tolerate being distressed or upset as well as other people, My feelings of distress and upset are not acceptable, I'll do anything to avoid feeling distressed or upset, Other people seem to be able to tolerate being distressed or upset

better than I can, Being distressed or upset is always a major ordeal for me, I am ashamed of myself when I feel distressed or upset, My feelings of distress or being upset scares me, I'll do anything to stop feeling distressed or upset, When I feel distressed, I cannot help but concentrate on how bad the distress actually feels (Simons and Gaher 2005). Likert scale (5=*Strongly disagree* to 1=*Strongly agree*), with higher scores corresponding to greater levels of distress tolerance (Leyro et al, 2010).

Before the researchers employed the distress tolerance scale exploratory factor analysis was used on the 14 items scale. The Cronbach alpha for the 14-item scale (Distress Tolerance Scale) equals 0.835, which means that the items were suitable for factor analysis. Furthermore, the KMO and Bartlett's test was 0.888, P< 0.0001 indicating that the 14 items are suitable and appropriate for factor analysis. Based on the factor analysis we can conclude that the 14 items scale is suitable and appropriate for assessing the distress tolerance scale among Jamaicans (See Appendix 1).

Finding

Table 1 showing demographic characteristics of the sampled respondents (n=1070). Of the sampled respondents (n=1070), the majority were females 70.4% compared to males 29.6.%, aged 18-22 years with majority 57.2%, aged 23-27 years with 15.6%, aged 28-32 years with 6.4%, aged 33-37 years with 5.1%, aged 38-42 years with 4.8%, aged 43+ years with 10.6% and the majority residing in St. James 48.9% (503). Westmoreland with 3.9% (42), Hanover with 4.8% (51), St. Elizabeth with 3.6% (39), St. Ann with 2.2% (24), St. Mary with 0.9% (10), Portland with 0.6% (6), St. Thomas with 0.9% (10), Kingston and St. Andrew with 16.4 (176), Manchester with 5.2% (56), Clarendon with 2.5 (27), St. Catherine with 5.0% (53), and Trelawny with 5% (53).

Table 1.Demographic Characteristics of sample respondents, n= (1070)

Details	% (n)
Gender	
Female	753 (70.4)
Male	29.6 (317)
Age Cohort	
18-22	57.2 (612)
23-27	15.6 (167)
28-32	6.4 (69)
33-37	5.1 (55)
38-42	4.8 (51)
43+	10.6 (116)
Parish of Residence	
St. James	48.9 (523)
Westmoreland	3.9 (42)
Hanover	4.8 (51)
St. Elizabeth	3.6 (39)

St. Ann	2.2 (24)
St. Mary	0.9 (10)
Portland	0.6 (6)
St. Thomas	0.9 (10)
Kingston and St. Andrew	16.4 (176)
Manchester	5.2 (56)
Clarendon	2.5 (27)
St. Catherine	5.0 (53)
Trelawny	5.0 (53)

Table 2 shows the reasons for traditional healthcare preference, n=1070. Majority of the respondents chose "More advanced medical technology" as their reason for utilizing traditional healthcare. This accounted for 16% (171) of the sampled respondents. 9.8% (105) reported that traditional healthcare is "More reliable than non-traditional healthcare",5.5% (59) reported that "Quality of care" was their reason for traditional healthcare preference. "Less time consuming" accounted for 1.3% (14), and lastly, "less expensive" which accounted for 1.0% (11). This question was deemed not applicable to 18.4 (197). 513 individuals failed to answer this question.

Table 2.Reasons for Traditional healthcare preference among sampled respondents, n=1070

Details	% (n)
Reasons for traditional healthcare preference	
➢ More advanced medical technology	16 (171)
➢ More reliable than non-traditional healthcare	9.8 (105)
➢ Less expensive	1.0 (11)
➢ Less time consuming	1.3 (14)
➢ Quality of care	5.5 (59)
➢ Not applicable	18.4 (197)

Table 3 depicts the reason for non-traditional healthcare preference, n=1070. The majority chose "More reliable than traditional healthcare" as their reason for non-traditional healthcare preference. This accounted for 9.1% (97) of the sampled respondents. 3.6% (39) chose "Less expensive" while 2.0% (21) chose "Less time consuming". 810 of the sampled respondents which accounts for 75.7% deemed this question not applicable. 103 people failed to answer the question.

