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Patients' written life stories: A gateway for understanding

A qualitative study from general practice

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Abstract

Objective. To explore how statements drawn from patients' written life stories can help general practitioners understand their patients' maladaptive thought patterns and their negative schemata. *Design.* Qualitative study of written life stories. *Setting.* General practice in Copenhagen, Denmark. *Subjects.* A total of 22 consecutive patients aged 23–49 years, who were invited by their GP to participate in cognitive therapy owing to depressive or anxiety-related disorders, including unexplained bodily symptoms. *Theoretical frame of reference.* Beck's information-processing model of anxiety. *Results.* Analysis of the written life stories disclosed aspects of negative expectations of life, the self, or the values and capabilities of others or of the patient him- or herself. Three main beliefs were identified: (1) the world is evil, (2) only the perfect is of value, and (3) emotions are dangerous. The patients describe events and experiences in negative terms that others might have interpreted as neutral or positive. For some this translated into a sort of all-or-nothing kind of thinking. Anger and other strong feelings were forbidden. Responsibility for the life of others was a dominant feature. *Conclusions.* Written life stories reveal knowledge of the patient's dysfunctional thought patterns. This may be a useful shortcut in therapy.

Key Words: *Cognitive therapy, family practice, qualitative study, written life stories*

Some 20–30% of all patients attending general practice suffer from psychological problems [1,2]. Psychosocial factors impact significantly on the course of somatic diseases and the concomitant consumption of health services [3,4]. Psychotherapy is accordingly a relevant option for many problems in general practice. Cognitive therapy aims at identifying and restructuring such maladaptive thought patterns and offering the patient alternative assumptions about the self, the world, and the future, replacing negative thoughts with more constructive thoughts or thought patterns [5–7].

Contextual awareness and narrative understanding may be essential to understanding the ambiguous and sometimes contradictory signs or symptoms presented to the general practitioner [8]. Written homework assignments are used with different therapies [9–11] and have demonstrated their value when combined with cognitive behavioural therapy.

Need for therapy addressing depressive and anxiety disorders can be handled by family doctors.

- Written life stories reveal information about the patient's negative schemata and maladaptive thinking.
- Recognizing the patient's maladaptive thought patterns could be a short cut to better therapy.

We experienced how analysis of thought patterns could clarify the prospects of positive recollection being instrumental in furthering therapy. Pennebaker and co-workers thus demonstrated "the psychological value of studying particles of speech, serving as markers of emotional state, social identity, and cognitive styles" [12].

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We aimed to explore how statements drawn from patients' written life stories can help general practitioners understand their patients' maladaptive thought patterns and their negative schemata.

Material and method

The practice, located in central Copenhagen, has a mixed patient clientele of students, singles, and Danish and non-Danish families. Data were gathered by BE and JH in their capacity as general practitioners while offering cognitive therapy and participating in a supervision group using written homework assignments and a cognitive behavioural model. Patients invited to participate in the cognitive therapy presented with depressive or anxiety-related disorders, including fear of disease and unexplained bodily symptoms. All patients commencing therapy were given as their first assignment to write down their life story. The patients were literally asked:

> "*Please write the story of your life, focusing on people, emotions and events of importance*".

We performed a retrospective, qualitative textual analysis on the basis of written life stories. All consecutive consultations involving therapy during the period October 2001 to January 2004 were registered. Data were collected from the written life stories after the end of therapy. The patients' ages ranged from 23 to 49 years; there were 9 men and 13 women, most of them suffering from mild depression. When therapy was discontinued, all patients could choose whether the life story should be destroyed.

We found 24 planned interventions deploying cognitive therapy. One was excluded because the written homework assignment was misunderstood and another because the life story was destroyed.

The 22 life stories were subsequently transcribed into texts. Analysis was inspired by Giorgi's procedure [13,14]. Starting by reading all the material, we drew up a preliminary list of topics to identify statements that could be interpreted as reflecting maladaptive beliefs. Supported by the theoretical frame of reference [5–7], yet taking the empirical data as guidelines, categories were developed and elaborated, so that coding and condensing could be accomplished. Finally, the content of each of the coded groups was summarized in order to generalize descriptions and concepts reflecting different groups of maladaptive beliefs relevant for the cognitive therapy. The study was approved by the local ethical committee.

Results

All life stories disclosed aspects of negative expectations of life, the self, or the values and capabilities of others or of the patient him- or herself. The analysis identified three main categories: (1) the world is evil, (2) only the perfect is of value, and (3) emotions are dangerous. Some of the statements could be subsumed under more than one main category and were hence located in more than one.

The majority by far of the life stories contained references to experience sustaining the belief that the world is evil. Most of the life stories disclosed perceptions that value could be ascribed only to perfection whether in oneself or in others. Nearly half of the life stories mentioned the dangers of showing anger and other strong feelings.

