

# **Rival Truths**

Common Sense and Social Psychological  
Explanations in Health and Illness

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# 1

## Introduction and Overview

The first aim of this chapter is briefly to introduce the key concepts and perspectives that underpin the chapters that follow. Its second aim is to explain their overall purpose and structure. In the first section “common sense” is defined, and the relationship between common sense and a particular way of thinking about health and illness, known as the “medical model”, is discussed. In the second section four common sense views of health and illness based on the medical model are identified and challenged, in order to outline four of the main purposes of this book. In the third section the biopsychosocial model of health and illness is introduced. As its name suggests, social psychological influences play an important role in this model. Their importance justifies the social psychological bases of this book. In the fourth section the focus is on social psychology itself. From the diversity of approaches in social psychology, four levels of analysis will be described in order to explain both the order of chapters and the emphasis of their content.

### 1. Common Sense and the Medical Model

To state the obvious, human beings have physical bodies. By means of our bodies we move around in our world and interact with others. Our bodies influence how others perceive and interact with us and how we feel and think about ourselves. Indeed, our very survival as individuals depends upon the survival of our physical bodies. Most of us rejoice when we feel fit and healthy; most of us fear threatening pathological processes when we feel ill. The importance of the physical reality of our bodies is common sense in our society.

The *Oxford English Dictionary* defines “common sense” in two relevant ways, which focus on individuals and communities respectively. In the first, common sense is “the endowment of natural intelligence possessed by rational beings; ordinary, normal or average understanding; the plain wisdom which is everyman’s [sic] inheritance;” or “more emphatically, good, sound practical sense; combined tact and readiness in dealing with the everyday affairs of life; general sagacity” and “ordinary or untutored perception”. In the second definition, common sense is defined as “the general sense, feeling or judgement of mankind [sic] or a community”.

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In the chapters that follow, “common sense” will be used in both of these senses. Most often, a common sense view will be described in order to identify a familiar, rational starting point for theorising about an issue of health or illness. In these cases, the term will simply reflect the views of friends, acquaintances, students, media, or myself. These will be taken to reflect an everyday understanding of the issue. Occasionally, (particularly in Chapter 6) the term “common sense” will be used in the second sense, in which case it will more formally describe empirical studies of lay beliefs.

There is an interesting paradox inherent in the nature of common sense views of health and illness: healers who can relieve suffering and postpone death acquire power, wealth, and status in most societies (Stainton Rogers, 1991). Furthermore, within each society, one system of healing generally develops an official status, which gives it precedence over the others. In Britain (as well as most Western and many other countries) biomedicine is the healing system that enjoys this status (Helman, 2000). Medical professionals not only control access to many resources, but also have the power to construct public knowledge about health and illness. The result is that medicalised clichés and ways of seeing the world are often taken for granted as common sense (Bartlett, 1998; Stainton Rogers, 1991).

For example, Cornwell (1984) interviewed 15 women and 9 men in the East End of London in order to gather common sense ideas about health and illness. She found that their theories seemed (or tried) to be medical in form and content. Prefixes such as “They [i.e. doctors] say” frequently showed a deference to medical authority and there was a general acceptance that health is a matter for experts. A glance at current media paints a similar picture. Terms such as “road rage”, “stress”, “premenstrual syndrome”, and “false memory syndrome” sound like medical problems that people have. In turn, this gives the impression that it is they, as opposed to their social experiences or circumstances, that require treatment. A similar, but funnier, example is the representation of liking to be fed chocolate by a handsome man as a menstrual symptom! (See Figure 1.1 and Section 2.4, below, where the example will be developed along more critical lines.) My argument is that common sense, or what everybody “knows” already about health and illness, has been medicalised. Therefore, it is appropriate briefly to describe the key characteristics of the medical model.

The medical model is based on scientific rationality which emphasises objective reality, precise measurement, and the elucidation of cause–effect laws, generally by means of hypothesis testing and experimentation (Helman, 2000; Still, 1996b). Since the scientific attitude is that individual opinions are unlikely to be objective because of interpretative bias, the interpretations of scientists are backed up by data which are open to public scrutiny and which can be (dis)confirmed by others. The assumption is that scientific explanations describe reality and therefore, have the authority of “truth” (Devalle, 1996).

The essence of the medical model is a scientific paradigm within which abnormalities of the structure and function of body organs and systems can be identified and named (Helman, 2000). Although there is an acknowledgement

# PERIOD PEACE

## the results



**You, him and your period. How do blokes react to it?**  
Our national survey reveals all...

### ALL BECAUSE THE LADY LOVES...

Chocololics, move to Scotland this minute. We asked what happened when you'd eaten the last bit of chocolate in the house, then burst into tears. Nearly 60% of Scots girls reported that their brilliant boyfriends would rush straight out for more chocolate – 10% more than average. But sadly nearly half the blokes just say patronisingly, 'you've got PMT', and Irish guys in particular should take some hints from the Scots.

**Your boss, your lover, your dad... In our July issue, Company and Feminax asked how these**

FIGURE 1.1 Craving chocolate can be represented as a menstrual symptom caused by hormones.  
Article from *Company* with permission.

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that appearances can mask it, it is assumed that an underlying reality exists and can be discovered. However, the knowledge and methods by which this can be achieved stand in contrast to common sense because they have to be taught over a long period to a carefully selected group of hard-working and intellectually gifted individuals.