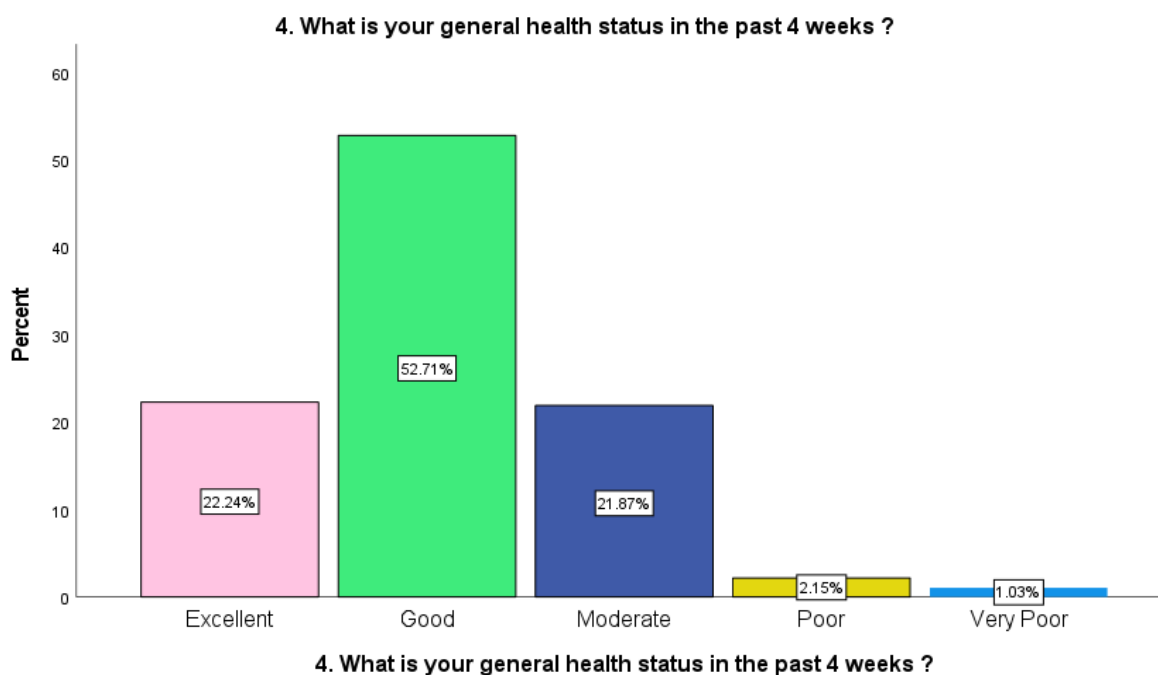**Table 3.Reasons for non-traditional healthcare preference among sampled respondents, n=1070**

Details	% (n)
Reasons for non-traditional healthcare	
➢ More reliable than traditional healthcare	9.1 (97)
➢ Less expensive	3.6 (39)
➢ Less time consuming	2.0 (21)
➢ Not applicable	75.7 (810)

Table 4.depicts the instances in which the respondents become less tolerant while seeking healthcare, n=1070

Details	% (n)
Instances one becomes less tolerant	
Long waiting hours	11.4 (122)
Inadequate resources	1.3 (14)
Attitude of healthcare professionals towards patients	3.2 (34)
Environmental conditions	0.8 (9)
Crowding	1.5 (16)
Fear of invasive procedures	1.1 (12)
N/A	4.1 (44)

Figure 1 shows the general health status of the sampled respondents, n (1070). Same reveals that 22.24% (n =168) had excellent health status in the past 4 weeks. 52.71% (n=564) reported their health status to be good. A moderate health status was reported by 234 respondents accounting for 21.87% of the sampled population. 2.15% (n=23) had a poor health status whilst 1.03% (n=11) had a very poor health status.