The world is evil

These life stories shared the common experience of an unpredictable and dangerous world. Several patients emphasized that physical or emotional fragility during childhood had caused them to become dependent on others' help. A female student in her early twenties described her anxiety as follows:

> *During the first six years of my life my mother cared for me at home. What a wonderful time. It came as a shock to me when I had to go to kindergarten at the age of six! I cried every day.* [# 3]

Divorce had left a mark on several patients. The patients felt that the adults failed to provide sufficient care. There was much fear of being abandoned or forgotten. A female preschool teacher with anxiety thus wrote:

> *I probably attended kindergarten during my parents' divorce. I remember being the last child that was fetched and thought that my father had forgotten me.* [# 1]

Many reported how a loved one suddenly disappeared, died or was dying. A 29-year-old unskilled depressed man wrote:

> *. . . and I often woke up when she had a "seizure". She spent much time in different hospitals and I was often very afraid that my mother would die.* [# 22]

Violence and other serious abuse were mentioned in several of the life stories, including repetitive attempts at or threats of suicide. Sexual abuse was mentioned in three of the life stories. Such experience was often not communicated in other ways.

A 28-year-old female shop-fitter apprentice with unexplained bodily symptoms wrote as follows:

> *I was only a child and it was not right of him to touch me in that way .... I was not able to say no at that time. Well, I think that almost no children would. Had it happened to others? My sisters? Scary*! [# 23]

Only perfection is valuable

Several patients described how they saw themselves as worthless as a person and therefore had to do something good, be the best, engage in activities, or bond with perfect people in order to deserve the attention, respect, or love of parents or others. A 29-year-old male preschool teacher with an alcohol abuse problem wrote:

> *I remember coming home from swimming, saying that I was one of the best swimmers on the B team. My mother told me that she had had two sons on the swimming team before and that the other two were both better.* [# 7]

Some remember they shied away from showing their "true self", writing that they tried to avoid attention because it could be difficult to live up to others' expectations or because they wanted not to become nervous or uncertain. A 28-year-old male skilled worker suffering from tiredness wrote:

> *They gave us and the other children the impression that all men, with a few exceptions, were male chauvinists, insensitive and inconsiderate. I think they forgot that we, the five boys in this cohabitation group, would grow up to become men*. [#15]

The need to maintain control was frequently mentioned in these life stories. This need sprang from a fear of being exposed as worthless or just an entirely normal person. Several patients described the importance of order. Two of the life stories described eating disorders as an extreme way of exercising control. Loss of control was associated with feelings of guilt and fear. A male student in his late twenties wrote:

> *In primary school the worst part was excursions and camps. The very thought of knowing that we had to travel and not being in control was very anxiety-provoking.* [#2]

A few of the life stories contained almost nothing in between the almost consistently rosy picture of friends and important events and "the absolute worst" of more negative experiences. This all-or-nothing approach was also expressed when falling in love with "the one and only". A 49-year-old female nurse with unexplained bodily symptoms wrote:

> *In 1996 I met Brian, who I thought was the man of my life.* [#17]

Emotions are dangerous

The life stories told of lives where the basic assumption was that negative feelings were associated with much discomfort. Such discomfort arose in the face of quarrel, grief, or suffering. A 28-year-old woman with unexplained bodily symptoms wrote:

> *I have only witnessed my mother cry once. Of course, she did cry a lot more, but I could not see it, so it did not exist. I just knew that I would never again see my mother cry.* [#23]

Strong personal feelings caused shame or anxiety. Participants felt incapable of expressing anger or saying no. This would also imply that they shied away from emotional situations.

> *... after just two weeks I felt trapped. The thought of having another person that close to me who might suddenly disappear was not at all appealing*. [#2]

Responsibility for other people's suffering or well-being was a burden for many patients. Feelings of guilt or bad conscience were a frequent feature in these life stories. A female environmental planner, aged 30, suffering from a mild depression wrote:

> *It is as if we all have to stop living just because John is sick. I think it is the same feeling I had as a child when my father was sick.* [#4]

Discussion

Strength and limitations of the study

Interpretation of the available data invites the question of to what degree the material collected actually represents the patients' own wording and basic schemata. Methodologically, writing allows a window of censuring and editing; the text may accordingly portray an idealized reality, or it may mirror the patient's perception of what he/she thinks the physician wants. The life stories, however, were written in the very early stages of the course of therapy and the instruction for the written home assignment was as open as possible to allow the patients room for their own interpretations of important events, persons, and emotions in their lives. In reader-response theory, the reader of a text is regarded as an active co-composer [15,16]. In this

case, the life stories appeared to represent personal and very concrete experience, allowing analysis to present findings and categories beyond the theoretical framework.

An alternative to the written life story could be tape-recorded oral narrations of life stories or the use of diaries that could be searched to identify expressions reflecting basic assumptions. The written word often captures essentially personal reflections that may not easily surface during a structured interview where the physician's non-verbal signals also interact with the patient. The written life story, therefore, offers several advantages over other methods: it is the patient's sovereign decision, a conscious or subconscious choice, on what issues should be raised.

