

## Chapter 5 Doctor–patient interactions

### CASE STUDIES

#### Case study: 'Heart distress' in Maragheh, Iran

Good<sup>20</sup> in 1977 described an example of this type of folk illness, *narahatiye qalb* or 'heart distress' in Maragheh, Iran. This is a complex folk illness that usually manifests itself in physical symptoms, such as trembling, fluttering or pounding of the heart, and feelings of anxiety or unhappiness, also associated with the heart ('my heart is uneasy'). This illness is 'a complex which includes and links together both physical sensations of abnormality in the heartbeat and feelings of anxiety, sadness, or anger'. The abnormal heartbeat is linked both to unpleasant affective states and to experiences of social stress. It is more frequent among Iranian women, and expresses some of the

strains and conflicts of their lives. 'Heart distress' often follows quarrels or conflict within the family, the deaths of close relatives, pregnancy, childbirth, infertility and the use of the contraceptive pill (which is seen as a threat to fertility and lactation). It is primarily a self-labelled folk illness that expresses a wide range of physical, psychological and social problems at the same time. The label 'heart distress' is an image that draws together a network of symbols, situations, motives, feelings and stresses that are rooted in the structural setting in which the people of Maragheh live. The basic presentation of this illness, however, is in the form of common physical symptoms associated with the heart.

#### Case study: 'Sinking heart' among Punjabis in Bedford, UK

Krause<sup>21</sup> in 1989 described a similar syndrome among both Hindu and Sikh Punjabis living in Bedford, England. The image of *dil ghirda hai* ('sinking heart') links together physical sensation, emotions and certain social experiences into one illness complex, which has specific meanings for the community. 'Sinking heart' – certain physical sensations in the chest – can happen repeatedly to the same individual, and may eventually result in heart 'weakness', heart attacks or even death. Among its many causes are: excessive heat from food or climate or from excessive emotions (such as anger) that make the body 'hot'; other emotional states such as shame, pride, arrogance or worry about one's fate, which are all seen as evidence of self-centredness; and

hunger, exhaustion, old age and poverty, which all make people 'weak' and therefore unable to fulfil their moral obligations and may in turn result in worry and sadness. 'Sinking heart' is thus especially linked to 'a profound fear of social failure', and to cultural values that stress the importance of carrying out social obligations, being able to control one's personal emotions, being altruistic and not too worried and self-absorbed and, for men, being able to control the sexuality of their female relatives. Failure in any of these – for example, being unable to prevent the disrespectful and promiscuous behaviour of one's daughters – may result in a loss of *izzat* (honour or respect) in the community, and in *dil ghirda hai*. Like many folk illnesses, therefore, the syndrome blends together physical, emotional and social experiences into a single image or metaphor.

#### Case study: 'hyper-tension' in Seattle, USA

Blumhagen's study<sup>54</sup> in 1980, carried out in Seattle at the Veterans' Administration Medical Center, was on patients suffering from hypertension. He discovered a lay EM (explanatory model), held by many of the patients about their condition, termed 'hypertension'. The majority saw their condition as arising from stress or tension in their daily lives – hence *hyper-tension*. In 49 per cent of the sample, chronic external stresses such as overwork, unemployment, 'life's stresses and strains' and certain occupations were blamed for the condition; 14 per cent blamed chronic internal stress, such as psychological, interpersonal or family problems. Fifty-six per cent of the total sample thought

that the condition could be precipitated by acute stress, such as anxiety, excitement or anger. In this model, 'hypertension' is characterized by subjective symptoms such as nervousness, fear, anxiety, worry, anger, upset, tenseness, overactivity, exhaustion and excitement. It is brought on by stress, which makes the individual susceptible to becoming 'hyper-tense'. In many cases, patients did not perceive that 'hyper-tension' was the same as high blood pressure, since their model emphasized the psychosocial origin and manifestations of the condition. A smaller number saw 'hyper-tension' as resulting from hereditary or physical factors, such as excess salt, water or fatty foods. Overall, though, 72 per cent believed that hypertension is 'a

physical reflection of past social and environmental stressors, which are exacerbated by current stressful situations', and this allowed them to withdraw from familial, social or work

obligations – which they saw as sources of tension. They also labelled themselves as 'hyper-tense', even in the absence of medical evidence for hypertension.

