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Telling tales: storytelling and disbelief in clinical encounters

Some clinical encounters can stir up strong feelings in us as clinicians; one such situation is when we do not believe what our patient is saying to us.

I recall (author A.P.), as a trainee in Accident & Emergency, attending to patients who came in with severe abdominal pain. For a few of these patients, it would transpire that they were not 'really' experiencing abdominal pain, or at least not to the extent it initially appeared. I would sometimes feel tricked – especially if I had given strong pain relief or taken time to arrange investigations – feelings shared by colleagues on shift. At times, we acted on these feelings by discharging these patients from the department in a somewhat perfunctory way, believing they had wasted our time.

At the time I thought, as many would: *perhaps they're just faking it.* But this may not be the whole story. Looking back, I regret, not necessarily that we discharged these patients from A&E, but the manner we went about it, and our lack of curiosity about why they needed to engage with care in the way they did.

Our response of annoyance is not unique. For example, here is a quote from a recent BMJ article within the Analysis column[1]:

> When 'Lucy' was a foundation year doctor in the NHS, she searched online for details about a patient who had been admitted with a femoral neck fracture and had a history of factitious disorder. "I think she faked a seizure for attention during my night shift," she says. "I googled her because I was annoyed." 'Lucy' found a Twitter account where the patient had posted pictures of herself in hospital and said she was there after a terminal cancer diagnosis.

When a patient's presentation evokes feelings of *disbelief*, we may sometimes respond in ways that inadvertently make things worse. In this article, we explore the psychological dynamics of this complicated clinical encounter. Rather than taking an approach to a patient that they are either telling the truth or lying, we suggest it can be helpful to consider a middle way: the patient may be faithfully describing a problem, but doing so in a coded or implied way. Perhaps related to past experiences, they may expect that telling their story in a straightforward manner does not work.

A developmental perspective

In trying to understand this kind of clinical encounter, it may be helpful to consider one of the ways we begin to give an account of ourselves as we develop. Children engage in imaginative storytelling without necessarily being accused of deceit. Children tell stories, draw pictures and invent fantasy worlds; and grown-ups tell stories to children. We – parents and carers – are usually interested in their creations and engage with their stories. This kind of activity is one aspect of what helps a child to develop a 'secure attachment': a secure sense of their own mind and a capacity to trust others.[2]

This engagement does not make the child's story real in a literal sense. Rather, when we tune into the story's various dimensions, we can create meaning together with the child. This helps to convey to them that their tales carry significance, and that they are being listened to and valued. Even when the child's story is obviously fanciful, there is usually some 'truth' contained within it.

Disbelief in clinical encounters – reading between the lines

As clinicians, we could apply the same openness to those patients whose accounts don't wholly ring true.[3] Across the lifespan, stories remain central to how we express ourselves – indeed, this is the central premise of narrative-based medicine.[4] A person's story can evoke feelings in others and may serve as a vehicle for communicating an emotion or for establishing a particular dynamic between oneself and others.[5] One might wonder what is behind, for instance, the story of a patient who repeatedly presents with 'abdominal pain' in such a way that evokes disbelief in the clinician. Moreover, what leads a patient to communicate an 'unbelievable' story, rather than express their needs in a more direct way?

We may need to read between the lines. Most of us take it for granted that our feelings and thoughts have a validity and meaning. However, some people come to distrust the reality of their own experiences. They might tell themselves: *You're not really sad*, *you're just faking this feeling*. This kind of inner dialogue might develop in relation to a number of inter-related influences, and like most human traits, is not necessarily reducible to a single 'cause'. A typical influence, however, is repeated experiences of having thoughts and feelings disbelieved or actively invalidated within key caring relationships during a person's formative years, which in some cases might amount to emotional neglect or abuse.[6] How such experiences might impact a young person likely depends upon a complex interplay with their own developing character and psychology, as well as on the presence or otherwise of more supportive experiences within relationships. Some people end up adopting a reproachful attitude towards their own feelings, internalising perceived implicit or explicit criticism from others: *There's nothing really wrong with you.* Or: *Be quiet or I'll give you something to really cry about*. This can leave the child doubting their feelings and with a problem in straightforwardly expressing themselves to others.

