

## Research papers

# Pain in the heart: primary care consultations with frequently attending refugees

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### ABSTRACT

**Background** This paper presents the results of a study conducted in a general practitioner (GP) practice in East London. The patient group studied were Turkish and Kurdish refugees who were frequent attenders at the practice and who had medically unexplained symptoms. The study had two aims: firstly to use joint working between health professionals to attempt to explore psychological issues in the consultations, and secondly to test consultation tools which would be accessible for other primary care workers to use with similar patients.

**Method** A GP, psychotherapist and health advocate worked with 17 Turkish-speaking refugee patients in a series of up to six sessions in which the patients' family structure and support systems were explored.

**Results** Results demonstrated an acceptability of joint working for professionals and patients and provided a means whereby workers felt less demoralised and more creative in approaching this group of patients. Successful consultation tools used included genograms, reattribution techniques and joint consulting between GP and therapist. Systemic questions and solution-focused therapy techniques were less successful. This paper also discusses cultural and theoretical issues arising from the study, and the impact of the study on the primary care team.

**Keywords:** consultation tools, frequent attenders, medically unexplained symptoms

## Introduction and background to the study

This study was carried out in a GP practice in East London which has a large Turkish and Kurdish refugee population. To provide more effective care to this group – about 20% of the practice list – the practice has employed Turkish-speaking advocates since 1989. Over this time it became apparent that a minority of the refugees were frequent attenders at the practice and were repeatedly consulting with medically unexplained symptoms. Hospital referrals had not provided diagnoses, and addressing presumed psychological distress had not altered the

consultations – attempts to suggest counselling or antidepressant treatment seemed to have no effect on this group's use of primary care or symptom presentation, although patients commonly took up these recommendations.

Patients who are frequent attenders in primary care have been researched fairly extensively. Heywood *et al* showed that frequent attenders were five times as likely to be referred to hospital as a control group, receive five times as many prescriptions and showed high levels of depression.<sup>1</sup> This has considerable resource implications for the NHS and can lead to unnecessary interventions and operations. The human implications of a service which does not appear to meet the needs of a substantial group of

the practice population are just as great, and can lead to frustration and anger for the clinicians concerned.<sup>2</sup> GPs are also often frustrated by the insufficient time they spend with each patient and such frequently attending patients contribute to the common feeling of having failed to provide good care.<sup>3</sup>

Dowrick considered that frequent attendance was a shared failure in communication between doctor and patient, and in our own practice we were concerned that, despite the use of health advocates, there may have been such a communication failure at a deeper level than mere translation of information.<sup>4</sup> Many of the patients in the study were considered by their GPs to be 'somatising' – that is presenting with a physical manifestation of psychological distress. The literature on somatising is constructed from the split between body and mind represented in beliefs about symptom conversion. These beliefs rest on dualistic thinking and the capacity of people to oscillate between the two.<sup>5</sup> However, in a review of the literature on culture and somatisation, Kirmayer and Young draw attention to the manifold ways in which somatic symptoms fit cultural idioms of distress. They argue that introducing psychological language as a way of understanding a problem is 'introducing a culture-specific concept of the person which may conflict with the values and perspectives of the patient's culture of origin and so create new dilemmas for them'.<sup>6</sup>

We wanted to maximise the strengths of the primary care setting, in which although each contact is brief, there is scope within each consultation to open small avenues for dialogue. Over a period of years this can lead to a relationship of great trust, particularly important for a group of people living with the loss of all familiar social networks.<sup>7</sup> We wanted to try and use this familiarity to free 'stuck' doctor/patient relationships in which the patient asked for referrals to more specialists or more analgesia for pain and the GP tried to argue that stress was a major factor and more prescriptions were not the answer.

It was also decided to offer a different approach to the consultation to see whether this could alter the dynamic between GP and patient. This involved using another person in the consultation to reflect, comment and intervene where necessary, and using different tools within the consultation to 'unstick' the repetitive narrative. Using a reflecting partner is not a new concept in general practice.<sup>8</sup> However there was no literature found describing work with refugee patients in this context. In fact, during this project the advocate acted as a second reflecting partner during the sessions, and increasingly took a more active part.