The writing process is ideal for furthering reflection and introspection. Writing can serve the function of organizing complex emotional experiences and can promote health by aiding the patient to come to terms with previous traumatic experiences [9]. Thus, Pennebraker has been studying and documenting the effect of writing therapy for many years and points to the critical importance of the written narrative as an indicator of health [10,12,18].

The study context, where general practitioners offer their patients cognitive therapy, may not be fully transferable to GPs without special training. Yet, our findings represent knowledge that can be used to achieve a broader understanding of patients suffering from psychological problems, irrespective of the kind of therapy provided. Our study did not predict the further course of the psychotherapy and whether the life story significantly improved the therapeutic outcome for the individual patient. However, we did observe a positive effect on the dialogue of the patient–doctor encounter in almost all cases and the patients discovered interpretations and resources previously unknown to them.

Implications for general practice

The material presented here included patients with a recognized need for therapy, i.e. young adults aged 20–35 years who are capable of expressing themselves in writing. Danish-speaking people generally have a positive attitude towards the writing process and cognitive therapy can be deployed in this group right away. The material presented here is drawn exclusively from this group of patients.

We gained new insights that benefited our subsequent work – both within the context of the psychotherapy and within our general practice. Our practice has a mixed patient population and does not differ in any significant respects from other Danish general practices. We therefore assume that similar

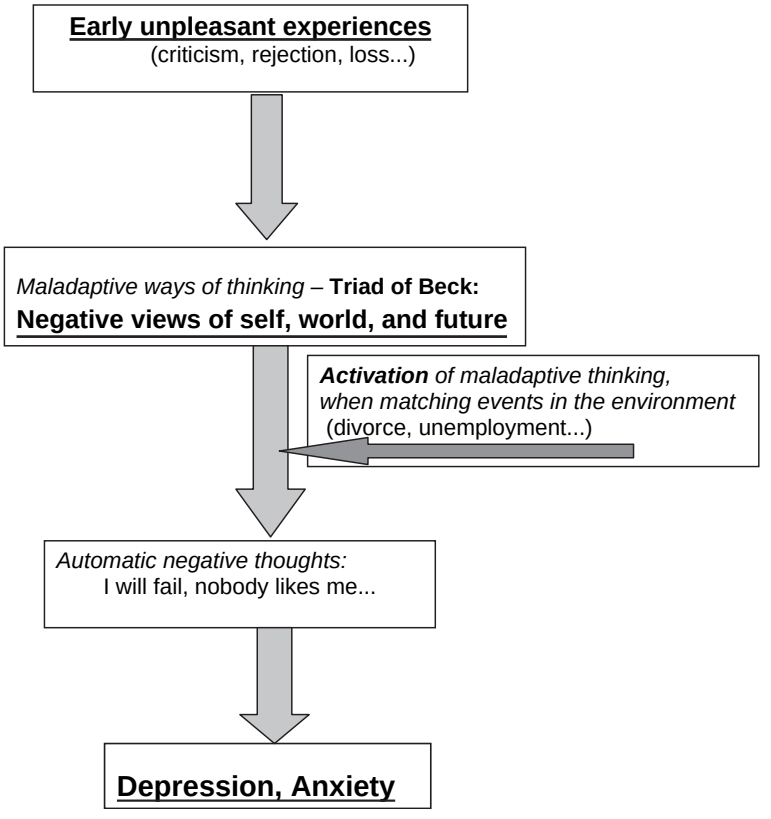

Figure 1. The Triad of Beck.

thought patterns could be identified in patients offered cognitive therapy in other general practices. We have learned, however, that language problems could make the relatively large population of immigrants less suitable for such intervention. We may also speculate that thought patterns causing maladjustment and dysfunctional behaviour may be particularly outspoken in Scandinavian cultures.

Conclusions and further research

Our work is rooted in many years of experience with cognitive behavioural therapy. Our ability and the precondition for offering this kind of therapy was access to qualified supervision. Particularly important was the availability of a well-documented model [5–7] as a basis for our work and the possibility to solicit help when needed. Our study was not intended to test the model, but to apply the approach of the model to develop new understanding.

The life stories have been a rich source for understanding the patients' perceptions – first and foremost a useful shortcut for mobilizing resources that could counteract dysfunctional basic conceptions [22].

Although our model rests on Beck's cognitive triad [5] (Figure 1), we do believe that knowledge of the patients' dysfunctional thought patterns can be useful in other conversational situations and to therapists other than general practitioners who offer therapy.

The present study addresses the patients' wording of their dysfunctional negative thoughts. Further research would benefit from studying how these findings could be used in subsequent encounters; such research could draw, for instance, on video- or tape-recordings. Their aim could be to trace a possible interaction between the patient's experience of the encounter and the irrational schemata found. Was it a shortcut or a blind alley? Studies using structured interviews of either clients or physicians with a view to discovering how the life story and its interpretation affect the course of the disease would also provide relevant knowledge.

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