As an adult, such a dynamic can manifest in complicated and indirect ways of communicating needs that may evoke disbelief in others. So, behind some patients' indirect or seemingly obscure presentations may lie distressing feelings – such as sadness, loneliness, or fear – coupled with anxieties about expressing vulnerable states of mind. For example, a history of 'abdominal pain' may be acceptable to a person, but to talk about sadness may not. Such an individual may inadvertently convey their self-doubt to others who then feel disbelieving of them.

These indirect and complicated communications may not always come through presentations that catch our attention. They may sometimes occur in subtle ways, as illustrated in the following encounter.

> Fiona* consults her GP, Dr Smith, and says she feels sad and miserable. Dr Smith observes the patient: Fiona seems, if not cheerful, certainly not how people typically look when they feel sad. Fiona is talking with some energy; her face doesn't convey sadness. Dr Smith doesn't feel like she often does when listening to people who are feeling down – there isn't a resonant feeling of sadness. In fact, with Fiona, Dr Smith feels more… disbelief, as if Fiona is making it up somehow. *Maybe Fiona isn't really miserable*, Dr Smith wonders to herself.

Suppose a part of Fiona *does* feel miserable, but she has learnt to expect that expressions of sadness go unacknowledged by caring figures. So, she distrusts her feelings and expects others to view them as false. This leads her to not express her sadness in a straightforward way: her facial expression and body language do not appear sad. Fiona instead communicates to her GP uncertainty and scepticism, rather than her unhappiness.

If Dr Smith acts on her feelings of disbelief directly without further reflection – for example by treating Fiona as if nothing is really troubling her – the doctor might, without realising it, be assuming the role of the disbelieving carer that Fiona already carries in her mind.

Psychologically informed practice

As clinicians, we can deal with these difficult clinical encounters by recognising and understanding our emotional responses to them. This makes us less likely to act unthinkingly to the detriment of the patient.

Many health professionals assume that not believing or feeling annoyed with their patients is unimportant or reflects a 'lack of empathy' on their part. On the contrary, from a psychological dynamics perspective, our emotions in clinical situation have the potential to reveal valuable information about both our patients' mental states and our own. For example, through our own scepticism towards a patient's story, we may, in fact, be picking up on a difficulty they have in trusting themself and others.

Feelings of annoyance in this kind of clinical encounter may tell us something about our own beliefs and values. For instance, some clinicians may interpret a lack of apparent 'honesty' from patients as a sign of disrespect. Additionally, for some healthcare professionals, indirect and complicated communications from patients may clash with a desired-for model about how patients and clinicians should interact – that is, straightforwardly and 'truthfully'. It may rankle – especially during long shifts or demanding working conditions – to aim for a transparent approach that inspires trust, only to feel this transparency is not reciprocated by the patient (who may not be in a position to do so at that moment).

This all matters as underlying psychological needs may be particularly great in those patients who lack trust in others and cannot say directly or what they need, but instead communicate their difficulties through interactions which evoke doubt, and possibly irritation, in healthcare staff.

When someone relates a narrative that does not ring true, this may create a (misleading) impression of an advanced or Machiavellian psychological process at work. However, telling

* 'Fiona' is a composite person drawn from clinical experiences from both authors.

a significantly distorted narrative usually reflects a more fundamental difficulty arising early in life, linked to major anxieties about communicating with caring figures and trusting them.[7] Kernberg, a U.S. psychotherapist, formulates that when a patient relates a distorted account of themselves to their treating clinician, this may be indicative of a basic hopelessness about caring relationships.[8] If we as clinicians don't reflect on and process our feelings of scepticism, we may automatically judge the patient a 'liar' or 'manipulator,' and miss their underlying difficulties. This can have negative consequences: the patient might feel worse, become less trustful of healthcare, and potentially experience a need to show more forcefully how they feel through escalating symptoms or presentations of distress (such as harming themself or suicidal acts). In some situations, the patient and healthcare professional end up in a vicious cycle of mutual mistrust, discontent and rejection – a risky clinical picture referred to as 'malignant alienation.'[9] The patient-clinician relationship can end up repeating aspects of the problematic developmental situation.

