Victim-blaming revisited: a qualitative study of beliefs about illness causation, and responses to chest pain

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Background. Health promotion is an established part of the general practice consultation. It is widely acknowledged that risk-behaviours are strongly affected by socio-economic status and the structural constraints of the individual, but little is known about the possible negative effects of lifestyle advice.

Objectives. To examine the extent to which self-responsibility, blame for ill health and risk behaviours feature in accounts of respondents with chest pain, and to ascertain whether perceived victim-blaming influences lay interpretations and responses to chest pain, and to ill health in general.

Methods. Qualitative interviews were carried out in two socio-economically contrasting areas of Glasgow, with 30 respondents (15 men and 15 women) from a socio-economically deprived area, and 30 respondents (15 men and 15 women) from an affluent area.

Results. Respondents recognized the causative links between well-established cardiac risk factors and heart disease. Individuals blamed themselves for their heart disease and general ill health and many also believed that they would be blamed for their behaviour and health problems by doctors. For some respondents, self-blame and fear of blame appeared to contribute to a reluctance to seek care. Self-blame, experience of blame and fear of blame were more common in respondents from the deprived area.

Conclusion. Emphasis by doctors on ‘unhealthy’ behaviours may deter patients from seeking medical care. Lifestyle advice should be given taking into account the health beliefs and the socio-economic context of individuals. Future studies should focus on the theme of blame in order to explore further the possible negative effects of lifestyle advice given by health professionals.

Keywords. Angina pectoris, chest pain, health behaviour, health promotion.

Introduction

Early health promotion policy in the UK played down the impact of social and cultural influences on health and emphasized the importance of individual behaviour choices.1 Research carried out in the 1980s into lay perceptions of the causes of ill health found a strong belief that ill health resulted from individual behaviours and lifestyle choices. For example, an interview study of Scottish women showed that ill health was perceived to be closely linked to individual responsibility.2 The authors commented “The self-responsibility theme was paramount” and added “It was behavioural causes that were offered for almost every disease . . . in other people, but also for oneself”. The Health and Lifestyle Survey, conducted in the early 1980s, also reported a strong belief amongst the general public that “Voluntary behaviours are the most important determinants of health”.3 In the 1980s, the term ‘victim-blaming’,4 whereby individuals are blamed for their health problems, entered common usage.

Since the early 1990s, there has been an increasing acknowledgement that health behaviours are affected by social and structural factors.5,6 Research has also
demonstrated that seemingly irrational health damaging behaviours may be used by individuals as part of a coping strategy. For example, smoking amongst women on low incomes can be “A way of coping alone with the demands of full-time caring and with the struggle of making ends meet”. The election of a Labour Government in 1997 saw a political shift which placed greater emphasis on social circumstances as determinants of health and health behaviours.

In 1990, health promotion activities which aim to change the risk behaviours of individuals became formally incorporated into the daily work of GPs. Research has since cast doubt on the value of such activity. Trials of giving advice to unselected populations have shown to have only small effects on risk behaviours. Qualitative studies have also highlighted the ethical implications of GPs giving unsolicited advice to patients presenting with unrelated problems. It is surprising, given the increasing acknowledgement that risk behaviours can only be properly understood in their social context, and the extensive debate about the potential value of health promotion in primary care, that the possibility of lifestyle advice having negative consequences has received little consideration.

Prompted by previous analysis of the data on which this paper is based in which ‘individual responsibility’ and ‘blame’ emerged as themes worthy of further analysis, we examined the extent to which blame featured in accounts of respondents with chest pain in the late 1990s. We then addressed the question of whether perceptions and experiences of victim-blaming influence lay interpretations and responses to ill health in general, and chest pain in particular.

**Methods**

In 1998–1999, qualitative interviews were carried out with individuals who had experienced chest pain in order to ascertain the perceived causes of the pain, and respondents’ reported actions in response to the pain. The sampling frame comprised people aged 45–64, identified as having exertional chest pain in epidemiological surveys carried out in two socio-economically contrasting areas of Glasgow. In the affluent area, 80% of survey respondents live in areas with Carstairs deprivation categories 1 or 2; in the deprived area, 77% of the population live in areas with Carstairs deprivation categories 5–7. Chest pain was ascertained using the Rose angina questionnaire. Samples of between 20 and 30 respondents are often considered adequate in qualitative studies because larger samples yield little additional data. This study used a larger sample to ensure an accurate representation of perceptions in each of the four predetermined sub-groups.