One of the great strengths of the medical model is its foundation in accumulated knowledge of clinical facts and general laws concerning the cause, course, and treatment of disease. Since this knowledge is untouched by the vagaries of individual experience, it is possible to make accurate estimates of the incidence and severity of a given disease. In populations these take the form of morbidity and mortality rates. Knowledge of these characteristics allow (for example) communities to be compared and resources to be diverted where they are most needed. In individuals, diagnosis confirms the incidence of a disease, and in the case of breast cancer, for example, “staging” is a way of representing its severity; T1 describes tumours of 2 centimetres or less, T2 tumours are 2–5 centimetres; T3 tumours are over 5 centimetres; and T4 tumours are fixed to the chest wall or skin, and can be of any size (Clark, 1991). Knowledge of a patient’s stage at diagnosis means that her treatment plan can be guided by accumulated wisdom.

However, this approach tends to result in the disease, as opposed to the patient becoming the focus of attention. Moreover, the disease and its “personality” become reified (Baron, 1985):

In general, modern medicine takes disease to be an anatomicopathologic fact. We tend to see illness as an objective entity that is located somewhere anatomically or that perturbs a defined physiologic process. In a profound sense, we say that such an entity “is” the disease, thus taking illness from the universe of experience and moving it to a location in the physical world. We use object words to describe illness—lesion, tumour, infiltrate and rely on pathologists reviewing diseased tissue to define disease for us.

As an example, Baron notes that comprehensive nosographies of the 18th and 19th centuries did not include peptic ulcer as a disease, but rather included a variety of symptoms and situations that would probably come under that label today. It was not until the 1830s that peptic ulcer was “born” as a disease entity, when “it” was observed as an objective finding at post-mortem that was thought to correlate with patients’ symptoms. Thus, the disease was defined by anatomical fact, as opposed to experienced symptoms.

Similarly, treatment based on the medical model employs the discourse of biological reductionism because it focuses on micro-level biological events. This has led to a “factor analytic” approach, in which it is assumed that one factor may be treated, while others remain constant (Engel, 1980). Helman (2000) neatly caricatures the approach with the phrase “spare-part surgery”, which suggests that analogous to car repairs, components of people may be replaced, without psychological and social implications.

To summarise, the gist of the medical model is captured in four common sense assumptions: “the facts are the facts”; “given time and resources, science will accumulate a full understanding of the facts about disease”; “medical advances offer the most effective way to combat disease”; “medical treatment is the best remedy for ill people”.

Recently a great many challenges to the medical model have been articulated (e.g. Engel, 1980; Taylor, 1995). Just four, which directly address the above assumptions, will be developed.

## **2. Four Challenges to Common Sense, Biomedical Ways of Thinking about Health and Illness**

### *2.1 The facts are the facts*

The phrase, “the facts are the facts” represents the common sense idea that objective, publicly verifiable biological facts are what matters in health and disease. However, the presence of a potentially serious disease can be of surprisingly little consequence, because it is frequently impossible to pinpoint its onset. For example, breast cancer is likely to have been caused by events 20 to 40 years before its onset, and once begun, it can take up to 16 years for a breast tumour to grow large enough to be detected (Clark, 1991). Such a state of affairs not only undermines the validity of morbidity rates, since the “true” incidence of disease is likely to be unknown, but it also shows that psychological experiences and management of disease can be more important than its presence or absence.

One of the strongest challenges to the phrase, “the facts are the facts” is to be found in a study of the interpersonal dynamics within a family of four (Minuchin, 1974). In the family, there were two daughters who were both diabetic and the study was carried out in an attempt to understand why the elder of the two appeared to suffer much more; for example, experiencing many emergency hospital admissions. During the study, the levels of free fatty acid in the bloodstreams of family members were continuously measured. These provided a measure of stress, because free fatty acid is liberated from body tissues and carried by the blood to the liver, to be converted into energy for flight or fight during stress reactions (e.g., Cassidy, 1999). In phase one of the study, the parents were interviewed while the two daughters, aged 17 and 15, were watching from behind a one-way mirror and the free fatty acid levels in both daughters rose, even though they were only observing from a different room. After an hour, the daughters were invited to join the parents and their free fatty acid levels rose further. Those of the older daughter however, rose almost twice as much and after the session they remained raised for over an hour whereas those of the younger daughter quickly returned to normal. Minuchin (1974) observed that each parent appealed for support to the older, but not the younger, daughter during disagreements. He reasoned that she experienced stress as a result of conflicting loyalties, and that the stress exacerbated her disease.

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Minuchin's (1974) study shows that disease processes are not determined by physical facts alone. On the contrary, it suggests that the social world permeates the physical boundaries of humans and that different personal experiences lead to different anticipations of a common physical world so that the same objective facts cause different biological events.

Further intriguing examples of the interaction between social meanings and biological events are case studies of "Voodoo Death" (Cannon, 1942). In one, a young man was invited to a feast and given chicken. He was assured that it was not wild hen, which was a taboo food for him, so he ate it. Much later, he discovered that it was in fact wild hen. He "immediately began to tremble", returned to his lodgings and died.

Without denying the importance of biological facts, I believe that a tight focus on them is frequently misleading in the quest to understand health and illness. It is one purpose of this book to challenge the primacy of biological facts by tracing the permeability of human biology to social psychological meanings and influences.

### ***2.2 Given time and resources, science will accumulate a full understanding of the facts about disease***

Helman (2000) identifies an increasing public conviction that biomedicine is failing to solve health problems. Since lack of resources is seen as its cause, the common sense solution is to increase funding and Health Minister Dobson, for example, announced an additional £40bn for UK Health and Education Budgets in July 1998, in order to pay for an extra 7000 doctors and 15,000 nurses. Extra funding for the National Health Service was set at £60bn in the first budget of the new millennium. In the USA, healthcare services have been estimated to consume 11% of US Gross National Product (GNP) (Taylor, 1995) and at least one long-term projection identifies the year 2055 as a kind of Armageddon for modern medicine. This is because 2055 is the year in which healthcare costs in the US are expected to reach 100% of GNP (Sheridan & Radmacher, 1992).

