Chat task 3: Patient beliefs about illness

Patients sometimes hold beliefs that are based on folk or alternative theories of health and illness. These beliefs can affect the way that patients respond to your questioning, advice or treatment.

Aim

To raise awareness of common patient beliefs about illness, especially in the UK, and to help the development of strategies to deal with them.

Preparation

Read the cases of folk beliefs in different communities in the UK. As you read them, consider the following questions:

1. Do the beliefs described in these cases also exist in your country?
2. Can you think of (other) folk beliefs that are commonly held in your country?
3. How do the patients' explanations of their illness differ from the medical explanation?
4. How can you overcome the differences between the folk and medical explanations without losing the patient's trust?

Case 1: **Causes of diabetes among British Bangladeshis living in London**

A study of health beliefs about the causality of Diabetes amongst showed that the illness was generally contributed to events or agents outside the body rather than primary failure of an organ within it. All interviewed patients believed that the primary cause of diabetes, and that of poor diabetic control, was too much sugar and only to a lesser extent other features of a Western diet. Other aetiological factors mentioned were heredity (an agent transmitted through "shared blood" rather than predisposition) germs, and physical or psychological stress. In practice, obesity is often attributed to "gland problems" rather than over nutrition; often, moderately overweight people claim to have heavy bones.

Case 2[1]: **'Sinking heart' among Punjabis in Bedford, UK.**

[A] syndrome among both Hindu and Sikh Punjabis living in Bedford, England. The image of *dil ghirdal hai* ('sinking heart') links together physical sensations, 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 – which 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.

[1] Taken from Helman, C.G. (2001) Culture, health and illness, 4th Ed. London:Arnold

Case 3[2]: **'Colds', 'chills' and 'fevers' in London, UK**

... 'Colds' and 'chills' are 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) cause 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) cause cold/dry conditions, such as a feeling of cold, shivering and muscular aches. Once they enter the body, these cold forces can move from place to place – from a 'head cold', for example, down to a 'chest cold'. 'Chills' occur 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 are 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 … are specially conducive to 'catching cold'. Because colds and chills are brought about primarily by one's own behaviour, they provoke little sympathy among other people; individuals are 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' are caused by invisible beings called 'germs', 'bugs' or 'viruses', which penetrate the body by its orifices … and then cause a raised temperature and other symptoms. The causative agents are conceived of as unseen, amoral, malign entities, which exist in and among people, and which travel between people through the air. Some, like 'tummy bugs', are thought of as almost insect-like, though of a very small size … Unlike with colds, the victims of a fever are blameless, and can mobilize a caring community around themselves. the germs responsible for these conditions can 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 can affect behaviour, self-medication and attitudes towards medical treatment in both adults and children.

Chat session tasks

Task 1: Share some experiences of folk or alternative beliefs about health that are common in your country.

Task 2: Discuss and come up with ways that you can deal with these beliefs in such a way that you do not lose the patient's trust.

[2] Taken from Helman, C.G. (2001) Culture, health and illness, 4th Ed. London:Arnold