

MORE ABOUT....MENTAL HEALTH IN THE COMMUNITY

NARRATIVE THERAPY

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Ben Okri, master storyteller and respected literary scholar, believes that people are 'as healthy...as the stories they tell themselves'. He asserts that it is through the 'stories we tell ourselves and others that we live the life, hide from it, harmonise it, canalise it, have a relationship with it, shape it, accept it, are broken by it, or flow with life'. Without stories one's life would 'lose its moorings or...its orientations. Even in silence we are living out stories'. We can't escape this reality, because telling stories is our essence, and ultimately it becomes our reality. 'We are part human, part stories – *Homo fabula*...storytelling beings.'

Narrative therapy (NT) is a respectful approach to counselling and community work. It firmly believes that the person who comes to consult the therapist is the expert on her/his life, and not the therapist. NT deeply embraces the idea that people construct their lived reality by means of the narratives or stories that they tell themselves. These stories are situated within a larger cultural and political context, and are therefore socially constructed. Each person distills the meaning of their life from these stories. In this regard, Erik Sween explains that people 'use stories about themselves like the lens on a camera'. The stories focus on certain

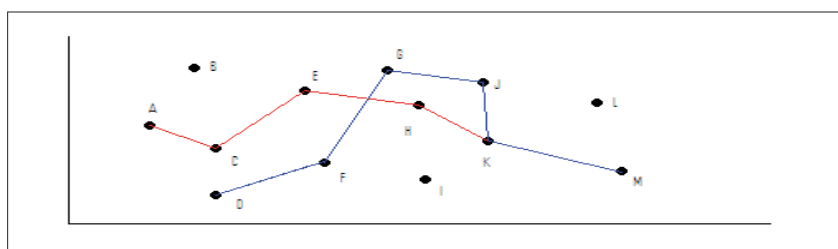


Fig. 1. Example of construction of a 'dominant story'.

Alice Morgan eloquently explains the process by which certain events in a person's life are chosen, and ultimately included, in a dominant, problem-saturated story, as well as how other events (not originally included in the dominant story) can be re-discovered to shape an alternative, more preferred narrative. She does this by utilising an ordinary example of how people refer to themselves or someone else as a 'good driver' (red line in Fig. 1) or not (blue line in Fig. 1). In any given person's life there might be different driving incidents or examples (A - M in Fig.1), Examples or incidents that support the idea of being a 'good driver': stopping at traffic lights (A); keeping to the speed limit (C); anticipating a specific action of another car that prevented an accident (E); passing your driver's license at the first try (H); being able to change gears when you were only 12 years old (K). Stories of being a 'bad driver': changing lanes without checking your blind spot that one time (D); getting numerous parking fines (F); driving in a skilled way although almost always exceeding the speed limit (G); the small bump against the shopping trolley (J); driving without license when you were 12 years old (K); the horrendous accident on the wet road (M). There are also incidents or moments that are neither seen as positive or negative (B, I and L in Fig. 1). Therefore, if a person connects certain events, e.g. (A)-(C)-(E)-(H)-(K) over time according to a certain theme (e.g. 'being a good driver') that becomes the dominant story for that person. If that dominant story is not preferred, the re-authoring of the person's present life narrative would mean having to 're-discover' those events or moments in the person's life which were not included in the dominant story, the 'sparkling moments' that challenge the dominant story and that can be connected to become an alternative, more preferred story. So in essence we can all tell ourselves stories of how we are either a 'good driver' or a 'bad driver'.

aspects of (for example) a traumatic event, while de-focusing from other aspects. Stories are defined as 'events linked in sequence across time according to a plot (or theme)', as illustrated in Fig. 1.

A dominant story about a specific aspect of a person's life therefore emerges, as certain events are privileged and selected out over other events as more important or true. This

process of selection is strongly influenced by the dominant themes or plots embedded in the story. These stories both describe and shape a person's perspective on his/her life – past, present and future. Often, by the time a person has come to therapy these dominant life stories have become saturated with the negative and the hopeless, with unsurpassable problems. In NT these dominant life stories are referred to as 'problem-saturated

stories'. The purpose of narrative therapeutic conversations is to collaboratively (i.e. between therapist and the person who comes for help) deconstruct or 'unpack' the dominant life-stories of the person, and thus open up the possibility to 're-story' or 're-author' these problem-saturated stories. The 're-authoring' of a problem-saturated story can be achieved by means of externalised conversations between the therapist and the person who wanted to be helped.

NT views a problem as separate from the person (seeking help for that problem), and accepts that he/she is in a particular relationship with that problem. NT also assumes 'people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to change their relationship with problems in their lives'.