Such figures suggest that resources to fund scientific understanding of disease cannot continue to grow steadily in the future. Irrespective of whether resources and progress are positively correlated, the related assumption—that there has been steady growth in the past—may also be challenged. This is the common sense idea that the medical model stands on a smooth accumulation of truths about our biology. Moreover, since these truths are objective, the idea is that they are impervious to fashion and bias (Lupton, 1994). This assumption may be challenged by historical analyses, which reveal that the medical model evolved out of its social context. According to Beattie and Jones (1992) an important reason for its emergence was the Reformation in the 16th century, which had the effect of reducing the church's power to police ideas and prevent practices such as carrying out post-mortems. A second reason was colonialism and the growth of capitalism, which together helped to change the view of the position of humans in the universe. As part of this

movement, scientists began to suggest that the world was rational and mechanistic and that there was a split between divine intelligence and the mechanical body. Subsequently, “the sick man” [sic] with his idiosyncratic symptoms disappeared from Europe and a new hospital-based medicine led to a focus on objectively defined diseases, diseased organs, and impersonal cases. Furthermore, these changes were supported by many other events, including the invention of the microscope and medical instruments such as forceps (Jewson, 1976).

Interestingly, Armstrong (1983) argues that human bodies had been seen as undifferentiated flesh before this time and it was changes in attitudes and beliefs, as opposed to a gradual accumulation of facts, that led to the recognition of specific organs. These only became visible once scientists “knew” them to be there. Such analyses suggest that the medical model is a way of thinking, which is socially constructed like other ways of thinking. It also suggests that the idea that truth has been steadily accumulated is part of that construction.

Without denying the reality and importance of medical advances, a second purpose of this book is to argue that the beliefs and practices of medical practitioners as well as lay people often reflect social constructions even though common sense assumes they are based on science and/or objective reality. I hope that social psychological analyses of beliefs and practices might help to encourage the development of new ways to enhance health status that do not depend on medical breakthroughs (and which might be quick, effective, and cheap!).

### ***2.3 Medical advances offer the most effective way to combat disease***

Perhaps the most important common sense assumption beneath a medical approach to health and illness is that it offers the most effective way to combat disease. This assumption may be challenged because there is no guarantee that advances in understanding, preventing, or treating a disease effectively reduce its incidence.

To illustrate, McKeown (1979) famously plotted the annual incidence of various acute diseases in the UK. Figures showed that marked and steady declines had begun in the mid-19th century and correlated with improvements in sanitation, housing, and other social changes. To focus on TB, a key medical breakthrough in the mid-20th century was the BCG vaccination, but this barely makes a “blip” in the already downward trend.

Whereas acute diseases such as pneumonia, ‘flu, and TB were the most virulent causes of death at the turn of the century, First World citizens at the dawn of the third millennium are likely to fall victim to cardiovascular diseases or cancer (e.g., Taylor, 1995). Since their incidence depends greatly on human behaviour, Becker (1976, cited in Stroebe & Stroebe, 1995) argues provocatively that most, if not all deaths from these are “suicides”, in the sense that they could have been postponed, had the victims adopted healthier lifestyles. Salovey, Rothman, and Rodin (1998) cite American statistics that vividly illustrate the point. If Americans stopped smoking, there would be a 25% reduction in cancer deaths and 350,000 fewer fatal

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heart attacks each year, and a 10% weight loss would decrease coronary artery disease by 20%.

Without denying the effectiveness of medical advances, a third purpose of this book is to challenge the assumption that they are always the most effective way to combat disease. It will be argued that changes in beliefs or behaviours might be essential to their success or even more effective in their own right. Moreover, it will be argued that relevant changes might also need to occur in the beliefs and behaviours of medical practitioners and politicians, since as well as being suicides, some premature deaths might be manslaughter!

### *2.4 Medical treatment is the best remedy for ill people*

A famous memoir is that of a doctor who was captured during the Second World War and put in charge of medical care for his fellow prisoners (Cochrane, 1971). Although he had virtually no medicine, to his surprise, most of his patients made a full recovery.

This story is only a weak challenge to the assumption that medical treatment is the best remedy for ill (or injured) people because, of course, the patients might have recovered better if they had been treated. Statistical analyses of British childbirths (Tew, 1990) present a stronger and more distressing challenge. First, Tew notes that the two exceptions to the fall in mortality rates during the 1870s were women and babies. Still more bizarre, records kept by lying-in charities during the mid-19th century showed that maternal death rates among urban poor, who were often half-starved and diseased, were frequently less than those of better-off patients who were attended by male accoucheurs with the latest instrumental interventions. Next, Tew (1990) cites an analysis carried out by the Registrar General for the years 1930–32 which revealed an “unexpected advantage of being poor”: the maternal mortality rate for classes I and II was 4.44 per 1000 whereas for social class V, it was 3.89. For all causes of death except abortion and post-partum haemorrhage, it was the relatively advantaged mothers who were more likely to die. In particular, the increased risk of dying from puerperal sepsis as a result of less hygienic living conditions, lower fitness, and poorer nutrition was “apparently more than offset by reduced risk as a result of fewer contacts with doctors”. Ironically, the reduction in maternal mortality that heralded current times was not achieved through a better understanding of obstetric medicine, but through the introduction in 1936 of drugs that enabled iatrogenic infections to be treated.

Tew (1990) continues that the years 1964–1975, which are the only ones for which data were published, show that maternal deaths were significantly higher for mothers booked for hospital delivery (.190 as opposed to .165 per 1000). Clearly, it might be that hospital figures were inflated by the inclusion of more high-risk cases, but figures dealing separately with these groups show the same pattern. This and a corpus of further evidence suggests that obstetric intervention only rarely

improves on the natural process, yet by the 1980s most of the world had accepted as common sense that birth should be planned and controlled by medical experts. In Britain, hardly 1% of births occur in the family home, which previously had been the traditional birthing place.