Purposive sampling was used to ensure equal representation of men and women from the two socio-economically contrasting areas. Respondents were stratified by gender and area of residence. Fifteen men (mean age 58.6) and 15 women (mean age 57.7) were randomly selected from each area. In order to obtain 60 interviewees, it was necessary to contact 114 people. Twelve people had died or the letter was returned unopened. Of the remaining 102, 24 (23.5%) did not reply and 18 (17.7%) declined to participate. The overall response rate was lower in the deprived group (30/61, 49.0%) than in the affluent group (30/41, 73.0%).

All of the interviews were carried out by HR, who made it clear to respondents that she was a GP. A semi-structured interview schedule was used, which included questions about perceived causes of chest pain and respondents’ illness behaviour in response to chest pain. ‘Individual responsibility’ and ‘self-blame’ were not specifically asked about but were explored further when raised by the respondents. Interviews took place in the respondents’ homes. The interviews were tape recorded and transcribed verbatim. The analysis was carried out as a 5-stage iterative process: development of a coding schedule; coding of the data; description of the main themes; linking of the themes; and development of explanations for the relationships between themes. Data were checked for negative instances and rival hypotheses and analyses were overseen by MR. QSR NUD*IST (4) software was used to manage the data. Code numbers and respondent’s gender, age, and area of residence are given in parentheses (D = deprived, A = affluent). Ethical approval was granted by the Greater Glasgow Community and primary Care Research Ethics Committee.

**Results**

**Beliefs about cardiac risk behaviours**

Respondents consistently recognized the causative links between cardiac risk behaviours and heart disease. After family history, risk behaviours were the most frequently mentioned reasons for respondents believing that they were vulnerable to heart disease. In order of frequency, risk behaviours mentioned were smoking, diet, being overweight and lack of exercise. A typical response to the question ‘Do you think you are at risk of heart disease?’ was “Ahmm, probably, uh-huh, because I smoke. If I didnae smoke, no, I wouldnae have” (R60, female, 48, D). With respect to diet, most respondents emphasized aspects of diet which are recognized as being related to heart disease, such as high fat content, cholesterol and not eating enough fruit and vegetables. For example, when asked what type of person he believed would be likely to get heart disease, R44 said

“Me, because I do all the wrong things. For a healthy diet, I do the exact opposite. I don’t eat the things
that they tell you, you know like lots of fruit an',
that, know? I don’t eat fruit and vegetables and stuff
like that.” (R44, male, 57, D)

Women were more likely than men to mention diet and
to emphasize more general aspects of diet, such as the
importance of eating a balanced diet:

“I mean we’ve got quite a well-balanced diet, we’re
no’ on salads all the time but ehmm no fries and, you
know.” (R61, female, 50, A)

Exercise, on the other hand, was emphasized more by
the men. A typical statement was from R6, who believed
that his chest pain had been caused by his lack of fitness:

“When I was playing squash, I started sort of getting
a bit of tightness in the chest, but I’d put that down
to not being fit enough.” (R6, male, 60, A)

Reports of self-blame
As in previous studies, respondents cited a range of
factors which they believed contribute to heart disease,
including family history, stress and luck, but accounts
were dominated by allusions to individual responsibility
and self-blame.

“I always thought heart trouble was brought on wi’
how you looked after yoursel’, know? That was my
opinion.” (R36, male, 36, D)

Two men (R41 and R3), both with multiple health prob-
lems including coronary heart disease, congestive cardiac
failure and chronic obstructive airways disease, reported
a clear belief that their health problems were of their
own making. They also believed that they ‘deserved’ or
should ‘pay for’ the consequences of their own actions.
It was suggested to R41 that he had been ‘unlucky’. He replied

“Och, unlucky? I don’t know about that. You only
get what you deserve.” (male, 53, D)

And R3 said

R: “Well, I’ve probably abused myself an’ I’m
payin’ for it now.” HR: “How do you mean
‘abused’ yourself?” R: “With smoking, you know.”
(male, 61, A)

R56 (female, 64, D) stated that she felt to blame for her
ill health and that because she had neglected her health,
she deserved the negative consequences:

“I know that emphysema does affect the heart
eventually and at that time I knew I had emphysema,
but it didn’t deter me [from smoking] one bit. So
I suppose you could say anything I’m getting, I
bloody well deserve it because I knew what the
outcome was.”