Externalised conversations:

- see the problem as the problem, and not the person as the problem
- speak of the problem as being outside of the person – this creates space for discussion about the person's relationship with the problem
- make visible the social practices that promote, sustain and nurture the life of the problem
- involve consulting people about changing or re-negotiating relationships with problems
- consider the agent of change to be communal – the conversations seek to discover what skills and knowledge are present
- often use 'it is' rather than 'you are'
- seek alternative descriptions and stories outside of the problem-saturated description.

Through these externalised conversations the therapist and the person whose story is being discussed can gain insight into the history of the problem, the effect(s) and influence of the problem, and the context within which the problem evolves and operates. The collaborative conversational process will also highlight times when the problem had less influence in the person's life. These moments, where the person had more control or power

over the problem, are called 'sparkling moments' or 'unique outcomes'. Working 'narratively' with a person that comes to consult you is therefore 'solution-focused' in nature, because it seeks to identify exceptions to a person's story about a problem besetting them. These stories defined by the exceptions and what meaning it holds for that person are called 'alternative stories' and are juxtaposed with the dominant problem-saturated stories with which the person came to seek help.

As humans, our lives are continuously marked by unseen story lines which have tremendous power in shaping our lives. The process of NT hopes to amplify these invisible texts in our lives, and helps us to give meaning to the different 'landscapes' we 'journey' through. When we become aware of these story lines, when we can start to 'see' the previously unnoticed ways in which we focused on certain aspects of our lives and filtered out other aspects, when we fully gain insight into how the problem managed to assert itself onto our lives – then, and only then, can we start to 're-author' our life story so that it creates a life that is preferred, positive, and content, i.e. a life full of possibility and hope.

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WHAT IS MIND-BODY MEDICINE?

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Mind-body medicine (MBM) explores the powerful ways in which emotional, mental, social and spiritual factors modulate disease and healing processes. MBM is really how thoughts, perceptions, emotions and behaviour influence physical well-being, and *vice versa*. It encompasses and integrates all medical disciplines.

Why is MBM so popular?

Modern medicine has struggled to move away from the biomedical model despite emerging evidence implicating psychosocial factors on physiological function and health outcomes. In the absence of hard data, psychosocial medicine is disregarded by those who believe that the fundamental origin of illness and disease is biological. Expectations, beliefs, emotions and psychosocial stress are largely ignored in mainstream medicine. Doctor-centered medicine as practised by disease 'detectives' has driven ordinary people to seek more holistic healing interventions that stimulate healing, rather than those focused on treating disease.

Thinking and feeling: evidence for the mind-body link

Although not all medical conditions are placebo-responsive, the placebo effect suggests that our thoughts and beliefs influence physiology. The functional neuroanatomy of the placebo effect has been shown using positron emission tomography where the administration of placebo resulted in a brain response indistinguishable from that seen with active antidepressant treatment.¹ The belief in and expectation of placebo analgesia induces discrete physiological changes leading to relief from pain – this response is thought to be mediated by endogenous opioids.²

It has been shown that a hidden injection of naloxone reverses placebo-induced analgesia, suggesting that it is possible to block a belief! There is a physiological basis for belief (placebo), a phenomenon once thought to be 'all in the mind'.

We can use our sensations to modify our physiology below the level of consciousness. Let's examine touch as an example. A 2001 Cochrane review refutes previous studies demonstrating benefits of touch on the growth and development of pre-term or low birth-weight infants.³ More recent research conducted at the Touch Research Institute at the University of Miami Medical School shows that, when compared with preterm neonates receiving sham massage (light pressure), preterm neonates receiving massage therapy (moderate pressure) exhibited greater weight gain and increased vagal tone and gastric motility during and immediately after treatment.⁴ They have also shown that stimulating the mother's feet, but not the hands or abdomen, can evoke fetal activity in mid-gestation.⁵ Depressed pregnant women who were massaged showed higher dopamine and serotonin levels, lower levels of cortisol and norepinephrine and better neonatal outcomes (i.e. lesser incidence of prematurity and low birthweight) compared with their controls.⁶