Tew (1990) develops the critical argument that medical intervention is responsible for *decreasing* the well-being of a majority of women during childbirth. She describes dreadful cases from the 19th century in which practitioners deliberately and unnecessarily used dangerous instruments to hasten birth in order to save time, impress the family, and justify a higher fee. She also condemns the apparent contemporary imperviousness of the obstetric profession to evidence that discredits its practices and philosophy. Finally, she notes that the increasing hospitalisation of birth advocated by doctors for the benefit of mothers and babies also resulted in a competitive advantage, which reduced the status of midwives and confirmed the ascendancy of male-dominated medical obstetricians.

Such critical analyses challenge the idea that medical treatment is the best remedy for ill people and raise questions about the “real” beneficiaries of medical treatments. Frequently they reveal a fallacious representation of social norms as laws of nature. This diverts attention away from the changeability of social conditions and towards the treatment of individuals who do not conform. The net result is maintenance of the status quo, and this might be of more benefit to high-status doctors than to their patients (Sapsford & Dallos, 1996). A striking illustration is *draeptomainia*, a disease of Negro slaves. Its main symptom was trying to escape, its causes included over-indulgent treatment, and its treatment included punishment (Jones, 1997; Stainton Rogers, 1991). To return to the example of childbirth, a critical analysis questions why normal, well women become patients, and why, only a generation ago, they were given treatments such as enemas and had their pubic hair shaved “for their own good”.

It is the fourth purpose of this book to attempt some critical analyses. The aim is not to accuse medical professionals of deliberate attempts to impose their explanations upon the public in order to advance themselves. Although issues related to power always lie at the heart of health debates (Beattie & Jones, 1992), personal blame of (powerful) scientists is rarely appropriate because most believe themselves neutral and objective. Second, lay people often adopt medicalised common sense ideas about health, which are to their own disadvantage (Sapsford & Dallos, 1996). Rather than to blame, my aim is to help raise awareness that the root of health problems might sometimes lie outside patients’ biology and inside social arrangements. To the extent that patients endorse and accept these arrangements, they are holding beliefs that justify the system and militate against improvements in their own health status. However, it need not be so. Large-scale social change or perhaps a small-scale change in personal beliefs or self-concept might provide a therapy to promote health and alleviate handicap.

### 3. Introduction to the Biopsychosocial Model

To help answer challenges to the medical model, Engel (1980) suggested a biopsychosocial model of health and illness in which, as its name makes clear, biological, psychological, and social factors are all-important determinants of health and illness. The model, which is shown in Figure 1.2, accommodates the common sense observation that nature is ordered in hierarchies, with simpler systems nested within more complex ones.

In the model, two main hierarchies may be distinguished, with the person at the highest level of the organismic hierarchy and simultaneously at the lowest level of the social hierarchy. The constituent systems of the person are the focus of the biomedical model, but in the biopsychosocial model, the person is not considered in isolation. Rather, “hospital”, “school”, “family” and so on represent social systems in which s/he is nested, and category labels like “patient”, “pupil”, “mother” and so on describe the person’s role in such systems. Although each system has distinctive qualities and demands its own level of study and explanation, its stability is maintained not only by its internal dynamics, but also by those of the systems above and below it. In other words, the systems transact such that disruption of one level can change other systems. Moreover, resultant changes can feed back to affect the original disruption of the first system.

To contrast biomedical and biopsychosocial approaches to illness, a seminal paper (Engel, 1980) describes the case of a man who has suffered a threatened heart attack, been admitted to hospital, is stabilising and feeling better. Unfortunately,

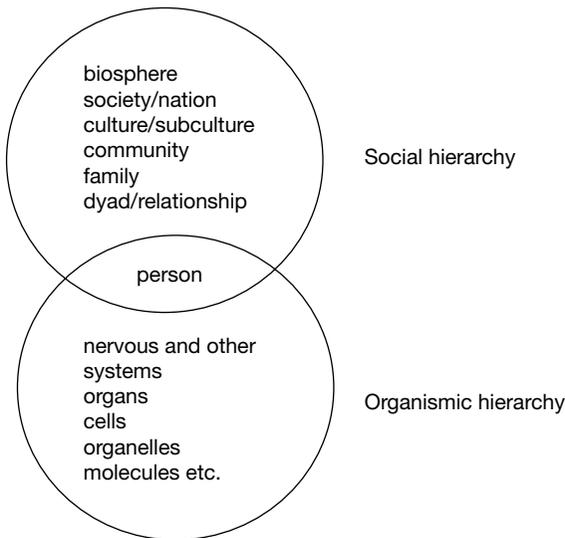


FIGURE 1.2 Systems of the biopsychosocial model (after Engel, 1977, 1980).

Casualty staff have difficulty in administering an injection and after several attempts, they leave the patient and go for advice. While he is alone, he suffers a cardiac arrest about 30 minutes after he was admitted.

An evaluation based on a medical perspective focuses on changes in the organ system, and attributes the cause of the cardiac arrest to initial myocardial injury. This leads to congratulating the patient on his good luck, because he might not have survived if he had been admitted half an hour later. An evaluation based on the biopsychosocial model however, focuses on the interplay between systems, and questions whether the cardiac arrest would have happened at all had the man not been admitted and stressed by his experiences. In this latter evaluation, the “trouble” was located in systems outside the heart.

It follows that the “critical flaw” (Engel, 1980) of the biomedical model, is that it under-represents what it is to be a person. Thus, unlike the medical model, the biopsychosocial model poses no clear boundaries to mark the end of the individual and no exclusive emphasis on physical factors. On the contrary, psychosocial systems not only present additional sources of information for the understanding of the individual’s health and illness, but also present additional loci for intervention.

