

CHAPTER TWO VERTIGO AND MEDICINE

Initial experiences of vertigo and the decision to seek medical help

For some people, the onset of a vertigo attack is sudden and violent:

I thought "Oh, I'm feeling a bit dizzy, I must be hungry or some such" ... within half an hour I couldn't stand.

I walked into a house and I felt perfectly alright, and suddenly I thought "I'm going to be sick". By the time I got to the loo I couldn't stand up straight. I was literally trembling, I shook all over. I went hot and cold, I burst into tears ... I just sort of went and fell over.

I thought I was dying, everything was spinning, spinning round, I was so violently sick. I went back to bed and it carried on for twenty-four hours.

When the attacks of vertigo are as severe and unexpected as in these descriptions, family, friends, or colleagues are usually sufficiently concerned to at once seek medical assistance on behalf of the afflicted individual. When attacks occur at work or in a place public a medical professional or even an ambulance may be summoned, while at home the spouse will generally call in the local doctor. Even if the attacks are not witnessed, the response of most sufferers themselves to such a frightening and bewildering experience is to turn to the medical profession for an immediate definition and explanation of what is happening, as well as prevention, or at least control, of the unpleasant sensations and incapacitation. Consequently, those individuals who initially have acute attacks may pass very quickly through the processes necessary to arrive at a diagnosis of their condition, as in the case of Mr W, who was given a diagnosis almost at once:

I was in a hotel and I got up in the middle of the night, fell on the floor, and the whole world started to spin. I phoned my wife who got the doctor out. He thought I was drunk or something, but he took the blood pressure and everything and they were normal, so he had a second little thought about it and said to me you might have Meniere's ... In the next three weeks I had some terrible attacks, in fact I was so bad one night the Doctor put me in hospital and then I went through the tests, you know the usual things -- I am assuming they eliminate everything, if you haven't got a brain tumour or heart disease they blame it on to Meniere's, and that is exactly what they did.

However, for many people the initial experiences of vertigo are less striking and distinctive. Consequently, there may be a long period during which the symptoms are monitored and their significance assessed without any recourse to medical opinion. Some of the factors and processes which may affect individuals' interpretations of their own symptoms are outlined in Leventhal's "self-regulatory" model of illness cognition (Leventhal et al., 1980). Leventhal suggests that when confronted by abnormal physical sensations people seek to define their condition using a label, which can be either an illness or an emotion. When the symptoms are unfamiliar, contextual cues may have a particularly strong influence on symptom interpretation; for example, the presence of recent or imminent sources of stress may lead people to attribute their symptoms to anxiety (Baumann et al., 1989).

The accounts given by many of my interviewees of their initial reactions to vertigo certainly indicate that the experience is interpreted in the light of situational factors. Sometimes the disorientation itself may not be perceived as the most prominent or central symptom, so that sufferers develop explanations for malaise which are based primarily on the ancillary symptoms rather than the vertigo itself, and see the vertigo as a secondary symptom of some more familiar ailment:

I developed a terrible headache, I just couldn't sit in the car, my head wanted to fall to the side and I was getting giddy ... I just at the time assumed it was a very bad headache or in fact a migraine.

I thought I'd had too much sun because I'd been laid out in the sun all day, and that started off everything just moving about, and I was sick and I had this headache, and I thought "Oh, I've had too much sun".

The first time I got it, I was driving long-distance. I thought it was because I was concentrating, using the brain so much on the motorway ... I started getting the head going round and round and I vomited. I thought it was an upset stomach or something.

Alternatively, when the initial sensations of vertigo are vague and mild they are often dismissed as the effects of stress or fatigue:

The first time I was in the kitchen preparing the evening meal. I move very quickly most of the time and I turned round and I felt dizzy -- not exactly dizziness, but veering to one side as if I was going to the right all the time. I just thought I was tired, my mind was on other things, and I should pull myself together and concentrate.

I remember the first one very clearly ... We went to the

school for him [the son] to show me around and we got to the top floor, and quite suddenly I was attacked by giddiness and I couldn't stand up at all. It wasn't a question of height, that had nothing to do with it, and I wasn't looking down a well or anything. My husband and son between them had to get me down and I was very, very sick ... at the time I didn't connect it at all with the trauma of [the son] going away, it's only afterwards with people having said to me that's what it was that makes me connect them even. I simply thought, we'd had a bit of a day and I was worked up, and I was frightened of making him ashamed of me by being sick upstairs.

This last account conveys particularly clearly the problem posed for vertigo sufferers by the ambiguity of their symptoms, and by their connotations, which include height phobia and emotional distress. In the case of vertigo, the problems associated with deciding whether the condition should be defined as an illness are exacerbated by the vague and intermittent nature of symptoms, and the absence of any well known label for the experience, such as 'flu or indigestion. Moreover, apart from vomiting, there are generally none of the customary visible signs of disease, such as a rash, fever, catarrh, or coughing. In his study of people with multiple sclerosis, Robinson (1988) notes that they often have similar difficulties in classifying and interpreting the early, vague and disparate signs of their disease.