Figure 1.General Health status of the sampled respondents in the past 4 weeks, n=1070

Figure 2 depicts that 61.3% (n=656) sought healthcare in the last 12 months whilst 38.7% (n=414) did not seek any healthcare in the past year.
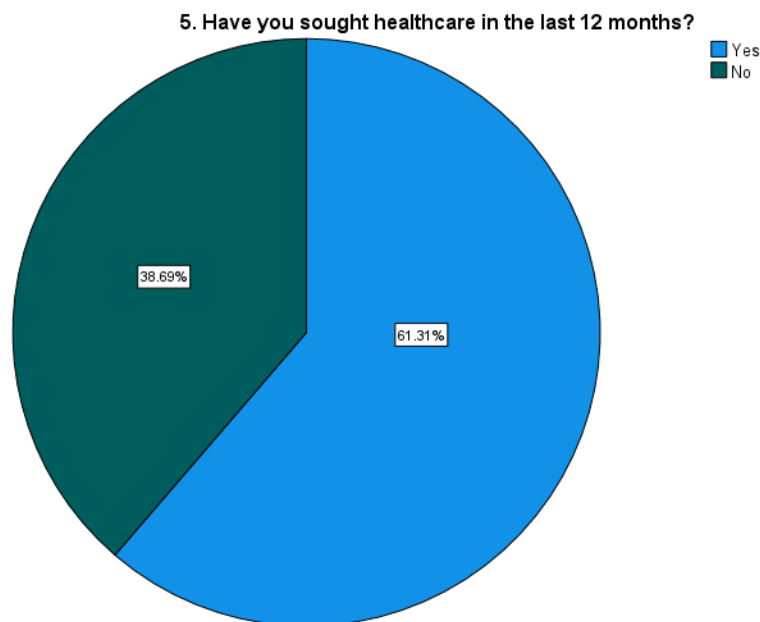
Figure 2.Healthcare in the last 12months, n=1070

Figure 3 shows that 84.11% (n=900) of the sampled respondents prefer traditional healthcare and 15.9% (n=170) rather non-traditional healthcare.
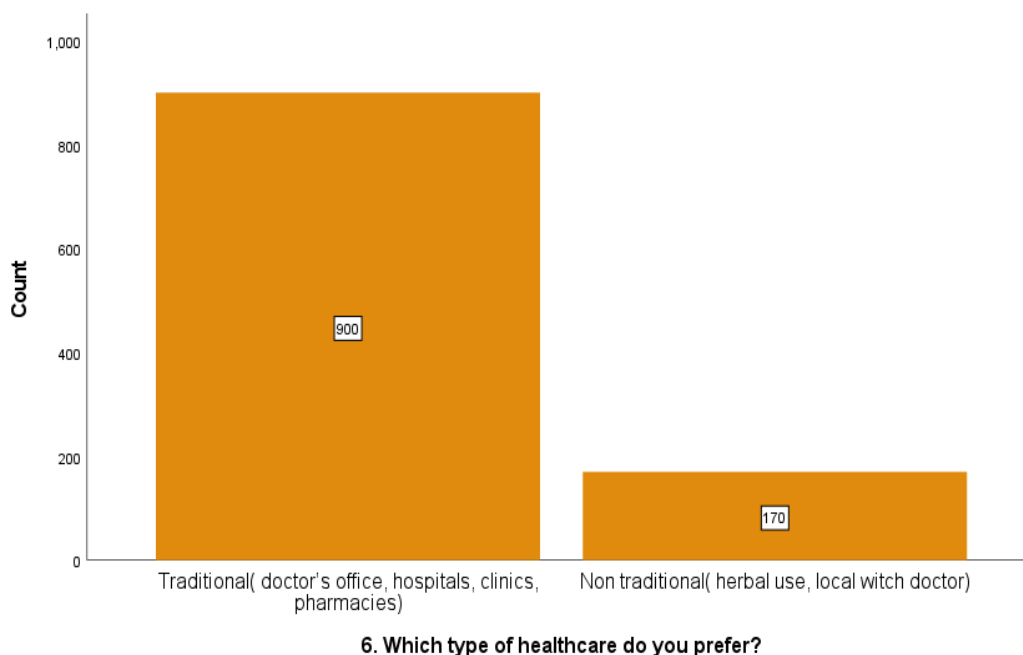