In order to build a more detailed impression of the systems that “constitute” a human and his or her ecology, the nature of the two hierarchies of the biopsychosocial model, and the way they interact need further elaboration. Stevens (1996a) identifies three dimensions that help to characterise what it means to be a person, which usefully suggest more about systems below the level of the person in the biopsychosocial approach. These are depicted in Table 1.1.

Stevens (1996a) notes the importance of emotions in characterising human experience and points out that their causes and precise nature might sometimes be unconscious. In addition, he emphasises the importance of conscious experience and argues that to be a person is to be aware not only of the world around us, but also of a multiplicity of inner worlds. Beyond that, humans are aware that they (and others) are aware. Third, he points out that to be a person involves experiencing oneself as a coherent entity in time, with a continuous past, present, and future. Moreover, people construct consistent, unifying narratives, although events themselves might be haphazard and aspects of the self fragmented. Emotions, cognitions and awareness, and the active construction of narratives provide examples of systems within people and offer alternatives to common sense sites

TABLE 1.1 *Five aspects of being human (after Stevens, 1996a)*

---

*To be a human involves:*

---

Having a physical body  
 Living in a social context  
 Sometimes being unconscious of reasons for personal actions  
 Living in a private world of experience  
 A sense of existing continuously for a finite time

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such as organs and other biological systems, in terms of which both “trouble” and positive influences for an individual’s health status may be conceptualised.

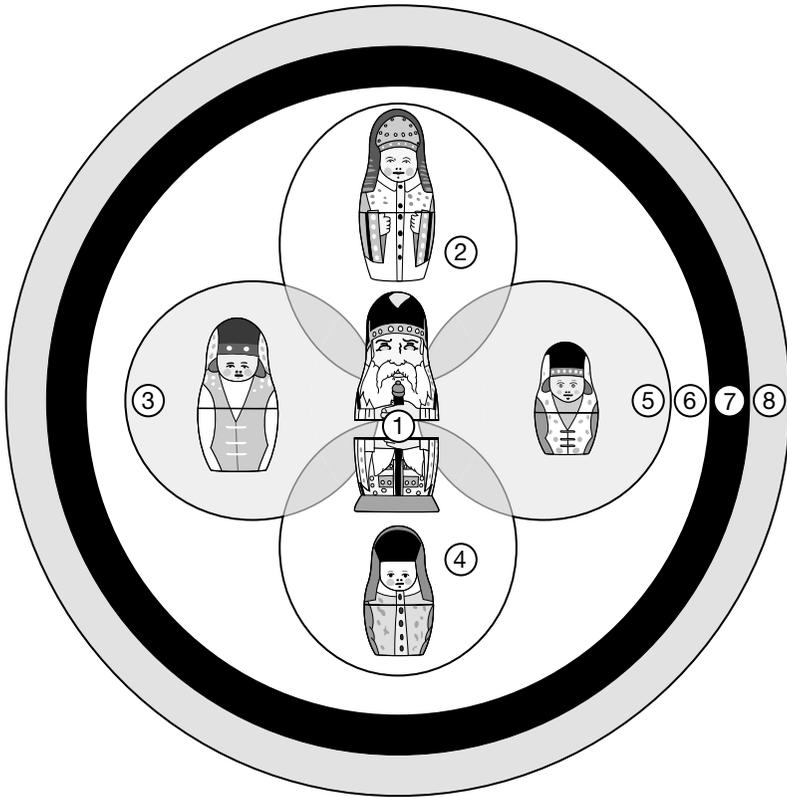
To turn to the hierarchy above the level of the person, common sense conceptualisations include “hospital”, “school”, “family”, “community”, and “culture”, which exist physically in the real world, and which can be operationalised. For example, someone who has an “extended family” may be compared with a member of a “nuclear family” or people from different cultures might be contrasted with each other. However, such operationalisation is vague about the ways in which the human ecology is internalised, that is, how it gets under our skins.

Bronfenbrenner’s (1979) ecological model of human development helps to clarify this issue. The model is broadly similar to Engel’s (1980) biopsychosocial approach but the crucial difference is Bronfenbrenner’s insistence on the importance of the way individuals perceive the systems in which they are nested, rather than on the importance of the systems *per se*. This means that the environment is filtered through the individual’s expectations, which are themselves socially constructed. In fact, Bronfenbrenner sees the human environment like a series of Russian dolls in which the individual is nested. At the first level is “the microsystem”, which consists of face-to-face environments such as the individual’s perception of his or her workplace, family, or friends. At the second level is the inter-related system of microsystems, which is called the “mesosystem”. Thus, an individual might enjoy a range of positive microsystem experiences, but conflict between some of these—for example between the relationship with his or her mother and the relationship with his or her father—might be a source of stress, which springs from the mesosystem level.

At the third level is the exosystem, which refers to perceived environments that affect the individual, but into which he or she does not actually go. For example, parents are likely to be profoundly influenced by their perceptions of an operating theatre in which their child is to undergo surgery. Finally, the macrosystem refers to perceptions of wider cultural influences, which are built up over generations of human activity. These include ways of thinking and communicating, social settings, and institutions. Examples are the perceived attitudes of healthcare personnel, or beliefs about the “proper” behaviour of men, which might influence a man’s pain experiences or his decision to seek help. Thus, the approach emphasises that many systems of the human ecology do not consist of physical entities but are made up of shared meanings and practices into which perceivers are born (Helman, 2000; Still, 1996b; Wetherell & Still, 1996). For example, the perceiver’s nuclear family does not simply consist of a few other individuals. It also consists of “inherited” normative expectations concerning the proper behaviour of mothers, fathers, sons, and daughters, mutually constructed meanings, including made-up words and family jokes, together with a shared family history.