The uncertain status of symptoms such as vertigo and dizziness not only causes subjective uncertainty and disquiet, but may also lead to social difficulties:

The main thing is that as it's not a visible thing therefore you know someone is sorry and all that, but you can tell that they just don't understand how you're feeling. You can't go somewhere, or you can't do this, can't do that -- people tend to think that you just don't want to go.

In the early stages she [a colleague at work] thought I was pulling a fast one ... they used to think it was funny [i.e. suspicious] at work because I was fine that day, and I'd go back the next day perfectly well, but I'd had perhaps just the one day off.

In his analysis of the way in which people evaluate signs of illness, Locker (1981) notes that it is socially requisite that claims of illness are legitimated either by observable manifestations or by accepted (i.e. medical) authority; only then will failure to fulfil normal roles and responsibilities be sanctioned. Consequently, one of the motivations for seeking medical advice may be to try to resolve the uncertainty concerning whether these symptoms represent true "illness", and to

combat suspicions of weakness or malingering by obtaining verification of the existence of a physical disorder. Indeed, formal certification of illness may be essential if the vertigo is interfering with occupational duties, for example by necessitating absence from work or avoidance of heights.

If the vertigo causes no significant social difficulties with family or friends and does not create problems at work, then the individual may not perceive any advantage in consulting a doctor. From the incidence figures given in the preceding chapter, it is evident that only a relatively small minority of cases of vertigo are ever brought to the doctor; whereas between a quarter and a half of middle-aged and elderly people report episodes of giddiness, fewer than one in a hundred people see their local doctor each year with a complaint of vertigo. This does not, of course, mean that vertigo causes no problems at all for those who do not seek medical assistance. Although there have been, perhaps surprisingly, no community studies of the distress or disability resulting from untreated vertigo, the long histories of difficulties described by many people who do eventually seek medical help suggest that at least some of those who are reluctant to complain to their doctor experience a degree of anxiety or handicap on account of vertigo. It is likely that, as in the case of hearing loss (**ref**), an attitude of resignation is commonly adopted, and the vertigo is simply tolerated as a minor annoyance or viewed as an unavoidable consequence of aging. This stoic acceptance of disability may nevertheless have detrimental effects insofar as it prevents the individual from gaining access to potentially beneficial treatment or rehabilitation. In addition, prolonged minor levels of disability may have unfortunate secondary consequences; for example, giddiness in the elderly may eventually contribute to loss of mobility and dangerous falls (Overstall, 1983).

In many cases, medical advice is only sought when the symptoms persist or worsen, but sometimes complaints of quite severe vertigo only come to light when the sufferer visits the doctor on account of a quite different symptom, although this may later prove to be related to the vertigo (for example, headache, hearing loss or tinnitus). Alternatively, consultation may be motivated by some change in circumstances; one of my interviewees saw his doctor because he wanted to learn to drive and was worried that vertigo might render him unfit, while another sought medical reassurance that the condition was not a sign of some serious hereditary disease, as she wished to start a family. In both these cases, it is clear that in addition to the immediate and explicit incentive to seek a medical opinion, there must have been some degree of underlying concern about the nature and significance of the disorder. Anxiety about the cause of the vertigo, and the possibility that it is a symptom of some serious illness, is very often the primary motivation for consulting the doctor:

The fear that it's there and what is it? That is the bottom line -- what's wrong?.

I just didn't know what was happening to me. I think you

think of the worst thing -- I thought that there was something serious wrong and any minute I was going to pop off.

In contrast, in the case of Ms P (cited below), anxiety about the sinister implications of symptoms of vertigo actually deterred her from consulting a doctor at first, although the combined impact on her lifestyle of both anxiety and disability eventually prompted her to seek help:

I initially thought "What is going on in my head?". You worry about tumours and goodness know what else, and, you know, it is frightening. You tend to think the worst and I think initially I didn't really go outside too much for information ... it has just gone on and on, and I think I must have started avoiding things. Worrying about it till eventually I thought "I can't take this any more, it is affecting my life too much, it is interfering with my life too much, every aspect of my life".

In summary, those people who do consult their doctor on account of vertigo appear to do so in order, firstly, to obtain confirmation of illness and a label for their condition, secondly, for explanation and reassurance concerning the nature, cause and implications of their symptoms, and finally, in order to obtain relief from their discomfort and alleviation of their disability. Unfortunately, as the following sections will relate, many people who turn to the medical profession for help encounter a variety of obstacles which impede the fulfilment of these aspirations.

Doctors' reactions to dizziness

Doctors' attitudes to vertigo and its management are, of course, as varied as the responses of sufferers themselves, and are heavily influenced by the characteristics of the complaint and of the patient. Nevertheless, in order to arrive at a broadly representative impression of the main-stream medical approach to vertigo in the U.K., my own personal observation of the management of vertigo (obtained through several years' experience of clinical audio-vestibulology) was supplemented by three main sources of information. The first was a review of all of the recent (post 1980) text-books kept in the library of a university teaching hospital which included sections on vertigo. The second consisted of descriptions of the experiences of medical management derived from a series of interviews with patients from several different hospital clinics, while the third source was responses to a questionnaire survey of one hundred consecutive patients seen at a specialist regional centre.