Figure 3.Healthcare preference among sampled respondents, n=1070

Figure 4 shows the perception of the level of severity which would require them to seek health care. Of the n=1070 respondents, 45.05% (482) would have to experience a moderate level of the condition, 31.68% (339) would have to experience a severe level of the condition, 16.8% (180) would have to experience a mild level of the condition, and 6.45% (69) would have to experience a very severe level of the condition.
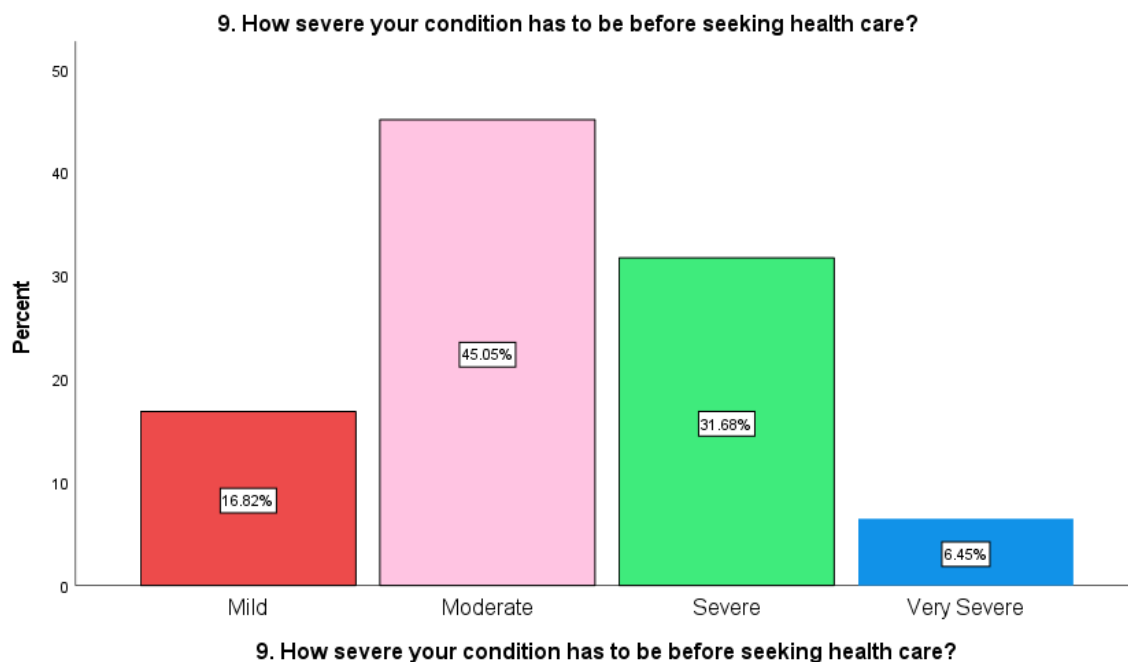
Figure 4.Perception of the severity of one condition before seeking healthcare among sampled respondents, n= 1070