The emphasis on perceptions as opposed to the environment *per se* also means that individuals living in the same physical context might be subject to non-shared influences, because the environment might mean something different to each.

## ACTIVITY 1.1 Key systems and contexts of well-being



- 1 Internal systems
- 2–5 Personal relationships
- 6 Balance between personal relationships
- 7 Influential contexts not entered by the individual
- 8 Wider institutions

1 is intended to represent systems internal to you, including for example, your cardiovascular system or your emotional system. For simplicity's sake, no further attempt has been made to represent systems nested within these, but you can note any that are salient to your own well-being.

2–5 are intended to represent a selection of key friendships or personal relationships including face-to-face relationships within your family.

6 is intended to represent the harmony—or otherwise—between the relationships you have depicted from 2 to 5. Are they mutually supportive or, for example, does your family disapprove of some of your friends?

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7 is intended to represent influential contexts that you don't usually enter yourself, such as your partner's workplace, your children's school, or your boss's office. 8 represents wider national institutions and ideologies such as "the government" ideologies or "attitudes towards women" in your workplace.

Annotate the diagram to identify the systems that are of importance to you in your life.

When you have identified important systems, consider how they affect each other. In particular, pay special attention to areas of conflict, which might be a source of stress to you. Note areas of harmony, where more than one of the systems combine to promote your health and well-being.

The construction of social norms and their effects on the structures and processes underpinning social cognition are core topics in social psychology. Therefore, a biopsychosocial approach means that social psychological techniques and theories are relevant to the field of health and illness and this justifies the social psychological basis of the chapters that follow.

Notwithstanding, the representation of the human ecology as a set of Russian dolls is paradoxically individualistic. This is because Russian dolls do not expand to engulf each other, nor do they change their order or even visit each other, so that a host can temporarily share a mesosystem. Humans, however, "are psychological group members who act in terms of shared social identities as well as individuals who act in terms of individual differences and personal identities" (Turner, 2000). In other words, the individual is not simply nested inside his or her family, hospital ward and other social categories—s/he has the psychological capacity to be a family member or a patient, or to act in terms of what Turner (2000) calls "higher-order" selves. Clearly, such a change is likely to recalibrate not only the systems of an individual's social ecology, but also the meanings through which s/he perceives them. Moreover, such changes do not occur in isolation. They might be synchronised with equivalent or complementary changes in other individuals, who are acting in terms of the same shared higher-order self. Alternatively, such changes might affect or be affected by changes in the social context, which is not static, but a pulsating universe of others' ecologies. An emphasis on the capacity of humans to act in terms of social categories is at the heart of the social identity approach and this approach will shape much of the theorising to come, which, especially in the later chapters, will attempt to consider the impact of "we-ness" on health.

However, in order to overview the way in which the coming chapters are structured, it is necessary to describe a little more of the concepts and approaches in social psychology that will be used to underpin them.

#### 4. Structuring Diversity in Social Psychology and Overviewing the Book

Social psychology is relevant to the field of health because the reflexive individual, who embodies and experiences health and illness, is embedded in a range of social and psychological systems. Experiences are directly or indirectly shared with, influenced by, and have influences on others, and it is the interaction between intra-individual psychology and the social that is at the core of social psychology. To describe social psychology more precisely is difficult, because it is characterised by diversity. However, brief histories of the discipline provide insights into this diversity and help establish a basis on which to structure the coming chapters.

Still (1996a), for example, sees two “ancestors” of modern social psychology which he traces back through two millennia to the writings of St. Augustine, in which a split was described between what is pure and unchanging in humans and what is subjective, changeable, and mortal. Today, Still discerns the former line beneath the experimental and cognitive emphasis of “psychological social psychology”, which seems to seek eternal, abstract, and general truths, detached from the hurly-burly of everyday life and which is firmly centred on intra-individual structures and processes. On the other hand, he discerns the latter line beneath the constructivist and hermeneutic emphases of “sociological social psychology”, which seeks to build an understanding of human experience bounded by space and time and which is centred on the interaction between the individual and the social. Although Graumann (2001) constructs a different “ancestry” which locates the origins of individual-centred approaches in Aristotelian schools and those of socio-centred approaches in the Platonic school, he agrees with Still (1996a) that tension lies at the heart of current social psychology: as a branch of psychology it deals with intra-individual structures and processes, and as a social discipline it focuses on the role of the social context. This tension means that social psychology is characterised by debates about definitions, approaches, and perspectives which reflect core disagreements about the nature of the individual and society and even about the type of knowledge that is possible (Wetherell, 1996a).

To stereotype briefly, one major contender in the debate is psychological social psychology, within which key assumptions are that social behaviour may be objectively described and measured, and is subject to general causal laws that may be discovered, chiefly through experimentation (McGhee, 1996). This perspective is emphasised in American social psychology, which tends to be relatively individualistic, ahistorical, ethnocentric, and laboratory-oriented; its key foci include social cognition and information processing and how these are modified by social factors (Graumann, 2001). From this perspective, definitions of social psychology are likely to emphasise its scientific basis (Wetherell, 1996a).

Criticisms of this perspective and of scientific methods in social psychology are well known (Gergen, 1985). They emphasise the ways in which what is truly social—such as cultural meanings and interactions between people—tends to be ignored, or operationalised as the presence of a few strangers in a laboratory, for

example. Other critics point out that scientific methods guarantee neither truth nor understanding, since alternative interpretations of empirical data are always possible and to establish the cause of an action is not to understand it (Banister, Burman, Parker, Taylor, & Tindall, 1994).