The literature is replete with studies showing poor health outcomes related to anxiety, stress and depressed mood. Negative emotions have a direct impact on immune and endocrine regulation. Depression is emerging as an independent risk factor for cardiovascular mortality, including stroke, heart failure and coronary heart disease, especially in elderly men.⁷ Inflammation has been linked to a spectrum of conditions associated with ageing, including cardiovascular disease, osteoporosis, arthritis, type 2 diabetes, certain cancers, Alzheimer's disease, frailty and functional decline, and periodontal disease.⁸ The production of pro-inflammatory cytokines that influence these and other conditions can be directly stimulated by negative

emotions and stressful experiences. Laughter, on the other hand, has been shown to reduce pro-inflammatory cytokines in rheumatoid arthritis patients.⁹ This field of psycho-neuro-immunology (PNI) provides the scientific foundation for interactions between the psyche, neuroendocrine and immune systems. The discovery of neuropeptide and glucocorticoid receptors on our immune cells links the chemicals of thought and emotion directly with the immune system.^{10,11} The immune cell's ability to produce small amounts of hormones such as β -endorphin and growth hormone,¹²⁻¹⁴ and the brain cell's ability to produce cytokines further supports an integrated network of systems that share a common language of communication between brain and body and *vice versa*.

Mind over matter

Neural plasticity describes the brain's ability to reconfigure depending on internal and external stimuli. For example, MRI scans show that the brains of violin players devote much more area to pathways representing the thumb and fifth finger of the left hand¹⁵ while taxi cab drivers have bigger hippocampi (areas devoted to memory) than the general population. The brain becomes the information it receives and this suggests our thoughts can literally change the material reality of our brains. Emotions also exert powerful effects on the brain, and untreated depression has been associated with hippocampal shrinkage.¹⁶ At a genetic level, depression has been linked to DNA damage¹⁷ while laughter was recently found to alter gene expression in immune cells.¹⁸

Mind-body interventions

The balance of evidence points to stress as a precipitator and aggravator of disease and the relaxation response as an antidote to stress-related symptoms and disease. It is possible that both share common physiological pathways.¹⁹ Mindfulness-based stress reduction (MBSR), a structured mind-body intervention adopted from the University of Massachusetts, is probably the most widely studied stress reduction intervention. Studies on

MBSR have yielded some promising, though varying, results for psychological, endocrine and functional health variables, but these are confounded by methodological problems.²⁰ There are however no studies comparing MBSR with other less intensive stress management programmes. Most mind-body interventions suggest a common self-healing mechanism based on a combination of relaxation and placebo-related physiology.

Conclusion

Current evidence supports the view that there is a physiological basis for everything that we think, feel and do – what we call psycho-physiology. 'Psychosomatic' illness therefore cannot be reduced to a symptom of the mind. Whereas past research largely focused on the negative effects of stress, an increasing number of studies now explore the impact of positive lifestyle, thoughts and emotions on disease prevention and recovery. Continued emphasis on biomedicine reduces patients to being seen only as their diseases, undermines the value of therapeutic relationships and fails to appreciate humans as unique psychosocial beings. Biopsychosocial medicine is mind-body medicine for physicians. And biopsychosocial knowledge skills and attitude are necessary to inject healing back into doctoring.

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APPROPRIATE SPECIAL INVESTIGATIONS FOR MENTAL DISORDERS IN PRIMARY CARE

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The use of screening investigations in psychiatry has been a topic of discussion for many years. According to Thomas screening investigations are performed for 4 main reasons:

- to exclude physical conditions presenting with psychiatric symptoms
- to exclude physical conditions resulting from psychiatric conditions
- to detect physical conditions coinciding with psychiatric illness
- to detect side-effects of treatment.

Little has been said about appropriate special investigations for mental disorders in the South African setting, especially in primary health care. Due to constant limitations and constraints, it is necessary to minimise and optimise appropriate screening investigations. When looking at patients attending primary care, there seem to be two sets of patients warranting investigations. The first is the group being managed within the primary care setting and the second is the group in need of referral to a psychiatric facility for management.

Patients managed at primary care level

The Western Cape Provincial protocol for routine screening investigations of first presentations to psychiatric services for organic, psychotic and mood disorders suggests the following guidelines:

- Psychotic disorders
 - rapid plasma reagent (RPR) and fluorescent treponemal antibody (FTA) or *Treponema pallidum* haemagglutination (TPHA)
 - human immunodeficiency virus

(HIV) (with consent if clinically indicated)

- Major depression: thyroid stimulating hormone (TSH)
- Anxiety disorders: TSH
- Dementia
 - RPR and FTA/TPHA, haemoglobin (Hb), white cell count (WCC), random glucose, urea or creatinine, gamma glutamyl transpeptidase (GGT), serum vitamin B₁₂ and serum folate.
 - HIV (with consent if clinically indicated).

Any further investigations should be determined by specific clinical indicators.

Patients needing referral to a psychiatric facility

This is a more difficult group of patients because of possible premature referral of 'medically clear' patients or unnecessary requests from the receiving psychiatric hospital. Proposed guidelines for the screening of patients for medical disorders before referral are discussed below.