Figure 5 depicts the Distress Tolerance for Jamaicans during the COVID-19 pandemic (2020-2021). Of the sampled respondents (n=1070), 97.9% were used to construct Distress Tolerance. It has been shown that 52.2% (n=547) respondents have high tolerance. 36.2% (n=379) of respondents displayed to have moderate tolerance. 7.6% (n=80) of the participants exhibit a very high tolerance. Low tolerance was observed to be 4.0% (n=42) of the respondents.
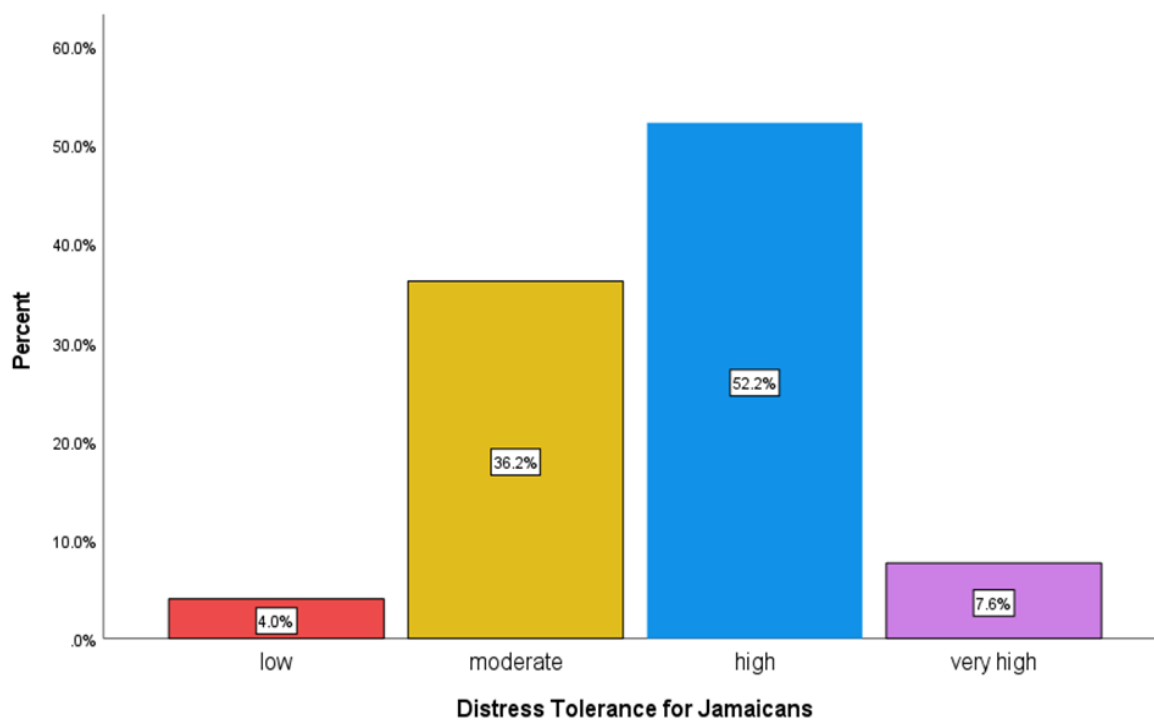
Figure 5.Distress tolerance among Jamaicans

H[1]: There is a relationship between tolerance and health seeking behaviours among Jamaicans

H[o]: There is no relationship between tolerance and health seeking behaviours among Jamaicans

Table 5 presents a Cross Tabulation between Distress Tolerance Stress and Healthcare seeking behaviours. The findings revealed that there is a relationship between the two aforementioned variables (χ^2critical = 9.348< χ^2calculated 14.251, df=3 with 5% (0.025), P=0.003). Based on the finding the χ^2 calculated (14.64) is more than the critical value 9.348. Therefore, we reject the null hypothesis which states there is no relationship between tolerance and healthcare seeking behaviours among Jamaicans.

Table 5. Cross tabulation between Seeking healthcare in the last 12months and Distress tolerance among Jamaicans

Details	Distress Tolerance for Jamaicans				Total
	Low	Moderate	High	Very high	Total
	% (n)	% (n)	% (n)	% (n)	% (n)
Healthcare in the last 12 months:					
Yes	45.2 (19)	59.1 (224)	61.8 (338)	77.5 (62)	61.4 (643)
No	54.8 (23)	40.9 (135)	38.2 (209)	22.5 (18)	38.6 (405)
Total	42	379	547	80	1048

Discussion

Health seeking behaviours are influenced by a variety of factors: socioeconomic conditions, age, gender, financial resources, an individual's perceived health status and illness, type of illness, as well as the availability of health services and access to them. These factors are the determinants of the tolerance level of the population (Gabrani et al., 2021). Tolerance functions by propelling and regulating the level of diversity in health care. Tolerance drives diversity by making people more accepting of different qualities. Health facilities conditions may cause an individual to be more tolerant while seeking health care (Nadiri & Hussain, 2016).