### Case study: 'colds', 'chills' and 'fevers' in London, UK

The author's own research,<sup>55,56</sup> dealt with a set of commonly held beliefs about 'colds', 'chills' and 'fevers' held by people living in a London suburb, and how these have changed from the 1970s to the present day. In the late 1970s, 'Nature' was seen as a potential cause of disease. 'Colds' and 'chills' were caused by the penetration of the natural environment (particularly areas of cold or damp) across the boundary of skin and into the human body. In general, damp or rain (cold/wet environments) caused cold/wet conditions in the body, such as a 'runny nose' or a 'cold in the head', while cold winds or draughts (cold/dry environments) caused cold/dry conditions, such as a feeling of cold, shivering and muscular aches. Once they entered the body, these cold forces could move from place to place – from a 'head cold', for example, to a 'chest cold'. 'Chills' occurred mainly below the belt ('a bladder chill', 'a chill on the kidneys', 'a stomach chill'), and colds above it ('a head cold', 'a cold in the sinuses', 'a cold in the chest'). These conditions were caused by careless behaviour, by putting oneself in a position of risk *vis-à-vis* the natural environment – for example, by 'walking barefoot on a cold floor', 'washing your hair when you don't feel well' or 'sitting in a draught after a hot bath'. Temperatures intermediate between hot and cold; where the former gave way to the latter, such as going outdoors after a hot bath, or autumn, where hot summer is giving way to cold winter, were specially conducive to 'catching cold'. Because colds and chills were brought about primarily by one's own behaviour, they provoked little sympathy among other people; individuals were often expected to treat themselves by rest in a warm bed, eating warm food ('feed a cold, starve a fever') and drinking hot drinks.

By contrast, 'fevers' were caused by invisible beings called 'germs', 'bugs' or 'viruses', which penetrate the body through its orifices (mouth, nose, ears, anus, urethra and nostrils) and then cause a raised temperature and other symptoms. The causative agents were conceived of as unseen, amoral, malign entities, which existed in and among people, and which traveled between people through the air. Germ infection was therefore an inherent risk of all social relationships. Some of these germs, such as 'tummy bugs', were thought of as almost insect-like, though of a very small size. Germs also had 'personalities' of symptoms and signs, which revealed themselves over time ('I've got that germ, doctor, you know – the one that gives you the dry cough and the

watery eyes'). Unlike with colds, the victims of a fever were blameless, and could mobilize a caring community around themselves. The germs responsible for these conditions could be flushed out by fluids (such as cough medicines), starved out by avoiding food or killed in the body by antibiotics, though in the latter case no differentiation is made between 'viruses' and 'germs'. These lay beliefs about the colds/chills/fevers range of illnesses could thus affect behaviour, self-medication and attitudes towards medical treatment in both adults and children.

Since the 1970s, the model has changed considerably.<sup>56</sup> Although in 2003 these beliefs were still held among many older people, there has been a significant shift in how younger people explain these minor respiratory infections. The two sets of opposites in the original 'feed a cold, starve a fever model' – colds, Nature, and self-blame on one side and fevers, social relationships ('Society') and innocence on the other – have now synthesized into a single, composite model. Now Nature is seen not as a source of infection, but as a positive, health-giving force – and one that is under threat from our modern, industrialized lifestyle. This shift is evident in the new vocabulary of 'natural' or 'organic' as positive qualities, especially in foods and in types of healing. It is now Society – that is, other people – that is now seen as potentially dangerous to the individual, and as a source of ill-health. Blaming illness on 'germs' from other people, rather than on the natural world, has now spread to cover almost all the common colds and chills (as well as fevers), as well as many other conditions. The effect of this shift is to make the ill people feel less guilty for their illness, and see themselves instead as the blameless victim of some external force. This shift in perception also matches several other ways that young people now increasingly blame their misfortunes on others, such as their parents, their teachers, their spouses, their employers, or the state. 'Colds' and 'chills' have thus become a much more *social* concept, an image which seems to express an underlying anxiety about the dangers inherent in all human relationships – especially in the over-crowded cities, apartment blocks, trains and subways of modern life.

Furthermore, this metaphor of invisible 'infection' from others causing illness and misfortune is increasingly used to explain many of the *other* aspects of modern life over which people feel they have no control (a cultural phenomenon I call 'germism').<sup>57</sup> Civil unrest, crime, inflation, terrorism, divorce are now often described in the media as reaching 'epidemic proportions', as if

they were somehow caused by invisible, capricious pathogens, outside of their victims' control. Despite all the modern empha-

sis on individuality and autonomy, this passive model of misfortune seems often to apply at the individual level as well.<sup>5</sup>

### Case study: illness without disease, London, UK

Balint<sup>79</sup> described the case of Mr U, aged 35 years, a skilled workman who was partly disabled as a result of having contracted polio in childhood. Nevertheless, he had managed to work, 'over-compensating his physical shortcomings by high efficiency'. One day he received a severe electric shock at work and was knocked unconscious; no organic damage was found at the hospital, and he was discharged. He then consulted his family doctor for pains in all parts of his body, which were getting worse and worse, and he 'thought that something had happened to him through the

electric shock'. Despite exhaustive tests, no physical abnormality was found, but Mr U still experienced his symptoms: 'They seem to think I am imagining things: I know what I've got'. He still definitely felt ill and wanted to know what condition he could have causing all these pains. Despite more hospital tests that were negative, he still felt himself to be ill. In Balint's view, he was 'proposing an illness' to the doctor, but this was consistently rejected; the doctor's emphasis was not on the patient's pains, anxieties, fears and hopes for sympathy and understanding, but on the exclusion of an underlying physical abnormality.