A more *social* social psychology addresses such criticisms and characterises the second main contender in the debate, which is labelled sociological social psychology. Its core subject matter is the interplay between society and the unique meanings and other experiences of individuals. These can be actively constructed, rather than caused by external variables. However, they are not amenable to objective measurement, since they are not observable, and are constantly changing or “becoming” (Stevens, 1996a, 1996b). This perspective tends to be emphasised in European social psychology and its critics focus on the unreliability of shifting intersubjectivity (Graumann, 2001; Wetherell, 1996a).

More recently, a third contender, known as critical social psychology has been proposed (Wetherell, 1996a). This takes as its subject matter the ways in which the social world has been structured over time by inequalities in the power of individuals and social groups. Of particular interest is how these social structures construct the individual, influencing his or her self-image, life choices, and other experiences. Wetherell (1996a) continues that critical social psychology is moral and political in the sense that it identifies what could and what should be.

Each of these social psychologies has already been mentioned in the challenges to the medical model. For example, psychological social psychology underpinned the idea that a person’s beliefs about a disease might be more important determinants of behaviours than its presence *per se*. Sociological social psychology on the other hand, underpinned the idea that the medical model and related ways of thinking are socially constructed, as opposed to reflecting a gradual discovery of “the truth”. Third, critical social psychology underpinned the idea that scientific “facts” concerning diseases and their treatment, often turn out to be socially, as opposed to biologically, constructed and often happen to be to the advantage of the healers, rather than the healed.

Each of these social psychologies will be met again in the coming chapters, which consequently, are epistemologically diverse. However, because health psychology is dominated by social cognition models (Lowe, 2001, personal communication) an attempt will be made to emphasise more social and critical social psychologies.

Diversity in social psychology is increased because there is a range of different perspectives from which these types of social psychology are approached and an even wider array of methodologies, which are shared by some perspectives but not others. To make sense of such diversity in social psychology, several classification systems have been suggested (e.g., Stevens, 1996c). The one suggested by Doise (1978, see also Sapsford, 1996) will be used to structure the coming chapters.

### ***4.1 Overview of the book***

Doise (1978) identified four levels at which explanations and activity in social psychology might be located. Sapsford (1996) prefers to use the term “domain” in order to avoid implying that higher and lower levels differ evaluatively. However, the earlier term will be retained here.

The intra-individual level focuses on structures and processes within individuals. Much literature in the health field is located at this level, since it encompasses biological, cognitive, emotional, and other systems that exist within individuals. A key argument in social psychology at this level is that we can only know the world (including our own part in it) through our cognitions and senses. Thus, we act on what we know, and whether or not there is an objective reality “out there” is a matter of debate. Important questions to arise at this level concern the ways in which the social world is represented in the cognitive systems of individuals and how these representations are acted out in the social world. The type of social psychology most likely to be encountered at this level is psychological social psychology, and experimental methods are also likely to feature.

The second level of analysis in social psychology is the interpersonal level, which deals with structures and processes that exist between individuals. A key contention at this level is that relationships can only be understood through understanding the shared meanings developed by participants, and that these meanings are not apparent to outsiders. Important questions at this level concern the influence of the expectations that individuals bring to new relationships or how power differentials and levels of intimacy vary, and interact with the meanings communicated. The hermeneutic approaches of social social psychology are likely to be especially relevant at this level and experimental methods are likely to play a relatively minor role.

Third, the intragroup level of analysis focuses on structures and processes that exist within groups. Key issues in social psychology at this level are conformity among group members and the ways in which group decisions and behaviours differ from those of individual group members. Important questions concern the ways in which an individual’s beliefs and behaviours change as a result of the salience of different group memberships. There is a rich seam of experimental research on groups dating from the 1930s (see H. Brown, 1996, for a review) but more recently other methods such as discourse analysis have emphasised the ways in which group identities can be constructed during conversations and interwoven into personal histories (Wetherell, 1996b).

Fourth, the intergroup level focuses on structures and processes that exist between groups. A central topic in social psychology at this level is the nature of interactions between people who are acting in terms of their group memberships, and important questions concern the effects of stereotypic perceptions. At this level, critical social psychology is likely to be especially relevant, raising awareness of differences in social status and other “arrangements” that have become self-fulfilling.

With reference to levels of analysis, the structure of this book makes sense. Each of the coming chapters begins with a common sense, biomedical view on a selected health issue, which (with the exception of doctor–patient communication) is grounded at an intrapersonal level. The second section of each chapter challenges common sense with case studies and empirical evidence that contradict what is taken for granted. The third and subsequent sections of each chapter attempt to evaluate social psychological influences to make better sense of the issue. These are rival truths to common sense explanations. The final section of each chapter tentatively suggests a more social social psychological approach to the issue. However, although social psychological explanations at all levels of analysis contribute to each chapter, the issues have been selected and ordered so that the emphasis moves from intrapersonal through to an intergroup level as the book progresses.

Thus, Chapters 2 and 3 especially emphasise the intrapersonal level, although other levels of analysis are briefly considered. Chapter 2 considers how the individual knows that s/he has a symptom. The intra-individual world of perception and cognition offers a rival explanation to the common sense idea that symptoms are caused by bodily signs. Chapter 3 focuses on responses to symptoms, specifically on how individuals understand or appraise them. In this case, intra-individual cognitions, specifically schema-based appraisals, offer a rival explanation to the common sense idea that symptoms form the building blocks of rational illness appraisals. However, Chapter 3 also makes an important transition to more social social psychological influences, in arguing that the individual's appraisals might be constructed by forces outside his or her own cognitive structures.

Chapter 4 focuses on the plans individuals make to remedy their symptoms. In particular, it focuses on the decision to seek professional medical help. Since this decision is enacted in the individual's social world, the chapter moves away a little from the emphasis on private worlds. Social psychological influences at all four levels of analysis offer rival explanations to the common sense idea that people seek medical help when they think they have serious symptoms.