The advances in medical and pharmacological treatments have greatly lowered the mortality and morbidity rates, and also reduced the cost of medical interventions thus improving the quality of health of individuals over many decades. Despite the significant gains in prescription medicines and medical treatments, a recent article in The Atlantic conveniently disregards the above data in favor of the "triumph of new-age medicine," also known as "alternative medicine" (Sullivan, 2018). The data from the study suggests that 15.9% prefers Non-traditional healthcare which is inclusive of (herbal use, local witch doctor.), while the majority 84.1 % prefers Traditional healthcare which encompasses (Doctor's office, hospital, clinics, and pharmacies.) For the respondents who chose Traditional healthcare, their reasons varied, where 16% selected (More advanced medical technology,) 9.8%, (More reliable than non-traditional healthcare,) 1.0% Less expensive, 1.3% (Less time consuming,) 5.5% (Quality of care). The majority relies on Traditional health care because of its advanced medical technology. The respondents with non-traditional healthcare preference chose (More reliable than traditional healthcare) 9.1% for their number 1 answer. 3.6 % said (Less expensive), and 2.0% said (Less time consuming).

Based on this study, a cross-tabulation was executed between the Distress Tolerance Scale and the health care seeking behaviours of Jamaicans in the last 12 months. This is done to determine where the research hypothesis could be accepted. H^1: There is a relationship between tolerance and health-seeking behaviour. The findings revealed that there is a relationship between the two aforementioned variables (χ^2 critical value= 9.348 < χ^2 obtained value 14.251, P= 0.003, and a degree of freedom = 3). Based on the findings the χ^2 obtained (14.64) is more than the critical value. Therefore, we reject the null hypothesis which states there is no relationship between tolerance and healthcare-seeking behaviours among Jamaicans.

Visiting a healthcare facility is dependent on one's perception of severity. This analysis supports the theory that the majority of the sampled respondents seek healthcare when they perceive their condition as moderate, (45%). As well as 31.7% will visit when it is severe, 6.4% are willing to take the risk at very severe, and 16.8% are not taking any chances with their health in mild conditions. Similarly, BioMed Central, provides very strong evidence to indicate that more severe episodes of illness increased the likelihood of visiting a health service. Therefore, despite the fact that all indicators were associated with each other, each severity indicator was to some extent independently associated with health-seeking behaviour. These results agreed with data from Belgium which showed that patients who sought care tended to have more symptoms and a longer duration of illness (Peppa et al., 2017).

In addition, this study revealed the Distress Tolerance level of Jamaicans. Of the sampled respondents (n=1070), 97.9% were used to construct Distress Tolerance. It has been shown that 52.2% (n=547) respondents have a high tolerance. 36.2% (n=379) of respondents displayed to have moderate tolerance. 7.6% (n=80) of the participants exhibit a very high tolerance. Low tolerance was observed to be 4.0% (n=42) of the respondents. This highlights why more than half of the respondents ,54.8%, have not sought healthcare in the last 12 months. Furthermore, giving a rational explanation for their seldom visits. The burden of chronic diseases is a central point of concern. A prediction was made that in the upcoming decades, the overload of chronic diseases in Albania would be elevated due to lifestyle practices, lack of awareness of the disease, lack of the culture of prevention, and increased reliance on curative care rather than prevention of the disease (Gabrani et al., 2021). With this high distress tolerance level, there may be a detrimental and more debilitating long-term effect. The presupposition lends itself to the example where one who disregards the minor condition may very well develop into a chronic case if healthcare is not sought thus adding significant strains to the health care system.