Review of the medical text-books on vertigo gives an overwhelming impression that the priority is to achieve differential diagnosis of the precise pathology responsible for the complaints of dizziness. Of course, accurate diagnosis is always a medical priority,

since the diagnosis generally contains essential information about the nature and likely prognosis of the disorder, and provides the rationale for the selection of a particular course of treatment. Nevertheless, it is remarkable that in the case of vertigo the textbooks are almost entirely devoted to descriptions of the symptoms and pathophysiology of the various disorders, and the signs and tests which can be employed to discriminate between them. Discussions of medical treatment and other means of managing the vertigo are typically relegated to the final page or two of each chapter, and generally make up less than a tenth of the total text. This relative allocation of text-book space might suggest that although differential diagnosis of the nature of the dizziness is complex, once a correct diagnosis is achieved the treatment of the disease is uncomplicated. Unfortunately, only the first of these two premises is true. While the ambiguity of the symptoms and the multiplicity of the possible causes of vertigo and dizziness make diagnosis a very difficult task, the provision of effective treatment may not be possible even when the diagnosis is established. For example, Linstrom (1992) concludes that "The task of the otolaryngologist, otologist, or neurotologist is not to make every dizzy patient well or even to diagnose the exact cause of imbalance in every patient. No one of us is capable of this." (p. 745), while Browning (1991) notes that "[since] we cannot make a diagnosis with any degree of certainty in the majority of patients, management has to be empirical" (p. 59). Thus, while medical research continues to seek well-defined aetiologies and effective remedies, irremediable vertigo of uncertain origin remains a widespread complaint. Today's patients consequently often find themselves in a medical wilderness, void of definitive diagnoses and cures.

This state of affairs is not only disquieting for the patient, but also causes distinct unease amongst members of the medical profession, from general practitioners to ENT specialists. Indeed, the sections on vertigo in two recent textbooks on otolaryngology open with the candid admission that "No other symptom strikes as much anxiety in the heart of the resident physician as the dizzy patient" (Katz, 1986, p105), and "Most otologists dread having to see a patient whose referral letter states that he has disequilibrium" (Browning, 1986, p. 223). Similarly, Linstrom (1992) begins his comprehensive guide to "Office management of the dizzy patient" with the observation that "For many otolaryngologists, the management of a dizzy or vertiginous patient is an exercise in frustration" (p. 745), while Wright (1988) introduces his guide for junior hospital doctors with the comment that "having to diagnose and manage the dizzy patient may seem like being thrown in at the deep end when you can only just swim" (p. 1).

When a patient first presents to the general practitioner with dizziness, the most parsimonious response of the doctor is to initiate a "wait-and-see" policy, unless there are indications of a serious pathology, which can usually be identified quite readily from accompanying unmistakable signs of ear disease or of central neurological dysfunction (e.g. loss of consciousness, numbness or paralysis of the face or limbs

etc.). The practice of awaiting developments is logical, since doctors are aware that the most common forms of vertigo resolve spontaneously, and that those which do not are likely to be "benign" (i.e. not life-threatening). Moreover, differential diagnosis of vertigo is based principally on the history of symptomatology over a period of time, while treatment is also largely a matter of trial-and-error. The initial response of the doctor to a complaint of vertigo therefore often consists of bland reassurance that the symptoms are not serious and will probably clear up. However, if the dizziness persists such reassurance is unlikely to be effective:

You see you are told there is nothing wrong with you, then you get up the next day and feel exactly the same as you did. So it is alright being told, but if you are still feeling dizzy and having problems with your vision you can't accept what [the doctor] told you yesterday. You need to have something to work on.

Sometimes the lack of a firm diagnosis and absence of positive treatment is interpreted by patients as an indication that the doctor does not believe that the patient is really ill, or thinks that their symptoms are a sign of psychological disturbance. Many people who eventually received diagnoses of vestibular dysfunction felt that it had been difficult at first to convince their doctor that they were genuinely ill:

They think you're putting the whole thing on, and you know you're not and it's so frustrating ... You know how rotten you feel and you know how it affects you but you can't really get it over to them and then they're out to say "What are you worried about?". You begin to wonder "Do they think I've got a problem?" and that's why you give up going back to the doctor.

They [the doctors] thought it was just sort of agoraphobia, that when I got out and somebody took me out then it would be alright, but it wasn't -- they wouldn't realise it was my balance as well. My doctor, at first, she just thought "Oh well, she's just exaggerating" and then I got so bad that she really did realise that there was something wrong. I know a lot of it was anxiety, I was prepared to say that, O.K., 80% was anxiety, but the other 20 was Meniere's because of the balance.

Doctors' views of vertiginous patients are indeed inevitably coloured by the awareness that dizziness is a common "psychogenic" or "non-organic" complaint; i.e. a symptom for which no physical explanation can be found, and which is believed to reflect underlying emotional problems. Specialists working in the field of otolaryngology

are also likely to be familiar with the prevalent hypotheses regarding psychosomatic initiation or aggravation of organic vertigo, mediated by anxious personality profiles and stress. Moreover, in many patients with organic vestibular disease, the absence of definitive signs of balance system dysfunction, coupled with the development of secondary anxiety and depression, can make their condition very difficult to distinguish from a psychological disorder. Similar diagnostic difficulties have, of course, been reported in the context of other disorders (Goudsmit & Gadd, 1991; Robinson, 1988). However, the considerable overlap between symptoms of vertigo and of anxiety may render diagnosis of the organic origin of vertigo particularly problematic. Interestingly, the case of a woman whose vertigo (caused by Ménière's disease) was at first diagnosed as "hysterical" illness is singled out by Roberts (1985) in her book on doctor/patient relationships, and is the only example she gives of a doctor mistaking physical disease for emotional distress.