Low suspicion of a general medical condition (GMC)

- Patients with a known past psychiatric history or a history of psychiatric symptoms of over 1 month's duration.
- No recent past medical or surgical history, in particular no recent history of head injury, epilepsy or severe alcohol abuse.
- Fully orientated and not confused.

In these patients a physical examination with basic observations (pulse rate, blood pressure, temperature, and blood glucose level) is indicated prior to referral. Include urine dipstick to exclude a urinary tract infection if the patient is older than 60 years.

High suspicion of a GMC

This would include patients with any of the following:

- No past psychiatric history, with recent (less than 1 week) onset of psychiatric symptoms.
- Not fully orientated, at times confused.

- Recent severe alcohol abuse.
- HIV-positive or a high clinical suspicion thereof, and clinically WHO stage 3 or 4 (AIDS).
- A history of epilepsy.
- Chronic medical illness.
- A first presentation of psychiatric symptoms in any patient over the age of 50 years.
- Patients on multiple or high dosages of medications.

In such cases the following investigations are indicated before the patient should be considered for a transfer to a psychiatric hospital:

- Full physical examination and observations, as well as urine Dipstick and blood glucose level.
- Blood tests
 - WCC – if $> 15 \times 10^9/l$ or $< 4 \times 10^9/l$, further investigation is required
 - Hb - fingerprick test sufficient unless $< 10 \text{ g/dl}$
 - serum sodium and creatinine.
- Lumbar puncture (LP) is required in patients who have any of the following:
 - known VDRL-positive
 - HIV-positive and WHO stage 3 or 4
 - abnormal chest X-ray suggestive of active TB,
 - any suggestion of meningeal irritation or raised temperature of unknown origin.
- Chest X-ray
- CT scan of the brain if any of the following are present:
 - any new focal neurological abnormality
 - a history of alcohol abuse and unexplained disorientation
 - any patient with a decreased level of consciousness with no clear cause.

Special cases

Please note that in certain cases, as identified below, particular investigations are indicated:

- HIV-positive or a high clinical suspicion thereof and WHO stage 3 or 4 (AIDS): LP, CT of the brain if not fully orientated, and investigations to rule out secondary infections and

malignancies.

- History of epilepsy.
- Exclude status epilepticus, especially partial or non-convulsive status (EEG may be indicated).
- Head injuries and drug toxicity must be considered and excluded (e.g. blood levels of anticonvulsants).
- Chronic medical illness (hypertension, diabetes, epilepsy, COPD).
- Appropriate investigations to show that psychiatric symptoms are not secondary to medical illness.
- Catatonia – the vast majority of causes of catatonia are non-psychiat-

ric and therefore all of the aforementioned investigations, including EEG are mandatory.

Please note that this guideline should not be a substitute for clinical judgement and, in cases of uncertainty, consultation with a psychiatrist is recommended.

Acknowledgements

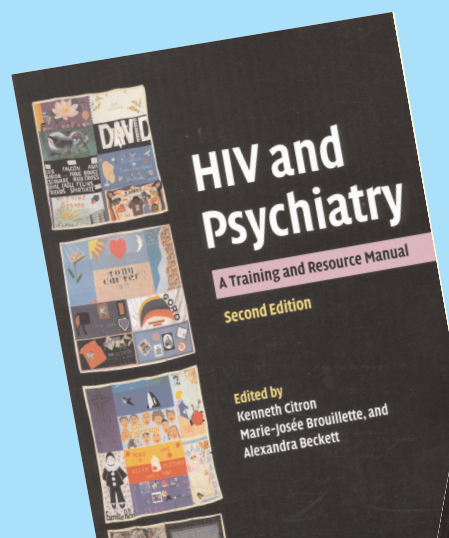
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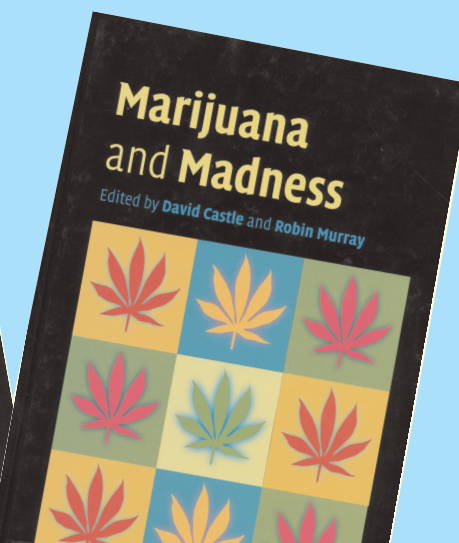
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