Conclusion

The study reveals that Tolerance and Health seeking behaviours are two variables that are closely linked. This plays an important role in a nation's health status, behaviours, choices, and opinions about one's health contributing to the maintenance of good health. The study highlights that the majority of Jamaica 52.2% (n=547) have a high distress tolerance level. This fact supports the argument that there is no immediate strain on the health system, however, this may very well be the case in long-term analysis.

Therefore, the researchers suggest that future studies be done to look at the long-term effects of distress tolerance and health-seeking behaviours on the nation's health. This study provides structure and clarity and therefore can further advance and support the goal to find the most effective mix of prevention and treatment measures that makes the best use of our resources in improving health and extending life.

Attaining optimal health is now well beyond the walls of the health facilities and health outcomes can only be improved by addressing social determinants of health and by promoting personal responsibility. This challenges the traditional view of the health sector domain and only through leadership and advocacy can the goal of enhanced health and welfare be attained.

As a nation, bold decisions and choices should be made to respond to the current health needs and safeguard our future generations; a new paradigm is needed to transform health and health care delivery.

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Appendix 1: Exploratory Factor Analysis

Descriptive Statistics	Mean	SD	N
11. Feeling distress or upset is unbearable to me	3.16	1.092	1070
12. When I feel distressed or upset, all I can think about is how bad I feel.	3.33	1.075	1070
13. I can't handle feeling distressed or upset.	2.83	1.094	1070
14. My feelings of distress are so intense that they completely take over.	2.54	1.109	1070
15. There's nothing worse than feeling distressed or upset.	3.01	1.157	1070
16. I can tolerate being distressed or upset as well as most people	3.44	.904	1070
17. My feelings of distress and being upset are not acceptable	2.88	.990	1070
18. I'll do anything to avoid feeling distressed or upset	3.66	.977	1070
19. Other people seem to be able to tolerate being distressed or upset better than I can	2.88	1.053	1070
20. Being distressed or upset is always a major ordeal (very unpleasant experience for a long time) for me	3.06	1.139	1070
21. I am ashamed of myself when I feel distressed or upset	2.36	1.018	1070
22. My feelings of distress or being upset scares me	2.70	1.129	1070
23. I'll do anything to stop feeling distressed or upset	3.36	1.045	1070
24. When I feel distressed, I cannot help but concentrate on how bad the distress actually feels.	3.02	1.094	1070

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.888
Bartlett's Test of Sphericity	Approx. Chi-Square	4619.560
	df	91
	Sig.	.000

Component Matrix[a]

	Component		
	1	2	3
11. Feeling distress or upset is unbearable to me	.493	-.510	.161
12. When I feel distressed or upset, all I can think about is how bad I feel.	.676	-.199	.112
13. I can't handle feeling distressed or upset.	.664	-.384	.156
14. My feelings of distress are so intense that they completely take over.	.717	-.317	.022
15. There's nothing worse than feeling distressed or upset.	.656	.155	-.007
16. I can tolerate being distressed or upset as well as most people	-.313	.514	.079
17. My feelings of distress and being upset are not acceptable	.527	.439	-.054
18. I'll do anything to avoid feeling distressed or upset	.495	.296	.614
19. Other people seem to be able to tolerate being distressed or upset better than I can	.596	-.182	-.142
20. Being distressed or upset is always a major ordeal (very unpleasant experience for a long time) for me	.637	.300	-.152
21. I am ashamed of myself when I feel distressed or upset	.533	.201	-.586
22. My feelings of distress or being upset scares me	.627	.161	-.373
23. I'll do anything to stop feeling distressed or upset	.582	.420	.410
24. When I feel distressed, I cannot help but concentrate on how bad the distress actually feels.	.740	.021	-.043
Extraction Method: Principal Component Analysis.			
a. 3 components extracted.			