Respondents who reported a belief that heart disease
was linked to personal responsibility or blame were
asked why they held that belief. Some respondents were
unable to give a specific reason and suggested that they
just accepted it. For example R3, a lifelong smoker, did
not generally consider himself to be at high risk of heart
disease but when it was diagnosed, said

“I just accepted the fact of heart disease, I must say,
it’s probably through the smoking.” (male, 61, A)

Others based their view on observing that in other
people, ‘unhealthy’ behaviour was linked to illness/death.
For example, R36 said

“I’ve seen hundreds of people that’s no [not] here noo [now] (i.e. dead)—some of them have
been younger than me—and they dinnae eat
well, they were drinkin’, and were nae eatin well.”
(male, 36, D)

A second common reason for linking poor health to
personal responsibility was information from a third
party. R41, when asked why he believed “You only get
what you deserve” said

“That’s what they say anyway, that’s what I’ve
heard, what they tell me. I wouldnae-say I was
unlucky.” (male, 53, D)

The importance of information from medical profes-
sionals and the media was emphasized by one respon-
dent who said

“I do not understand how the general population
cannot get this message because it’s blazoned out
from every pillar and post.” (R15, male, 57, A)

Personal responsibility and self-blame for poor health
was common and some respondents made a link to their
decision of whether to seek medical care for their chest
pain and other symptoms of illness. A belief was
expressed that because they were responsible for their ill
health, health professionals would be able to do little to
help them, or that they would not be welcome. R41 who
had reported that “You deserve what you get” said

“I try to keep away from the doctor’s as much as
possible, tae [to] gie [give] him peace and ehh, he’d
say ‘Oh not Mr × again’.” (male, 53, D)

For others, self-blame was associated with a sense of
demoralization about their health and with a belief that
their health problems deserved lower priority than those
of other people and compared with competing demands
on the GPs’ ‘valuable’ time. A typical comment was:

“I feel I’m wastin’ people’s time, you know. There’s
more people out there iller than I am, you know.”
(R52, female, 49, D)

Self-blame and its association with demoralisation
about health were more common in people from the
deprived area.
Perception of being blamed by health professionals

As well as emphasizing the importance of self-responsibility for heart disease and other health problems, respondents commonly reported a belief that they would be blamed for their behaviour and health problems by health professionals. In some cases, those beliefs resulted from a perception that they had been blamed in the past. Many respondents talked spontaneously about their recollections of being made to feel guilty about their behaviour by GPs and hospital doctors, while consulting about a specific health problem. For example, R43 explained that his GP had previously attributed his health problems to alcohol, and chastised him for drinking:

“He [the GP] doesnes look too keenly on alcoholic. If I go up tae him wi’ anythin’ wrong he’s sayin’ it’s the booze (laughs) an’ so, slap, slap, forget it. . . . Well obviously, he’s blamin’ that for aw the symptoms I’ve got.” (male, 60, D)

He went on to express a belief that his GP takes little interest in him “He [GP] will say, ‘There’s 3 years [sick note], but don’t bother me’”; and that because of the GP’s attitude to him, he doesn’t “bother too much” about attending the GP. One woman reported a distressing experience of attending hospital outpatient clinic for angina where the specialist had focussed on her smoking:

“He [the doctor] was not even looking at me. Still doodling—‘If you don’t pack in your smoking, you won’t be here in another 2 years’, I says ‘I’m hoping to see my granddaughter, I’m hoping I can see them growing up and enjoy them’. ‘There’s no way you’re gonnae do that if you don’t pack your smoking in. You’ll be lucky to see 2 years.’ I said ‘I have tried but I certainly will try harder’. And I came out of there and the tears were tripping me.” (R30, female, 47, A)

Other respondents anticipated that if they presented with certain symptoms that the doctor might again remind them of their unhealthy behaviours. That fear sometimes led to a reluctance to present with chest pain. The following conversation with R52 followed a question about whether she would tell her doctor about her chest pain:

R: “No, because I probably knew what he would say.”
HR: “What would he say?” R: “Stop smoking, yeah.”
HR: “Is that the sort of thing that they normally say to you?” R: “Well, I’ve never actually had it said to me by a doctor but I would imagine that’s what he would say if I went with that complaint [chest pain].” (female, 49, D)

In addition, several respondents reported being actively discouraged by health professionals from seeking care because of their risk behaviours. For example, one respondent reported that a doctor had threatened to withdraw treatment if he did not give up smoking.