In addition to the prevalence of psychogenic dizziness and the similarity between symptoms of anxiety and balance system dysfunction, there are two common psychological phenomena, which have been shown to affect interpersonal perception in a wide range of situations, which may also contribute to the tendency of doctors to suspect that patients complaining of dizziness are neurotic or emotional. The first is known as the "actor-observer effect", because it can be attributed to the difference in perspectives between an observer and the person who is the centre of their attention (the actor). The actor looks outward towards the environment, and is therefore acutely aware of the changing situational factors which impact upon his or her attitudes and behaviour, whereas the observer focuses upon the actor and may not notice or fully register the importance of environmental influences. In the context of the doctor-patient relationship, the consequence is that the patient is conscious of the changing circumstances (in this case, a frightening and debilitating illness) which induce anxiety, whereas the doctor's attention is concentrated on the patient, who may appear to be an extremely agitated and distressed individual at the time of consultation. From my own experience, I can attest to the compelling nature of this perspective-induced perceptual bias; despite an intellectual conviction (based on intensive examination of the literature) that there is currently no sound evidence that those people who develop vertigo are psychologically unstable before its onset, when attempting to reassure a succession of desperate and tearful patients I often find it difficult to imagine the same individuals as the confident and competent people that they were before they became ill, and as they are once more after recovery.

The second relevant cognitive process is the phenomenon of "victim-blaming", which occurs in situations when one person feels powerless to alleviate the suffering of another. Unable to accept the bleak and uncomfortable reality that the suffering of an innocent person cannot be prevented, most people unconsciously tend to rationalise the situation by supposing that the victim must be in some way responsible for his or her plight. It is clear from the preceding paragraphs that doctors feel

particularly helpless when confronted with a complaint of persistent vertigo, and their own uncertainty and unease may sometimes unconsciously motivate them to dismiss their patients' problems as self-induced (by hypochondria or stress), or a sign of personal inadequacy (Hausler, 1981).

Even when the physical origin of the symptoms is undeniable, doctors may be unwilling to discuss the diagnostic possibilities and prognosis in detail at an early stage. Although the genuine diagnostic and prognostic uncertainty make such reticence entirely comprehensible, the lack of information can leave the patients in an undesirable state of ignorance and apprehension, as the following accounts illustrate:

The [company doctors] told me it was stress, so they sent me home. And the next day it happened, so it was happening every day ... When they [colleagues] was carting me home from work they were just getting straight on the phone to [the company doctor]. He'd just come in, "Oh, having one of these attacks again?" -- but I didn't know what "one of these attacks" were.

I asked [the doctors] perhaps for something to be done and they say "Well, you've just got vertigo, its one of those things, a lot of people get it".

The duty doctor arrived about seven a.m. after I had been vomiting continuously since about one a.m. and his words to me were "You've either got Meniere's disease or a tumour" and he walked out the door.

In many cases, patients with recurrent vertigo simply receive reassurance from their G.P. that the vertigo is not a dangerous sign, sometimes coupled with trial or long-term prescriptions of a variety of drugs intended to limit or control the vertigo. Such treatment is presumably satisfactory or at least sufficient for many people, although no formal investigations have actually been carried out concerning levels of handicap, potentially remediable disability, or satisfaction with medical management amongst vertiginous patients who are not referred to a specialist. However, some people are unsatisfied with this state of uncertainty, and in their continuing quest for a diagnostic label, prognostic information and effective treatment they may seek a specialist opinion concerning their condition. The experiences of those referred to hospital are considered in the following section.

Undergoing testing and achieving a diagnosis

Referral to a specialist may be requested by the patient for the reasons given above, or may be considered appropriate by the doctor either because of a desire to exclude any possibility of a sinister cause, or because the patient exhibits relatively high levels of disability or distress.

Patients referred to an otolaryngologist (i.e. ear, nose and throat or ENT specialist) or neurologist will be examined for signs of otological or neurological disease. Evidence of balance system dysfunction will also be sought, using tests of ocular control (such as the assessment of the control of eye movement when looking to right or left, or when following a moving object) and postural control (for example, the ability to stand heel-to-toe with eyes closed).

Significant central neurological dysfunction almost always leads to serious performance deficits on various tests of sensation and motor control, and the existence of central lesions can then be definitely confirmed or excluded by radiographic imaging (X-ray, CT scan or MRI scan). Similarly, the presence of active ear disease or injury can generally be quite easily determined by visual inspection and auditory testing, perhaps supplemented by surgical exploration. The most acute forms of vestibular dysfunction are also easy to recognise and confirm. On examination, the clinician can observe a distinctive pattern of eye-movements ("nystagmus") which indicates disturbance of the vestibulo-ocular reflex, and if the sufferer is able to march on the spot with eyes closed, he or she will steadily turn in the direction of the damaged vestibular organ.