Communalities	
	Extraction
11. Feeling distress or upset is unbearable to me	.529
12. When I feel distressed or upset, all I can think about is how bad I feel.	.510
13. I can't handle feeling distressed or upset.	.613
14. My feelings of distress are so intense that they completely take over.	.615
15. There's nothing worse than feeling distressed or upset.	.454
16. I can tolerate being distressed or upset as well as most people	.369
17. My feelings of distress and being upset are not acceptable	.474
18. I'll do anything to avoid feeling distressed or upset	.709
19. Other people seem to be able to tolerate being distressed or upset better than I can	.409
20. Being distressed or upset is always a major ordeal (very unpleasant experience for a long time) for me	.519
21. I am ashamed of myself when I feel distressed or upset	.668
22. My feelings of distress or being upset scares me	.558
23. I'll do anything to stop feeling distressed or upset	.683
24. When I feel distressed, I cannot help but concentrate on how bad the distress actually feels.	.550
Extraction Method: Principal Component Analysis.	

Total Variance Explained				
Component	**Extraction Sums of Squared Loadings**			**Rotation Sums of Squared Loadings**[a]
	Total	**% of Variance**	**Cumulative %**	**Total**
1	5.031	35.935	35.935	3.895
2	1.484	10.598	46.533	3.996
3	1.146	8.183	54.716	3.22
Extraction Method: Principal Component Analysis.				
a. When components are correlated, sums of squared loadings cannot be added to obtain a total variance.				

Pattern Matrix[a]

	Component		
	1	**2**	**3**
11. Feeling distress or upset is unbearable to me	.806	-.201	-.001
12. When I feel distressed or upset, all I can think about is how bad I feel.	.552	.101	.188
13. I can't handle feeling distressed or upset.	.752	-.048	.118
14. My feelings of distress are so intense that they completely take over.	.680	.149	.040
15. There's nothing worse than feeling distressed or upset.	.141	.401	.274
16. I can tolerate being distressed or upset as well as most people	-.681	.045	.292
17. My feelings of distress and being upset are not acceptable	-.231	.540	.358
18. I'll do anything to avoid feeling distressed or upset	.032	-.230	.922
19. Other people seem to be able to tolerate being distressed or upset better than I can	.448	.330	-.076
20. Being distressed or upset is always a major ordeal (very unpleasant experience for a long time) for me	-.050	.617	.211
21. I am ashamed of myself when I feel distressed or upset	-.074	.955	-.305
22. My feelings of distress or being upset scares me	.053	.762	-.091
23. I'll do anything to stop feeling distressed or upset	-.097	.084	.820
24. When I feel distressed, I cannot help but concentrate on how bad the distress actually feels.	.318	.406	.183
Extraction Method: Principal Component Analysis. Rotation Method: Promax with Kaiser Normalization.			
a. Rotation converged in 5 iterations.			

Structure Matrix

	Component		
	1	**2**	**3**
11. Feeling distress or upset is unbearable to me	.706	.198	.233
12. When I feel distressed or upset, all I can think about is how bad I feel.	.680	.468	.467
13. I can't handle feeling distressed or upset.	.777	.383	.406
14. My feelings of distress are so intense that they completely take over.	.771	.506	.397
15. There's nothing worse than feeling distressed or upset.	.454	.608	.533
16. I can tolerate being distressed or upset as well as most people	-.537	-.147	.032
17. My feelings of distress and being upset are not acceptable	.185	.604	.532
18. I'll do anything to avoid feeling distressed or upset	.301	.246	.820
19. Other people seem to be able to tolerate being distressed or upset better than I can	.580	.514	.275
20. Being distressed or upset is always a major ordeal (very unpleasant experience for a long time) for me	.344	.698	.499
21. I am ashamed of myself when I feel distressed or upset	.273	.766	.142
22. My feelings of distress or being upset scares me	.393	.742	.311
23. I'll do anything to stop feeling distressed or upset	.284	.445	.821
24. When I feel distressed, I cannot help but concentrate on how bad the distress actually feels.	.595	.655	.518

Extraction Method: Principal Component Analysis.

Rotation Method: Promax with Kaiser Normalization.

Component Correlation Matrix

Component	**1**	**2**	**3**
1	1.000	.496	.415
2	.496	1.000	.500
3	.415	.500	1.000

Extraction Method: Principal Component Analysis.

Rotation Method: Promax with Kaiser Normalization.