A 67-year-old lady, who I shall call Mary, comes to see me in my clinic sent by her physician. I greet her, ask how she has been feeling and she says; 'I pray everyday for God to have mercy on me and take me with him! I am too strong! I survived a terrible separation, a devastating cancer, but no one understands me. Everybody says I am a trouble maker, that I am a problem!'

I ask her if she agrees with these comments and she goes on… ‘Everything started in my thirties, I felt very nervous, and I was very unstable. In those days my husband had another woman, but I was mad about him, I just couldn’t think about living without him. I already had my two daughters then, and I believe it was for their sake that I kept myself alive. Soon after that my health problems began. You know, I’ve seen a lot of professionals all these years…’

‘I’ve seen a cardiologist for 28 years on account of a cardiac arrhythmia, in 1998 they found out that I had a condition called cornea guttata; on the skin I’ve got pityriasis rosea for years, and I suffer from plantar fasciitis. Not to mention that as a woman I only have one breast left, they took me all the rest out, everything! Nowadays the medication to prevent the cancer from recurring gives me an awful pain in my joints, my eye sight is getting worse each day and the medical professionals keep postponing an operation for fear that I might need a cornea transplant. In short, I can’t even read my books!’

Cases like this arrive at our clinics every day, driving us therapists to a deep level of impossibility, impenetrability, and lack of resources before the complexity of a picture of commorbidities.

The questions that we usually ask ourselves when confronted with such situations are: is there anything to be done? If so, what? And how?

Since 1976, to classify a disease, the World Health Organization (WHO) has taken into consideration the consequence and unfolding of the disease to the daily activities, adding to the medical service the work of rehabilitation and social security, aiming at less deficiency, incapacity and disadvantage in the patient’s life. In parallel, recent studies argue that the increase of non-transmissible diseases is, paradoxically, due to the rise of the level of life expectancy observed in the last decades, associated with the changes in the life style brought by the socio-economic development, mainly in the western world. Based on these data, WHO set the promotion of a better health for all as a goal for the 21st century, defining ‘better health’ as a longer and higher quality life, with fewer incapacities and diseases.

Mary, for example, is quite well-off and can afford the best professionals and the most recent medical treatments. Despite that, there was no visible sign of comfort whatsoever.

The word comfort, incidentally, seemed absent from Mary’s speech. And would there be any possible way in which one could offer comfort to someone so full of pain? Could we do something for her life not to be reduced to pathology?

The challenge lies in finding out how to relate with the chronic condition, making use of all the health that is left, of all that is not sick. Finding the threshold and the necessary look for this connection is not easy.

Many times, in situations like the one above, the health professional ends up feeling tied up, a hostage of the circumstances, and why not, sick too. It is not uncommon for us to be imprisoned by the story of the disease or diseases, bound to the sick narratives of the sick person. These narratives originate from limited, narrow, reductionist understandings that merge the individual into the disease.

In order to alter these understandings we need to change our paradigms, our beliefs. We need to question our certainties, and ponder over possibilities. We have to be curious to explore unknown territories and find courage to
experiment with situations never before imagined. We need to pick and choose, through the process of re-authoring, the spice and the rhythm we want life to have.

When we explore these themes we move away from the disease and from the chronic condition and, consequently, we get closer to our desires, dreams and the pleasure of living.

This was precisely how the Narrative Therapy, created by M. White and D. Epston, entered the therapeutical scenario to start treating patients, many of which suffering from chronic conditions, whose main question was the impenetrability.

In this approach, the most important is to build a therapeutical bond based on a conversation that makes the difference for the patient; a conversation that makes sense in a context of multiple realities and so many meaningless realizations. Something that finally prioritizes the patient’s view on his or her own stories.

The way to approach the problem is also different, focusing, for example, not on what prevents the patient from adhering to a certain treatment but, mainly, on everything that favors it.

Through the construction of new stories, the approach aims at helping people to transform tales of failure into narratives of possibilities, finding ways that enable them to change the manner they relate with their problem.

In this way, their problems no longer define who they are.

The process of breaking the identification with the problem allows people to feel capable to move towards a different and broader sense of identity, to leave the dominant story and all of its negative impediments behind and try other perspectives of life.

It is a collaborative approach that aims at building responsible ethical relational understandings, and that always places people as authors and experts in their own lives, assisted by their personal skills, competencies, beliefs, values and commitment to change their relationship with the difficulty they are dealing with.

But how does it work in practice?

Returning to the question investigated in the beginning of this article, the reflection about the capacity to actually supply comfort to someone in pain, I remember the day Mary came to her session complaining about an awful pain...

‘Dr. Lucia, I’m here just because of you, I’m in great pain! It is my trigeminal neuralgia, I can hardly speak!’ she said, holding her face with both her hands. My first thought was on the great challenge: how could I at least lessen her discomfort? How could I help?

It occurred to me to invite her for a cup of coffee. ‘Well, since you are here, I’m very glad to see you! How about a cup of coffee? In the meantime you could perhaps tell me what happened!’

Accepting the invitation, she commented, ‘I could hardly sleep last night. The pain was so strong. I’ve taken lots of painkillers but it won’t go away!’

Over coffee, we talked about what had happened, about the feelings the situations had awaken in her and about why those wounds hurt so much.

Gradually, her expression started to change, the hand that supported the face reached for the biscuit on the sauce, and the situation seemed different. I asked her about the pain and, with a smile, she said, ‘Dr. Lucia, that is incredible, but I hardly feel it now! How was that possible?’ ‘Well, That’s the coffee... it was made with some different ingredients,’ I said playfully.

It had been made of attention, construction of meaning and analysis of possibilities.

Michael White would often say - how people do not live by the exceptions/unique outcomes, but rather by the storylines of their lives.

Through the “coffee break” talk we were able to co-construct an alternative storyline that prioritizes Mary’s view on her own stories, making it clear to her that she was not the problem, the problem was the problem.
REFERENCES


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