



Becoming the illness

“What you think, you become” – Buddha

One of the advantages of general practice is that one can observe patients over a long period. Every now and again, I have had the feeling that a few of my patients seem to have “become” their illnesses. When they started out, the condition and its symptoms were vague and unformed. Slowly, as more information was obtained and labels were applied, they began to identify with the labels and almost live them. If the mask is worn long enough, they say, it becomes the face.

These conditions may affect their relationships, and can be used by the patient to avoid personal, social or work responsibility. It is often difficult to know whether this is performed consciously, or whether they are no longer able to view it from an external perspective. The condition takes on a life of its own. Perception starts to outweigh reality. There is often a marked disparity between the subjective reality of the patient, and the hard analytic reality of the doctor, or even the obverse, of the subjective views of the doctor and the life world of the patient. In order to move forward, I sometimes find that I have to sacrifice some of my own realities and perspectives for those of the patient, as long as I can judge that there is no harm in doing so.

As the journey of the illness continues, the patient and the doctor may build up the condition as further tests are carried out, and they both place their beliefs and agendas into the mix (known as the joint construction of narrative). Parts of the story are added by specialists and other alternative agencies, such as homeopathy and physical therapists.

The condition may start off in the eyes of medical science as a false premise, and then become a self-fulfilling prophecy as the patient searches for confirming evidence. The sociologist, Robert Merton, called a self-fulfilling prophecy a situation where “a false definition in the beginning evokes a new behaviour, which makes the original false conception come true”. The alleged causes allow the patient to make sense of their world in ways that medical theories may not accept. This is, in some ways, a good thing, and therapeutic for the patient, as well as having its disadvantages.

Reducing an experience into a diagnosis may embed it further, especially in a patient with a disposition that is susceptible to suggestion. An existential transference may occur, although this does not need to be consistent with all facets of the patient’s life. It may only occur within certain relationships, or in consultation with the doctor. It may not

be present unless social stressors arise in the rest of the patient’s everyday life. We all carry several identities, and I often wonder about all the parallel universes in which we live. This occurs when a patient leaves my consulting room after a consultation involving much angst and despair. I then see, through the window, that she is merrily greeting and laughing with friends in the car park.

The patient’s belief in the cause and description of his or her illness is often an imaginative enterprise. There are reference points from the past, i.e. “Since the accident” and “It gradually came on after”, which are told as epiphanies or as Damascene life events. This is part of what is called narrative reconstruction. Over time, as the patient repeats the story to doctors and family members, the condition firms up, and the patient may start to communicate through their new illness persona. Many of these patients may not fully accept the medical explanations of their illnesses, and add in other more mystical and social dimensions. This can be both beneficial and detrimental.

One can gain control over an illness by justifying a cause, but also by denying it, or at least denying some of the alternative explanations. There are many theories around this way of being, which include the patient adopting what is called the sick role or having secondary gains or a hidden agenda.

Many of these illnesses are forms of pain and fatigue syndromes, as well as psychiatric diagnoses, and may carry different meanings for the patient and the doctor, as well as advantages and disadvantages to both parties.

The Roman philosopher, Seneca, famously said that it was part of the cure to wish to be cured, and I often find in these cases that I have acquiesced into a listening and agreeing mode. Perhaps one of the ways of coming to terms with some of these life worlds is to *grok* them. “*Grok*” means to understand deeply or intuitively, and is a sort of advanced empathy. It was coined by Robert Heinlein in his book, *Stranger in a strange land*. To *grok* something is to be one with it in a way whereby the observer and the observed get onto the same wavelength, and then move forward in a joint venture of healing.

Dr Chris Ellis, Family Physician,
Pietermaritzburg, KwaZulu-Natal
email: cristobalellis@gmail.com