Listening to patients' stories

Storytelling approach in family medicine

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SUMMARY

This paper discusses the relevance of a storytelling approach for understanding psychological problems in family practice and assesses the value of such an approach.

RÉSUMÉ

Cet article discute de la pertinence de l'approche d'écoute pour mieux comprendre les problèmes psychologiques en médecine familiale et en évalue le mérite.

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PSYCHOTHERAPY, DERIVED FROM the greek words psyche (mind) and therapeia (treatment), has been defined as a method for treating emotional problems and disease by mental rather than physical means,[1] or as treatment of mental disorders using psychological methods.[2] Sutherland[3] defined psychotherapy in terms of relationship qualities:

> By psychotherapy I refer to a personal relationship with a professional person in which those in distress can share and explore the underlying nature of their troubles and possibly change some of the determinants of these through experiencing unrecognized forces in themselves.

While providing for psychotherapy to be practised by a range of medical professionals, including family physicians, these definitions do not acknowledge two important aspects of the psychotherapeutic encounter: context, in which psychotherapy is open, discreet, and intensive; and the special qualities of the therapist-patient relationship, particularly as regards the therapist's skills.

For family physicians, the organized hours required for formal therapy are often difficult to find. Normally, patients have about 10 minutes of doctors' time,[4] which might be interrupted by other patients, nurses, other team members, or telephone calls. In family practice there is often no easy way to balance the rights of patients with those of nurses to enter the room or those of other patients to telephone.

Family physicians must thus find unique and diverse ways, such as being sensitive to verbal and nonverbal cues from patients or their families that might signify emotional problems; observing patients' behaviour or family relationships; noting patients' or families' reported behaviour (at home and at work); and being aware of patients' histories, general backgrounds, and present and past illnesses. To these are added physicians' reactions to patients and their problems (self-analysis, countertransference). A novel approach to

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psychotherapy in family practice is the storytelling or narrative mode.

Storytelling

To understand and make sense of the world, humans tend to structure the stream of time and events into a story with a beginning, middle, and end. History represents the desire for not only a true and reliable report of events, but also a way to understand the present as an outcome of the past. Every individual has a personal and family life story. The telling of this story is already an interpretation, based on what the individual perceives to be true, even when he or she has knowingly told different life stories at different stages of life.

Patients know the conventions of presenting their problems to psychotherapists. They usually come prepared for deep self-disclosure of innermost conflicts and problems. However, patients could be less amenable to revealing complicated emotional processes to family physicians because of the medical context or because deep disclosure is not part of the doctor-patient contract.

The storytelling approach to psychotherapy is quite different from the conventional approach in that it involves the construction, not of logical arguments, but of subjective stories. Among the forerunners in this approach are Kleinman[5] and Bruner,[6,7] who stated that by talking about our lives we become the autobiographical narrators through whom "we tell of our lives." Our stories selectively include or omit information, the omissions being no less important than the inclusions. Hunter[8] likens patients to texts to be examined and studied and understood by physicians.

A physician's agenda is to collect information and to classify and organize it into an existing concept of disease. Thus, during an intake interview, family physicians begin by asking patients their histories. But when patients start to talk, they are usually interrupted with specific diagnostic questions. Studies report that patients have an average of 18 seconds to talk before being interrupted by a physician.[9]

Listening

Listening is often selective and has preconceived biomedical or psychological constructs. What is usually overlooked is that patients also have personal constructs around how they (and often their families) perceive the course of events leading up to the complaint, symptom, or illness for which they have consulted the doctor. For some patients it is important to relate the whole story: how it started (the beginning); how it has developed (the middle), especially their personal understanding of the etiological chain of events; and what they fear, do not know, or expect (the end). Depressed and anxious patients often need to talk longer.[10] Listening to such personal narratives is time-consuming, but hearing them once is often enough. Even if the story is not particularly relevant at the time of its telling, it should be accorded equal importance with presenting symptoms. Many patients are confident that family physicians know and will remember their special stories.

Dachau: *Some patients tell stories of nightmares and experiences during World War II.*

A case can illustrate this point. A 68-year-old man was seen for a knee

problem by a new family resident at his regular clinic. After examining the knee and prescribing the proper treatment, the resident asked the standard question, "Anything else wrong?" The patient replied, "Yes, I don't sleep well." When asked why, the patient replied, "Do you really want to know?" When the resident indicated that he was interested and still had time, the patient told a long story about his nightmares and experiences during World War II in the Nazi holocaust. At the end of the moving narrative, in fact a part of the patient's life story, the resident inquired if his regular physician was familiar with the story. The patient confirmed this, adding that he also received sleeping pills whenever he needed them without having to repeat the story.

Need to tell

Some patients need to retell their stories again later, emphasizing other and new aspects and leaving out old ones. A personal life story is not, and should not be, static. It keeps changing. Patients should not be judged or blamed for being inconsistent or contradictory. Personal stories, which can be told in many versions, always have a certain inner and subjective logic. At the time the story is being told, it is for the teller true and relevant for that moment.

Many patients work through a part of mourning when telling their personal life stories: mourning the world of yesterday; the death or loss of important people; the loss of functions of body and mind; or the loss of profession, culture, and status (eg, new immigrants). During the narrative, patients sometimes experience painful emotions or feelings of nostalgia and longing. They are reminded of guilt feelings and unresolved conflicts. In some cases, where deeper mourning is needed, physicians have to listen to the story repeatedly and with enduring empathy. Empathetic listening requires experience, knowledge, communication skills, sociocultural familiarity, an awareness of one's own limitations and prejudices, and an understanding that the way the story is told is part of its meaning.[8]

In patients' tales, the storyteller (patient) and the central figure of the story (patient) are matched and the story is told subjectively. For doctors, it is important to examine the following aspects of the unfolding narrative: main themes (Bruner[6] lists jealousy, authority, obedience, and ambition; we could add comfort, caring, and anxiety); the kind of language used (its richness, metaphors, and active or passive tense provide important clues); and the working through of the story and its implications.