Of course, it is important to consider the medical realities of a situation. For example, if a person is describing severe abdominal pain but their doctor does not think this fits with the overall clinical picture, they would not necessarily rush to prescribe opiates. Furthermore, by no means is it always helpful or possible to undertake an in-depth psychological exploration. We suggest a dual focus of 'boundaries plus understanding'[10]: namely, the importance of attending to the realities of the clinical situation and managing these accordingly, whilst also holding in mind there will be meanings contained within the patient's presentation.

These can be frustrating clinical encounters for clinicians, and it can be difficult to read between the lines of our patients' stories and make sense of our own responses. Access to reflective spaces, such as Balint Groups or Reflective Practice Groups, can help clinicians to step back and think about the interpersonal dynamics. This can reduce the stresses of clinical work and make us less likely to take up unhelpful positions.[11]

Changing the story

When we can step back, reflect, and become interested in communications that provoke disbelief, it may free up some space to work with the patient. A person's need for their 'story' may lessen over time if the underlying dynamics can be considered, even if they cannot be fully addressed.

A note of realism is important though. When a clinician tries to show interest in someone who distrusts their own thoughts and feelings and expects caring figures to be invalidating, it can induce anxiety in the patient. The patient may be in two minds about what they want from the encounter. In part, they may want to be listened to and taken seriously. However, if they have learnt to expect that others disbelieve them, accepting a clinician's efforts to listen to them can feel very risky. So, in conflict with a desire to be heard, another part them may be (outwith the patient's full awareness) working hard to move the clinician into being *mis*understanding and *dis*believing. *Yeah, I didn't expect to be listened to anyway* may, paradoxically, feel like a more familiar and thus safer position.

Ingrained ways of relating to others can change, but this requires repeated opportunities to learn from new experiences. Patterns of 'how to be with the other' derive from procedural memory, the same memory system as involved in riding a bike. Procedural memories are 'hard to learn and hard to forget';[12] imagine trying to un-learn to ride a bike, or learning to ride it completely differently. Therefore, we may need to be very patient with those patients who lack trust in validating their own needs and feelings. This kind of change may require developmental timescales – change over a phase or phases of an individual's lifespan – rather than a quick fix. In practice, a patient's story might evolve over years through an accumulation of interactions with clinicians and caring figures that offer something subtly different to what is expected.

Conclusion

In this paper, we have suggested that patients' stories that leave us feeling disbelief, can contain something of validity and significance. We may feel sceptical, or even tricked – but if we leave our feelings unexplored, convinced we have the whole story, we may neglect the underlying meanings. A clinician's feelings of disbelief may carry important clues as to the patient's relationship history and how this manifests itself in their current ways of relating to healthcare figures. Admittedly, this is not a clear presentation such as a broken hip; the diagnosis here is more akin to 'broken trust'. This is a subtle but important clinical presentation that requires appropriate clinical care and close attention to the interpersonal dynamics, including the doctor's emotions in response to the patient.

Recognising this presentation is important as it may reflect significant underlying difficulties related to trusting oneself and others, and with care-seeking. A style of relating involving 'unbelievable' stories runs the risk of the patient's needs remaining unmet or even being exacerbated if clinicians assume a dismissive response. By connecting these presentations to storytelling as an understandable human activity since childhood, we may discover a creative perspective which moves us from 'this patient is just telling stories' to 'what are their stories telling us?'

Key messages

A person who has come to expect that caring figures will not believe them may have learnt that straightforward communication does not work. They might:

- Not know or distrust their own feelings
- Express their needs in complicated or indirect ways which may inadvertently evoke feelings of disbelief in healthcare professionals
- Relate a 'story' that may not ring entirely true, but is likely to contain some 'truth' and meaning

A significant lack of trust in others is important because:

- It may reflect important unmet psychological needs
- It may limit a person's ability to take in care and treatment for their healthcare needs

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Conflict of interest statement

The authors declare that we have no competing interests.

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