Chapter 5 considers what happens if the individual visits a doctor to seek help with symptoms. The common sense level of analysis of doctor–patient communication is interpersonal, and common sense assumptions are that the patient tells the doctor about his or her symptoms; the doctor listens and works out what to do; the doctor advises the patient; the patient takes the advice. Challenges to each of these assumptions are discussed and subsequently all levels of analysis in social psychology contribute to rival explanations. In particular however, group-level analyses trace how conformity to patient and doctor roles might influence communication. The critical argument is that intergroup-level influences provide a backdrop to the relationship between doctors and patients even though only two people might be engaged in a private and confidential consultation. These might subtly transform individually tailored patient care into rituals that reinforce expectations for his or her behaviour.

Chapter 6 considers what happens when the individual feels well again. The focus is on how s/he makes this decision. Common sense assumes that an

individual's self-assessment is an intrapersonal matter. It assumes that health status is judged rationally with respect to health beliefs that are like a medical model of health, or perhaps like a more positive model of health as mental, physical, and social well-being. Common sense is challenged by the fact that people often say they are well even though they have serious signs and symptoms. Next, social psychological influences on health beliefs are reviewed. These offer rival views of the cognitive model people might use when evaluating their health, and although all levels contribute explanations, group levels of analysis suggest that relevant health beliefs might belong to situations and groups, as opposed to individuals. Subsequently, social psychological influences on the process of evaluation are considered and a social identity approach is used to understand how a person's judgements about his or her own health might vary according to changes in self-categorisation and creative strategies to protect self-esteem.

The tone of Chapter 7 is different from the rest of the book because it focuses on a single topic, menstruation, and attempts to integrate themes that have been met in previous chapters. A common sense model assumes that menstrual pathology causes disabilities in women's performances and that these disabilities, in turn, cause social disadvantages. Each of these assumptions is challenged with logic and empirical evidence. In the third section social psychological influences on menstrual experiences are reviewed. Although all levels of analysis contribute to the discussion, the emphasis is on group- and cultural-level influences, which suggest that menstrual symptoms, deficits, and consequences are often socially constructed. A critical analysis of menstrual experiences questions who benefits from the assumption that menstrual pathologies cause women to be unable to perform normal roles, and whether the status quo can be resisted. In the fourth section of Chapter 7 a social psychological model is suggested in order to deconstruct the common sense causal relationship between menstrual pathology and its consequences on women's performance and social status.

Chapter 8 ends the book with a review and some suggestions for future directions.

## 5. Summary

This chapter defined, introduced, or otherwise discussed key theoretical concepts and themes that underpin the chapters that follow.

In the first section, common sense and the medical model of health and illness were defined, and the relationship between them was discussed.

- It was argued that common sense ways of viewing health and illness are often medicalised.

In the second section, four common sense views of health and illness, which are based on the medical model, were challenged in order to outline four purposes of this book and introduce the biopsychosocial model

## 20 Rival Truths

First, the phrase “the facts are the facts” represented the common sense idea that the medical model deals in objective reality and biological facts. This was challenged by the demonstration that social conflicts can trigger pathological processes, and by the argument that beliefs about a disease can sometimes be more relevant than its presence.

- The relevant aim of the book is to show that human boundaries can be permeated by social psychological influences.

A second common sense view is that given more resources and time, scientific progress will lead to a full understanding of disease. This was challenged by the fact that medical resources cannot continue to be increased indefinitely, and in any case do not guarantee that more advances will be made. Moreover, historical analyses revealed that the medical model evolved out of its social context, and does not represent a progressive accumulation of objective truth.

- The relevant aim of the book is to explore the ways in which beliefs of medical carers are social constructions and how these together with lay beliefs might influence health outcomes. Since these are potentially open to interventions by health psychologists, new ways of alleviating suffering and promoting health might be identified.

A third common sense view is that medical advances are the most effective way of combating disease. This was challenged by evidence that secular changes and people’s lifestyles, as opposed to medical advances, often hold the key to health and longevity.

- The relevant aim of the book is to show that social psychological therapies might sometimes be the most effective weapons against diseases.

A fourth common sense view is that medical treatment is the best remedy for ill people. This was challenged by critical analyses which suggested that medical treatment is sometimes more beneficial to doctors than its recipients, whose illnesses may reflect social deviations as opposed to biological dysfunction.

- The relevant aim of this book is to attempt critical analyses to raise awareness that changes in attitude or social arrangements might promote health.

In the third section of this chapter, the biopsychosocial model of health and illness was introduced. What it means to be a person, the importance of shared traditions and beliefs to the human ecology, and the human capacity to act in terms of shared group identities were described in order to justify the social psychological approach of the book.

In the fourth section, the focus was on social psychology itself. From the diversity of approaches in social psychology, four levels of analysis were described, and although all levels will be picked and mixed as appropriate in each chapter, the emphasis moves from intrapersonal to intergroup as the book progresses:

- Chapters 2 and 3 emphasise the intrapersonal world of symptom perceptions and appraisals but show that these are influenced by social psychological factors.
- Chapter 4 considers what individuals do when they have a serious symptom, in particular, why they are likely to delay seeking medical help.
- Chapter 5 considers doctor–patient communication and although the common sense level of analysis for this topic is interpersonal, group-level influences emerge as likely to impede it.
- Chapter 6 considers what happens when the patient feels well again. In particular, the focus is on how s/he knows s/he is well. Again, all levels of analysis contribute to an answer, but the emphasis is on (1) intergroup differences in beliefs about health which provide individuals with social cognitive structures on which to base their judgements; (2) strategies to protect self-esteem, which influence in individuals' judgements of health status.
- Chapter 7 attempts a critical analysis of the consequences of menstruation on women's health, behaviour, and social standing, which integrates all four levels of analysis.
- Chapter 8 provides a brief review and suggests a few future directions.