The narrative approach as an effective single intervention in functional somatic symptoms in a multi-disciplinary referral clinic for primary care frequent attenders

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Mental health problems are underdiagnosed in general practice, primarily because they are often somatized and the patient reports only physical symptoms. These somatized symptoms are responsible for a large percentage of the frequent attenders in general practice. Palpitations are among those somatized symptoms. Here we present the theoretical background and the process of assessment and treatment of patients referred to a special counselling clinic for frequent attenders, through the report of a patient with palpitations. It illustrates the use of the narrative approach and the possible mode of action of this specific intervention.

Keywords. Functional somatic symptoms, life review, narrative approach, palpitations, sense of coherence.

Introduction

Life narrative is not yet adequately developed as a medical tool. Doctors are more accustomed to using the genogram for detecting family medical problems, even those not purely genetic.1,2 The narrative approach, a psychotherapy technique used especially in crisis situations,3–5 can also be used in general practice.4,6 It helps create a strong bond between physician and patient, facilitating the understanding of symptoms within the context of the patient’s life. Within this context, suffering acquires a logical meaning as an ‘inevitable’ product of previous life experiences, of ongoing stress or of a specific stressful event.5 The narrative technique could be especially useful for the somatization patient, who is generally blind to, and often antagonistic toward, the mental aspects of health. It mobilizes the patient to accept diagnoses and treatments previously ignored or even refused. Quite possibly, the assessment itself, without formal psychological therapy, may be used as a treatment, understanding and changing patients’ beliefs about their symptoms, disability or distress.7

These techniques require time, which is at a premium in family practice, so that even doctors versed in addressing the psychosocial aspects of health and disease and the family influence on them are often unable to do so. To overcome these hindrances, and following the latest models for the treatment of the somatizing patient and the unexplained physical symptoms, we developed a specialized collaborative counselling unit in the community.8–10 The main goal of this unit is the diagnosis and treatment of frequent attenders and of patients defined as ‘difficult’ by their family physicians.10 The present paper reports on one patient referred to this unit, describing the interview and the use of the narrative technique, which for the elderly can be renamed life review. We discuss the possible mode of action of this specific intervention.

Case presentation

Lea, a German-born widow of 84 years of age, was referred to our counselling unit by her family physician after prolonged complaints of palpitations. These
palpitations were not followed or preceded by chest pain, tightness or shortness of breath. In the year prior to consultation, she had undergone the entire array of tests indicated for her condition, and had tried several anti-arrhythmics, none of which alleviated her symptoms.

When she came for consultation, she had been suffering from arthritic pain in both hips, and in recent months had been limited to taking only short walks around her house. Her sleep was disturbed, and she had abdominal pain, nausea and general feelings of weakness. Again, all abdominal and gynaecological examinations and tests yielded normal results, as did her blood tests. Her physical examination was also normal. Yet she looked sad.

As we turned to address her sadness, it was then that her symptoms fell into context.

A year before she came to our clinic, her husband had died of cancer. Prior to his death, they had spent 20 years in their native Germany, and Lea described the last decade as a second honeymoon. When she was widowed, her older daughter invited her to return to Israel, and live with her. The move soon soured, and she felt rejected by her daughter who now wanted to transfer her to a nursing home. This succession of changes rendered her very anxious and depressed, and she claimed that she would rather be dead. She would not actively commit suicide but dreamed and prayed every night not to wake up the next morning.

Her life story also seemed important in understanding her dilemma.

Lea was born in Germany, the first daughter of a wealthy Jewish family. Her entire extended family—grandparents, uncles and aunts—lived harmoniously in a four-storey building. She remembered a happy childhood, despite frequent illnesses for which their family doctor visited their home to treat her ‘weak constitution’, frequent episodes of tonsillitis and especially early morning nausea and vomiting. Throughout her school years, she had abdominal pain, which only manifested itself in the morning (a kind of psychosomatic symptom, in her words). As an adolescent, Lea joined the Zionist movement. Against her parents’ advice, she refused to go to medical school, married a man she met at the Zionist movement and came to Israel. Her sister, 2 years her junior, her parents and all her family remained in Germany, where they perished in the Holocaust.