For instance, a patient developed posttraumatic stress disorder after a serious accident. He refused to drive his car, thus limiting his functioning. He became increasingly irritable, anxious, and socially isolated. He needed to be asked what happened to him personally and whether he had thoughts, feelings, dreams, or fantasies about the event that he would like to share with a physician: in other words, his subjective and individual reaction to the accident. This is not the same question asked by representatives of other services and agencies with whom he came into contact, such as his employer, the surgeon, the police, the insurance company. Family physicians should listen carefully to the emotional aspects of patients' stories to elicit a unique and personal reaction.

Serious compliance problems often arise among young patients suffering from severe and progressive syndromes.[5] Allowing patients to tell their personal narratives–how the various stages of illness developed, their personal views, and the meaning of their current resistance and rebellious behaviour–is very important. It might not only increase compliance but improve the doctor-patient relationship dramatically as well.

Intervention strategies

A family physician's ability to listen carefully and attentively to patients'

stories is important for intervention. Physicians must be sensitive to the unfolding story in order to place it logically or rationally in context. As Howard[11] has stated, "a life becomes meaningful only when one sees himself or herself within the context of a story, be it a cultural tale, a religious narrative, a family saga, the march of science, a political movement and so forth."

Physicians can learn something about patients' (and families') subjective and lay beliefs about illness and how they interpret the meaning of its manifestations. Doctors will be able to get a rough idea of a patient's life orientation, plans and goals, and events and pressures surrounding the particular problem. Over time, doctors might be able to decide whether the problem represents a minor deviation from an otherwise healthy life story or whether the story represents a more fundamental disorder.

For example, a patient might say, "My stomach pains and headaches have been affecting my work and I am worried about it. Am I seriously ill?" and then go on to talk about illness behaviour in the family and about the recent discovery of AIDS in a close friend. At this point, he or she might talk of having being closely involved in caring for the friend. After hearing the main theme of the story and having ascertained that this is a normal and appropriate adjustment issue, the doctor is able to intervene (eg, with supportive psychotherapy or crisis intervention techniques). In this perspective, as Howard[11] points out, part of the work between doctor and patient can be seen as life-story elaboration, adjustment, or repair.

Intervention in this context aims at understanding the stories in an effort to effectively rewrite them (ie, produce changes). When looking at problems in the storytelling mode, emotional conflicts can be viewed as instances of life stories gone awry and psychological intervention as exercises in story repair. The perspective of emotional problems thus presented to family physicians changes from a purely clinical modality into an area rooted in human development and fantasy. Therefore, patients revealing emotional problems to family physicians often present subjective complaints hidden in "somatic camouflage." Their hidden agendas (ie, hidden stories) must be retranslated into overt motives they can accept as real and relevant. The act of revealing oneself might be therapeutic in itself,[12-15] or it could contribute directly to improved outcome through the support and care implicit in attentive and nonjudgmental listening.[16,17] By adding insights and negotiating a resolution,[18] the physician actively brings order to the patient's often chaotic perceptions of illness.

Time and understanding

The approach requires communication skills: how to listen with enduring empathy, and knowing when and how to intervene actively. Family physicians might need to make time for such medical-psychotherapeutic intervention. Kleinman[5] recommends six sessions of 40 minutes for severe mourning reactions. Otherwise, effective intervention probably requires two to six special sessions of 20 to 40 minutes each. Because it is so time-consuming, physicians might need to be selective about which patients they treat this way. Physicians also must decide during these sessions whether additional approaches, other than just listening, are necessary, such as social support, practical problem solving, or clarifying obvious and significant blind spots in the narrative. Chronically or terminally ill patients or those with posttraumatic stress disorder often have a great need to tell their personal stories, and having a physician who is willing to listen improves the doctor-patient relationship very much.

The storytelling approach requires appropriate doctor-patient matching for effective intervention. Physicians must show openness, empathy, and tolerance of patients' culture, race, sex, and belief systems. Physicians must

also be aware of their own personal stories and how these can influence their ability to interpret patients' narratives (countertransference) by trespassing on professional boundaries. A 35-year-old woman consulted her physician for a condition very closely resembling that of the physician's mother, who had just undergone a mastectomy. Because of strong identification with the patient, the physician saw the patient daily, took charge of arrangements to ease her plight, and had difficulty keeping a suitable perspective of the situation.[4]

Conclusion

The storytelling mode enables family physicians to analyze a story that applies to a particular problem (or situation), to understand the issues at stake, and to devise suitable intervention strategies.

Family doctors need a mode of intervention that is different from normal, exploratory psychotherapy, which is often time-consuming and inapplicable in the family medicine context. Storytelling requires careful and empathetic listening and understanding without necessarily deeper interpretations. Sometimes, merely listening to a patient's story with its expression of emotions and meaning can produce desired changes. Listening to a story now could have implications for future interventions because the doctor-patient relationship is an encounter between two life stories.

Bruner[7] wrote, "My life as a student of mind has taught me one incontrovertible lesson. Mind is never free of precommitment. There is no innocent eye, nor is there one that penetrates original reality. There are instead hypotheses, versions, expected scenarios. Our precommitment about the nature of a life is that it is a story, some narrative incoherently put together." ■

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