“He [the GP] said to me, ‘You require medication to live. Do you still smoke?’ , and I says, ‘Aye’. He says, ‘Right. There your medication. The prescription’s made out to you. But if you’re smokin’ next month, don’t bother comin’, you’ll get nothin’ from me’.” (R38, male, 65, D)

In some cases, respondents did not believe that negative attitudes of the medical profession towards them were unjustified. R56 reported that she no longer felt that she could attend the GP because after repeatedly advised her to quit smoking, he had justifiably given up on her.

“I think doctors have just given up now because they’ll just say, ‘Well, you know what smoking does, but if you’re quite prepared to accept it, what can we do?’ That’s what they say now. And they’re right.” (female, 64, D)

Discussion

We found, like previous researchers, that the causative links between well-established cardiac risk factors and heart disease were widely known. Risk behaviours were an important component of cardiac stereotypes, which also incorporated factors identified in previous studies, such as gender and physical appearance. Individuals blamed themselves for their heart disease and ill health in general, and many respondents expressed the concern that they would be blamed for their behaviour and health problems by GPs and hospital doctors. For some respondents, self-blame and fear of blame by health professionals appeared to contribute to a reluctance to present to a health professional.

Our study has several limitations. First, because this is a study of respondents’ reported experiences and perceptions of what doctors think, we could not judge whether our respondents had actually been blamed for their behaviour by health professionals. However, people’s actions are often affected by their beliefs about others’ views of them and hence respondents’ beliefs that doctors blame them for their risk-behaviours may be as important as doctors’ actual views. Second, although the Rose angina questionnaire predicts mortality in men and women, it is not a diagnostic instrument, so we were unable to ensure that respondents had chest pain of similar clinical severity. However, its use meant that all respondents had the symptom of exertional chest pain. Third, the lower reply rate and rate of agreement to being interviewed in the deprived area may have led to bias. The main reasons for lack of participation in the deprived group were poor health in potential participants and difficulties contacting potential interviewees by phone and it is likely that inclusion of those individuals would
have accentuated observed socio-economic variations in responses to chest pain. Fourth, exploring blame and personal responsibility were not the primary aims of the study, which means that the results of this analysis are mainly descriptive rather than explanatory.

This study suggests that, despite the shift in focus of health promotion from attempting to change individual behaviour (in the 1980s and early 1990s) to the acknowledgement of wider influence on health (in the late 1990s), individual responsibility and blame still feature strongly in personal accounts of illness causation. The persistence of notions of blame may relate to a ‘cultural lag’ between current officially sanctioned versions of disease causation and lay ideas about illness causation. For some individuals, the perceptions of responsibility and blame for their own health problems were reported to have been reinforced by the attitudes of doctors.

We also suggest that self-blame for ill health and fear of being blamed by health professionals might lead to a general demoralization about health and to delayed presentation. The relationship between fear of reprisal and tendency to seek health care was touched on in a recent study of patients’ perceptions of GPs’ advice to stop smoking.23 That study found that for some patients who were not ready to give up smoking, advice to stop could lead to feelings of guilt and to a reluctance to present. In the USA, it has been suggested that obese patients may delay seeking medical care because of “concerns about disparagement by physicians and health care staff”.24 Self-blame and fear of blame were both more evident in respondents from the deprived area. It has been suggested that health promotion “represents a potential weapon in the battle against socio-economic inequalities in health”.25 However, this study raises the possibility that repeated emphasis by health professionals on ‘unhealthy’ behaviours, however well intentioned, may reinforce a culture of victim-blaming and deter patients from seeking medical care.

Our findings lend support to the recommendations made by others in relation to smoking cessation23 and management of obesity26 that if health promotion is to continue to be an integral part of the primary care consultation, it should be carried out in a caring and sensitive manner which takes into account the health beliefs and priorities of the patient and that health promotion should avoid “stigmatizing and blaming patients”.26 In addition, our study suggests the need for further research focussing specifically on theme of blame in order to explore the possible negative effects of lifestyle advice given by health professionals.

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References