Upon arriving in Israel, Lea and her husband were given 1 acre of thorny land in a new agricultural settlement. They used to wrap towels around their fists in order to prevent wounds when working the land by hand. They lived without electricity or running water. Their lives were very difficult in the pre-state Israel in the 1940s, while they worked and raised three daughters. The daughters are now married, with children and grandchildren of their own. Lea and her husband worked very hard until their retirement, when they sold what had become a modern, wealthy agricultural farm in the north of Israel. She was 64 years old at the time. With this money, and after all the daughters were married and settled, they bought an apartment in Israel and another one in the Alps of southern Germany. For the next 10 years, they spent their winters in Israel and their summers in Germany.

After her husband was diagnosed with lymphatic cancer, they decided to move and live permanently in Germany. He eventually responded to chemotherapy and achieved a cure. The next 10 years were those described by her as their second honeymoon. They lived in a small quiet town with beautiful views of lakes and forests, and travelled extensively in Europe. They appreciated the politeness of the Europeans in contrast to the roughness and stress of the Israeli culture.

Lea and her husband had friends and enjoyed an active social and cultural life. However, this tranquility ended when one and half a years ago her husband suffered a relapse of his lymphoma, leading to his death. The couple entered a nursing home for his terminal care and he died without suffering. Lea accepted his death as a fact of life, and was grateful to their doctor, the nursing staff, the social services and the medical insurance that allowed him to die with dignity. They had had a wonderful life together. She portrayed him as her great and only friend; they had lived together for more than 60 years, worked together in the same place, built a family and created wealth, and felt that they had actively participated in the building of the State of Israel. Together they overcame famine, frustrations, wars and disease until they reached their last 10 years of serenity and happiness.

After her husband’s death, Lea longed for her daughters and extended family, and she accepted her daughter’s invitation to come and live with her and her son-in-law, in their big house, now empty of children. Initially, Lea relived the house of her childhood, but soon she felt alone, as her daughter, she thought, had no time for her. Lea was disillusioned with the new materialistic Israeli society with its lack of social services for the elderly, and was especially frustrated by the inhumanity of the medical system, referring to the ‘technological Israeli doctor’. She lamented the political turn and the slowing down of the peace process. She had few friends in Israel—her old ones were either dead, bedridden or brain damaged by age or disease. She felt isolated and bitterly lonely.

A few months after Lea’s arrival, her daughter thought she would feel better in a nursing home. Against her will, they began looking for one, only to discover the high cost of nursing homes. Lea felt exploited and thought that there was no limit to greed. She fluctuated daily between considering returning to Germany, buying a new house or even entering an old peoples’ home, but did not have it in her to begin a new life. The family’s pressure to move to a nursing home...
was very stressful, and she felt anxious, depressed, frustrated and betrayed.

After listening to her medical history and life story, Lea agreed with us that we had a good understanding of her symptoms and present conflict. We suggested a short break, and she went out for coffee with her daughter, while we reflected on the case. I remember thinking that we had a tremendous opportunity to understand a ‘family life cycle’. We felt enlightened by her biography of heroism, ideology, the building of Israel and, secretly, also by her continuous loving partnership with her deceased husband. Despite her age and fragility, her strength, intelligence and clear mind were impressive. She was clearly depressed and we could almost feel her anger, disappointment and sadness, especially in the dilemma she was facing, yet we felt that life could be worth living and meaningful even at its last stages.

Following our consultation protocol, Lea returned 2 h later. In the presence of a social worker, I retold her story, which consisted of Lea’s biography and passages through crisis, interweaving her medical history into her life narrative. The retelling of her life story allowed me to accentuate and emphasize her positive and successful passages through life and its crises, ending with a reflection on her feelings. I felt she had acknowledged that her only alternative was to consent to the common will of her family and enter a nursing home. By now, however, she was feeling different. She no longer resisted the idea; it was as if she had undergone a personal transformation. She felt that our previous talk allowed her to see clearly and decide. She ceased longing for life in Germany, and began thinking not only about being a resident in the nursing home but actually working there, managing the library. She always liked to read books; she had a splendid memory for them and liked the order and the silence of libraries. In these 2 h of reflection, she had already chosen a modest nursing home, where she could walk and be close to nature. She decided to sell her apartment to finance the move. I was touched and impressed by the change. At the end of our meeting, she asked for help with the arthritic pain in her hips. I referred her to physiotherapy and she was very grateful for the consultation.

One month later, she was going through a smooth move to the chosen nursing home, and was beginning her work in the local library. Her symptoms did not bother her much and she had not seen a doctor since.