In many cases, however, the signs of balance system dysfunction are not so distinctive and definitive. Because of the natural process of compensation (described in the previous chapter), the manifest effects of balance system dysfunction caused by vestibular disorder are relatively brief, and their conspicuous influence upon the commonly-performed activities used as clinical tests (such as standing still and looking to each side) often persists for no longer than a few days or weeks. Although latent vestibular-induced dysfunction may be detected by removing vision during these activities (so that the visual information cannot be used to compensate for distorted vestibular input), compensation frequently eliminates even these signs of vestibular imbalance during the many weeks or months that the patient may wait before requesting or obtaining an appointment with a specialist. Nevertheless, the individual may still be appreciably disabled when attempting more rapid or complex physical activities than those routinely tested in the clinic (see Chapter 3).

The clinical examination is usually supplemented by some specific tests of audiovestibular function. The most common are: a) tests of hearing sensitivity (the "audiogram"); b) the positioning test, in which the patient is rapidly moved into various positions (including lying down) in order to examine the effect of head position on subjective sensations and eye movements; and c) the caloric test, in which the vestibular organ in each ear can be independently stimulated by pouring warm and cool water into each ear canal in turn, thereby setting up thermal currents in the fluid in the inner ear which induce feelings of rotational movement and reflexive eye-movements (nystagmus). However, abnormal audiovestibular test results are typically found in only a proportion of those patients whose clinical histories strongly suggest vestibular disorder (Yardley et al., 1992). For example, examination of the test results of

people who eventually developed unmistakable signs of Meniere's disease (progressive unilateral hearing loss and tinnitus plus severe episodic vertigo) revealed that only half had clear evidence of vestibular imbalance on caloric testing (Oosterveld, 1979), and in the early stages less than half of such patients had the typical pattern of (low-frequency) hearing loss (Stahle et al., 1989). Moreover, even when abnormalities are found, these are relatively non-specific with respect to the underlying pathology. Hence, positional nystagmus may be associated with degeneration of the otoliths, viral infection, some deficiency of the blood supply to the inner ear, head injury, perilymph leak or endolymphatic hydrops (Baloh et al., 1987; Dix & Harrison, 1984; Jongkees, 1975; Oosterveld, 1979). Similarly, vestibular imbalance revealed by the caloric test may be due to virtually any kind of disease or damage involving the inner ear or audiovestibular pathway. Moreover, while many signs of vestibular imbalance (particularly disordered vestibulo-ocular and postural reflexes) are transient, and disappear before the doctor has an opportunity to examine the patient, others (notably, an imbalance on the caloric test) persist indefinitely, and may be found long after compensation for the injury which originally caused the imbalance is achieved, and the patient has completely recovered. There is consequently little or no relationship between the subjective severity of symptoms and objective signs of vestibular dysfunction (Arenberg & Stahle, 1980; Spitzer, 1990; Yardley et al., 1992).

The limited sensitivity of the basic tests may be augmented by a range of additional measures of hearing and balance function, including recording of auditory-evoked responses from the audiovestibular neural pathways, recording of eye-movements induced by visual field motion or by rotation of the patient, and measurement of postural sway. However, no amalgamation of these techniques can yet provide a truly reliable and totally comprehensive evaluation of balance function. For example, even the optimal combination of results derived statistically from a fairly comprehensive test battery misclassified 36% of the original classification sample of patients as normal, despite careful pre-selection of these patients on the basis of clear-cut, recent symptoms or signs of audiovestibular pathology (Allum et al., 1991). Similarly, in a review of 112 patients with a diagnosis of peripheral vestibular disorder, Voorhees (1989) noted that measurement of postural sway revealed dysfunction in 43% patients, comparing favourably with traditional tests of vestibulo-ocular function which were abnormal in only 28% of patients. Although research into new diagnostic and functional tests continues, owing to the variety of pathologies and the differing rates of compensation for the diverse perceptual conditions and motor activities that the balance system must cope with, it is currently neither practicable nor even possible to identify the particular type of dysfunction of every patient.

Of course, when patients are sent by their doctors for specialist investigations they are unaware that the outcome may not entirely resolve their uncertainty. When the reason for referral is anxiety on the part of the patient or their doctor about a possible sinister cause for their

symptoms, the results of specialist testing may be awaited with a keen apprehension:

I can't tell you what the anxiety was from week to week -- not knowing what was wrong, and I was really ill.

Unfortunately, one of the consequences of the limitations of current tests of the balance system is that even after extensive testing, no clear indication of the cause of the vertigo may have been discovered. The doctors concerned will probably be fairly confident following testing that the vertigo is not caused by serious and active disease, but the complex details of whether and to what extent it is possible to exclude sinister pathology are not usually discussed with the patient. Salkovskis (**ref**) has noted that, far from reassuring patients, referral for extensive investigations is frequently perceived by them as an indication that there is a real possibility that they may indeed be seriously ill. Consequently, when testing is inconclusive and the significance of the results is not explained in depth, the ignorance and anxiety experienced by patients may be exacerbated or prolonged, sometimes for years. This is illustrated by the following accounts, given by two patients whose examination and test results actually showed no evidence of sinister disease:

When I first saw my doctor nothing was explained, and then I went to the hospital and nobody sat there and explained what was happening, why it was happening. Well, perhaps they didn't know, but you just go up to the hospital and they say, "Right, we'll send you for some tests, take these tablets" and you don't know ... nobody has said to me that I haven't got a tumour in my head, see nobody has said that, so there's slight concern still.