Discussion

Mental health problems are underdiagnosed in general practice, primarily because they are often somatized and the patient reports only physical symptoms. Palpitations are among those somatized symptoms. In the present case, both the patient’s symptoms and her emotional state were elucidated during the consultation. The impact of immigration on an 84-year-old woman who had lost her beloved husband and only friend became clear. In a dynamic approach, we can speculate on her conflict: at this specific time and life situation, grieving for her husband, she felt herself reverting to being the weak and dependent child of her past, a weakness that she attributed to herself, to her constitution. In a physiological sense, it could be an emotional arousal of her feelings of anger toward her daughter, her feelings of rejection or the fear of a possible new change in life trajectory. The palpitations could also have a symbolic meaning: they could symbolize her wish to die from a ‘broken heart’.

When dealing with crisis, we should address firstly the feelings of confusion and anxiety (failure of the coping mechanism and ability to adapt) as well as the loss of normal equilibrium. We also deal with the crisis state (depression), the personal meaning of the events for the individual, and the formal and informal social support systems available to the person and the pre-morbid personality. In our management, we must try to lead to reconciliation with an altered life trajectory.

In the normative life cycle crisis of old age, Erikson points out the struggle between ‘integrity’ and despair. Despair is the feeling that time is short, too short to begin another life trajectory. This feeling is associated with ‘an unconscious fear of death’ that sometimes, as in this case, is transformed into the wish to die. Integrity is the acceptance of one’s own and only life cycle.

This integration and reconciliation could be achieved through deep listening that is an important part of the narrative approach. By emphatic listening to Lea’s story, the physician allowed her to talk about emotions and irrational subjects, giving legitimization to anxieties, fears and doubts. This non-judgemental approach helped her strengthen her efforts to remain autonomous and to regain control over her destiny, and might also have facilitated the working through of her anger and disappointment toward her oldest daughter. The narrative approach helped Lea discover a possible new outcome through regaining her sense of self. Gergen wrote about narratives as boosting directions, in which a particular goal is advanced and insight is gained. The narrative approach helps patients reinterpret events, pushing away pathogenic feelings and cognitions, and finding in themselves resources for healthier coping. The retelling of her life story gave Lea the opportunity to accentuate and emphasize her positive and successful passages through crisis, immigration, wars and diseases, thereby increasing her self-esteem and sense of coherence, so that she could again re-identify with the heroic figure she had pictured herself to be.

We may assume that Lea had ‘almost decided’ before she had visited the unit that her mind was quite made up. Therefore, one long and meaningful consultation could help her make the final decision, or to approve an
internal decision that she had almost made previously. However, this time, the decision was her free choice, and not a result of her daughters’ pressure. The team functioned as her ‘digestive system’. It offered her a holding environment through which she could mirror herself and come to accept herself.

The success of this treatment, by just eliciting the life review, relied on the achieved sense of coherence of Lea’s experience of physical and mental stress in this specific life situation, and in the creation of a new narrative of strength and positive coping. The physician emphasizes the salutogenic (health-promoting) elements in her entire life as well as in the present situation. This means perceiving the present life problems more as a challenge than as stress, and doing so by using the mental resources that she had often used successfully in other struggles through life. One may use Antonovsky’s frame of references by stating that this patient had a strong and flexible sense of coherence. She perceived, with the help of the interview, the structure and the rationale of her life situation (‘comprehensibility’). She understood that she is, at least partially, able to decide autonomously and freely, not under pressure from her daughter, whether she wants to move to a home for the elderly (‘manageability’). She thought and felt that it was important to prepare for this new stage in life creatively by asking for a voluntary job in the library (‘meaningfulness’). In addition, it is possible that her decision not to return to Germany, and to go to a Hebrew-speaking Israeli home (rather than a German-speaking one), represent a partial solution of her basic problem of identity and belonging.

This report raises many questions such as how transferable is the success of a single consultation using the narrative approach based on a case report. In this report, the patient was unaware of her mental health state and frequently attended her family physician with non-specific somatic symptoms. Whether this technique should be restricted to patients with mental health problems or to frequent attenders or to patients presenting with functional somatic symptoms is to be debated. We suggest that this biographical life narrative technique is potentially very powerful and should be explored further in family practice both in clinical and in formal research studies.

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**References**