[The consultant] put me through a CAT scan and a caloric test (which I vomited violently to), X-rays, hearing tests (my hearing is supposed to be fine). He put me through all these tests and he couldn't really say what it was, he couldn't give me an exact diagnosis ... He said "A couple of years and it should compensate." So I waited a couple of years and it didn't compensate, so I went back to him ... In all the tests put together I was slightly off the range -- only by 1%, 2% in sort of worrying areas. Nobody would commit themselves 100% and say "You are O.K.", which I wanted. I thought "That is unfair, you have got the X-ray, you have got the CT scan, you can see if anything was lurking". He would not tell me 100%, and because I am a worrier I latched on to the fact he wouldn't tell me 100%, so that exacerbated things and I came away feeling "Nobody seems to be able to help me, they have washed their hands of me."

This problem may be partly attributable to a failure in communication due to differences in the meanings that doctors and patients attach to customary medical phrases or styles of explanation. For example, when the doctor informs the patient that after extensive testing they could find nothing wrong, this message may be intended to convey reassurance that the potentially serious causes of the patient's illness have been excluded. However, the patient may interpret this information as meaning that the doctor has no idea what is causing the symptoms, which may therefore still signify some sinister, unidentified, and therefore untreated disease. Alternatively, the phrase may be taken to imply that the doctor doubts the organic basis of the symptoms, as Ms A seemed to suspect:

When I went back to speak to [the doctor] I would have liked him to have actually talked to me a lot more about it, and said you know there's nothing wrong there or there, but he just said "Oh, they couldn't find anything, read this letter" and sort of smiled ... Its very difficult, because I don't think I am at all the type of person to get het up, but when the doctor says that, you might not think you are but underneath you start to feel you are, so you've got to have a pretty strong mind to say no.

Stacey (1986) notes that if a health complaint is not legitimated by a medical diagnosis it cannot be attributed to external causes, and may instead be ascribed to attributes of the sufferer, such as their personality, age, gender or way of life. The preceding quotation certainly indicates that the failure to obtain a diagnosis may be viewed as an implicit accusation of personal inadequacy.

The provision of a diagnosis of vertigo due to peripheral vestibular dysfunction consequently brings relief from anxiety about sinister disease or accusations of malingering or emotional weakness:

I was having all these tests, everything -- heart, a brain scan -- all of which showed absolutely nothing at all. My husband said to me "Aren't you lucky you are so fit" and I said "Why do I feel so awful?". That was before I came here [and was given a diagnosis of vestibular disorder]. I was pleased because at least I knew something was wrong, I mean it is much better than thinking that you are gradually going to deteriorate and not knowing the reason. It's pleasant to know that you've got an ear complaint and you've also got this dizziness problem and they're related. I feel a lot better to know that it's to do with my ear and balance than if it was to do with my heart.

I was happy to find out that they had actually worked out what the problem was. Having gone on for nearly two years not knowing what the problem was, and people

telling me "There is nothing wrong with you" makes you wonder what is wrong. With being a balance problem one of the first things that came to mind was MS because my mother had that -- that was a worry, or possibly even a tumour of some sort. It was a relief to find out it was something relatively minor.

In his anthropological studies, Kleinman has identified "cultural healing", which he defines as the "provision of personal and social meaning for the experience of illness" (1986, p. 35), as a core function of any health care system. It is clear from the preceding quotations that a medical diagnosis plays a vital role in helping patients to make sense of their illness. Nevertheless, the significance of the test results and diagnosis must be carefully explained, as the following account given by a woman with advanced bilateral Meniere's disease illustrates:

As part of the hospital treatment I had a balance test, when they shushed water into my ear, and [the doctors] told me I hadn't balance in my ears. And I was terrified then -- they had told me initially I had no balance in one ear, and I thought if it goes to the other side I'm going to be on my back for the rest of my life".

This woman would have been spared considerable distress had she been told that orientation can be satisfactorily accomplished in most situations using vision and proprioception alone. The finding that she had virtually no vestibular function in either ear simply indicated that the disease had nearly run its course; although some problems with balance and ocular control would remain, the vertigo was likely to abate and she would certainly not be bed-ridden. Indeed, information is one of the most important aspects of care that the doctor can provide for people with vertigo, and will therefore be considered in greater detail in the final section of this chapter.

Medical management

Treatment of acute vertigo caused by vestibular dysfunction normally consists of symptomatic control by means of anti-emetics and drugs which partially suppress vestibular input. These drugs are not intended for long-term usage as they tend to retard natural compensation processes, and many have undesirable hypnotic properties (for a more detailed review of treatments for vertigo, see Chapter 6). Alternatively, or additionally, long-term prescription of antihistamines may be employed in an attempt to reduce the probability of further attacks. However, vertigo is a condition notoriously subject to placebo effects, spontaneous periods of remission, and unpredictable prognoses, and the true efficacy of preventative medication remains in question (Browning, 1986; Dix, 1984a). In cases of severe and intractable vertigo, an operation is sometimes suggested. The "endolymphatic shunt" (or similar operation)

may be offered to patients with Meniere's disease, although in the only clinical trial of this operation to include a placebo surgery group the improvement apparently effected by the shunt operation was no greater than the rate of placebo or spontaneous improvement (Thomsen et al., 1983). In cases of very severe vertigo, surgery to remove vestibular input may be performed (Brackmann, 1983). This is a fairly major procedure; there may be permanent hearing loss on the operated side, and many operations also involve a small risk of temporary facial palsy, cerebrospinal fluid leak, or meningitis. In addition, the presence of either bilateral disease or a failure of central compensation can render the procedure ineffective.

Since there is no ideal treatment or panacea for vertigo, even after extensive testing and the provision of the diagnosis the specialist may well adopt the same empirical approach to management as that employed by the local doctor:

And [the consultant] will say "Oh yes, you've got Meniere's disease and having problems with dizziness and that sort of thing ... Um, come back and see me in six months".

It was vagueish, [the consultant] could not be precise as to what was the actual cause or what necessarily the actual problem was, but in common with the symptoms that it was likely to be vertigo and one of these three pills should have some effect. Unfortunately they didn't.

This outcome can be intensely disappointing to those individuals who originally espoused what has been termed the "mechanistic" model of illness (Stainton-Rogers, 1991), and believed that their symptoms were the result of a discrete physical breakdown which would be fixed by the doctors once they had identified the cause:

I wanted a magic cure I suppose -- get rid of it, tablets for a week and then I am better.

I was hoping they would just find out what it was and sort it out and have something to cure it -- that was my idea.

Even people whose initial expectations concerning the outcome of medical investigation and management were less optimistic may be dismayed by the dearth of prognostic information, which would allow them to plan for and adapt to their condition:

The worst thing is not knowing how long it's going to last, and not knowing when the next one [attack] is going to come, and not knowing what I suppose the prognosis is -- really, for me, I think it's the unknown.

In recognition of the profound disquiet that persistent vertigo can provoke, the main form of non-pharmacological support currently offered by the medical profession consists of "reassurance". The textbooks are unanimous in identifying reassurance of the patient as a key element of medical management, yet no specific advice as to how reassurance should be achieved appears to be considered necessary. In order to examine the effectiveness of routine reassurance, I used the statements about consequences and perceptions of vertigo made in interviews as the basis for a questionnaire which was administered to all vertiginous patients attending a specialist clinic in a one year period. Although all of these patients had been thoroughly investigated, and reassured that their condition was "benign" on at least two occasions by at least two different people, I found that two thirds of the respondents admitted to continuing anxiety that something might be seriously wrong with them, and that this belief was highly correlated with reports of becoming depressed because of the vertigo (Yardley & Putman, 1992).

The questionnaire also contained items relating to perceptions of treatment by medical staff. Previous studies of other types of illness have found that patients are generally unwilling to criticise medical care explicitly, but that dissatisfaction may be detected in the form of specific complaints, commonly concerning a perceived lack of information and interest in their problems, or the expressed belief that medicine has little to offer (Fitzpatrick, 1984a; Roberts, 1985; Thompson, 1984). Responses to my questionnaire conformed precisely to this pattern; 81% of respondents agreed to some extent that their doctors had been helpful, yet 70% believed that nothing could be done for them. Many of the interviewees also tentatively suggested that more time and attention could have been devoted to discussion of their problems:

[The consultant] was very nice, but he tends to have his own idea as to what the cause of the problem is, and he doesn't listen. I suppose they've got so many patients -- they have about five minutes before each patient to read through the notes and get their own idea of what the problem was. He didn't seem to really understand, he seemed to get the idea into his head that it was one thing and give me [vestibular sedatives, anti-emetics and antihistamines] -- he couldn't think beyond that.

We do talk now, my doctor, but if we'd done it right from the start then I wouldn't have bothered him so much -- that was one of my main problems. I do understand that perhaps there's not a lot known about the problem, why it happens, so I'm not blaming anybody you know, but that's the way I feel.

More detailed analysis of the questionnaire results revealed two distinct attitude profiles. Those who felt that they had benefited from

drug treatment (and who had therefore presumably improved or recovered) stated that their doctors were helpful and understanding, and felt no desire for additional information and advice. However, half the sample agreed with the statement "I wasn't given enough explanation of the illness and how to cope with it." These people were characterised by elevated levels of reported handicap, disability, distress, and anxiety about the cause of the vertigo, and were less likely to consider their doctors helpful and understanding. These findings suggest that dissatisfaction with medical care may be the consequence of an awkward or belated transition from the traditional, doctor-centred mode of management which may be necessary in cases of acute illness, to the co-operative style of doctor-patient relationship which is better suited to the management of chronic illness. Patients are quite content with minimal explanation and discussion if the problem of vertigo is quickly resolved, but the longer the symptoms persist and the more evident it becomes that there is no simple solution, the greater their desire for information which might help them to become actively involved in the management of their illness:

If there'd been something that actually said this is what's going on, this is the area of your body that's affected, this is what aggravates it, this is what can make it better, this is the drug therapy that's open to you, the different types of treatment available to you, this is what other sufferers have experienced, this is what they say about getting on with life -- if that had been there, particularly if it had been written by somebody who'd actually been through it, I'm sure it would have been a help."

A further source of dissatisfaction described by many people concerned the hypothesised link between vertigo and stress. Because of the suspicion that psychological disturbance may be contributing to their patients' problems, doctors not infrequently mention that the vertigo may be stress-related. In the questionnaire study described above, virtually all the patients had diagnosed organic disease, but half the people in each diagnostic category responded positively to an item asking whether it had been suggested to them that stress might be a factor in their condition. Although this question did not specify whether the suggestion came from medical personnel, the interview statements on which it was based indicated that such suggestions most commonly originated from a medical source. Being told that the vertigo was stress-related was strongly associated with the complex of handicap, distress and dissatisfaction detailed above.

There are several possible explanations for this finding. Doctors may be particularly likely to proffer the suggestion that the vertigo is due to stress to patients whom they feel are unusually anxious. In addition, the failure of medical tests and treatments to provide a clear diagnosis and cure may simultaneously increase patients' anxiety and dissatisfaction

with medicine, and doctors' suspicions of a non-organic contribution to their complaint. However, such comments tend to suggest to patients that their symptoms are thought to be exaggerated or neurotic, thus promoting a sense that their physical problem is not fully appreciated, and dissatisfaction with medical attitudes and care (Thompson, 1984).

Previous research has shown that reassurance is only effective when the patient feels that the doctor truly understands the nature of the complaint (Fitzpatrick, 1984b); consequently, patients who believe (often rightly) that their symptoms have an organic cause are unlikely to accept "reassurance" when accompanied by a comment that their symptoms may be stress-related. Indeed, those interviewees who had been told their vertigo was due to stress described three sources of anxiety: the original fear that there might be a sinister cause for symptoms that they knew to be real, coupled with the additional concern that the doctors believed them to be hypochondriac or neurotic, and a nagging doubt as to whether they might actually be so.

The management implications of the hypothesised link between vertigo and distress can be a further source of dissatisfaction. Since many psychoactive drugs are believed to also sedate the vestibular system, doctors not infrequently attempt to solve the suspected physical and psychological problems simultaneously by prescribing tranquillisers, phenothiazides, phenobarbitone, or other drugs with significant central effects. In this situation, the exact nature and purpose of the medication is seldom explained, and several patients in our sample were dismayed to eventually discover that the tablets they had been taking to prevent dizziness were tranquillisers. Such medication may have significant mentally and physically disorienting effects, as psychoactive drugs can disrupt balance system function and retard compensation. Since drugs of this kind are often habit-forming, there is also considerable potential for creating an indefinitely prolonged cycle of dizziness and drug dependence. Some specialists go so far as to suggest surgical remedies for the anxiety experienced by people with vertigo. For example, Barber comments that "fear of a recurrent vertigo ... is a potent source of anxiety in some patients, and may constitute the main indication for surgical treatment" (1983, p. 29), while Browning follows a pessimistic evaluation of the probable physical value of surgery with the suggestion that "the placebo effects of surgery should not be dismissed altogether, because it can be difficult to achieve similar placebo rates by non-surgical means" (1986, p. 240). However, the relative costs and benefits of these solutions have never been formally compared with any alternative non-surgical or non-pharmaceutical programme of management. The advisability, and indeed ethics, of deliberately addressing psychological problems by means of such techniques therefore deserves closer attention, particularly since patients are typically not informed of the psychotherapeutic rationale for these treatments, while both drugs and surgery carry the risk of undesirable side-effects.

Even when psychoactive medication is not prescribed, simply telling patients that their symptoms are stress-related can have negative

psychosocial consequences, since formal attempts to help people suffering from vertigo to identify, eliminate or cope with sources of stress (for example, by referral to a stress-management programme) are exceedingly rare. Many people perceive the mention of stress as a covert accusation that they are responsible for their illness, while the reaction of some is to assume that they should adopt the passive, restrictive life-style of a chronic invalid -- a role which is itself a source of extreme frustration and stress for those who wish to be active. More often, patients attempt to find a sensible balance between activity and relaxation, but feel hampered by uncertainty about the likely time-course of their symptoms and ignorance of how best to manage their disorder:

You don't understand -- is it going to go away, or is it something that you're always going to have, or is it something that will progress? You're never told that. I think right from the beginning it would have been really helpful to have been advised how to cope with it -- not actually what's wrong with you or what it is. It's all very well being told to rest, but until you actually understand how to recognise when you are starting to have some problems ... I think you have to almost, yourself, test yourself out -- what you can and can't do.

As the preceding comments indicate, for many vertigo sufferers the final outcome of their "medical career" (i.e. their contact with the medical system) is the realisation that they will have to work out how to live with their illness themselves, often with little help from professional sources:

In the end you become very philosophical about it because the impression you get is that nothing can be done about it anyway. I don't think the medical people knew, or still know nothing about it as far as I can see and they're really poking about in the dark, [so] in the end you don't bother people unless you're really desperate.

The following chapters analyse the practical, physiological, social and psychological problems which confront people with chronic or recurrent vertigo, and describe the way in which people respond to these difficulties and learn to cope with the disorder.