## Aims of the study

The aims of the study were:

- to explore joint working with refugees in a primary care setting to try to change patterns of consultation
- to pilot the use of techniques that could be used by primary care workers with similar groups of patients.

## Methods

Practice members were invited to refer any Turkish-speaking patients that were frequent attenders, presenting with unexplained medical symptoms and considered to be a problem for the clinician. The referrers invited each patient to attend a series of up to six, half-hour sessions with one GP, a well family worker (who was trained as a psychotherapist) and an advocate. The patients were told that the referrer felt that there were other factors contributing to their illnesses, these might include stress or other psychological issues, and that the sessions would look at these areas specifically. Attendance was voluntary, and the patients could continue to see their own GP in the usual way. Consent was obtained to tape the sessions and in a few cases to video them. It was important to obtain both written and verbal consent as some of our group were illiterate. All patients agreed that information could be used for training and research purposes and that their anonymity would be protected.

In the initial consultation, the participants introduced themselves and talked about the sessions that were being offered. It was stressed that the patients could decide at the end of each session whether to book another one. It was emphasised that the doctor and therapist would look at the effect that the patients' symptoms had on them and their lives, but were not acting as a 'second opinion'. The use of tapes and videos was discussed.

At the beginning of each session, the GP and therapist decided on who would 'lead' the session and who would act as the reflecting partner. During the session, the reflecting partner would indicate if a break was needed to discuss progress and the GP and therapist would leave the room for a few minutes. The advocate would explain to the patient what was happening, and the GP and therapist would discuss their conversation with the patient on their return. Systemic tools such as genograms were used to facilitate conversation initially and to

allow the patients to tell their stories within that context. Re-attribution techniques were frequently used during the sessions. These included commenting on facial gestures or body language indicating pain while stressful or traumatic topics were being discussed, and trying to use the patient's own words to describe the emotional effect of their physical symptoms.

At the end of each session, the patient was asked if they wanted to book another appointment. If they did, appointments were booked at two to three week intervals.

## Results

Seventeen patients were referred to us over the duration of the study (14 female and 3 male). The average age was 44 years with a range of 24–76 (see Table 1). The median stay in the UK was 10 years (range 10–40 years).

The average consulting rate over the year prior to referral was 16.9 for this group of patients (range 8–34 per year); the average consulting rate for our practice population per year was 3.9, approximately the national average (see Table 2).

**Table 1** Age range of patients

Patients ( <i>n</i> )	Age range of patients (years)
2	20–30
6	31–40
4	41–50
4	51–60
1	61–70
1	70+

**Table 2** Number of consultations per patient

Consultations per year ( <i>n</i> )	Patients ( <i>n</i> )
8–10	2
11–20	11
21–30	3
31–40	1

Seventy-five percent of this group had had at least one previous referral for counselling or psychiatry.

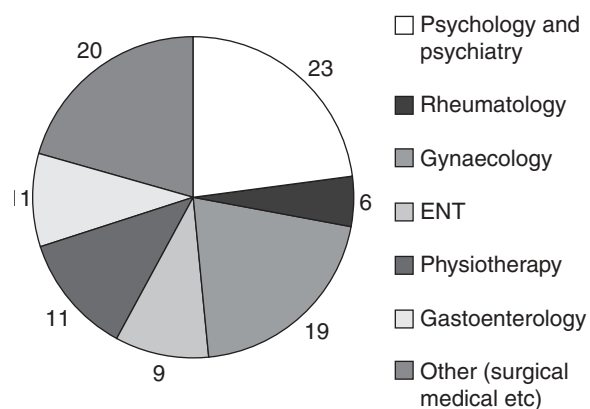
The average number of referrals to secondary care for the five years prior to the study was 8.2 per patient. The pie chart in Figure 1 shows the types of secondary referrals made. As can be seen some patients were re-referred to the same speciality within five years.

## Consultation rates

Analysis of consulting rates for a six-month period before and after the intervention was carried out for each patient and showed a significant reduction. ( $P = 0.046$ ; Wilcoxon matched pairs). Only GP consultations at the surgery were counted for this, we did not include nurse attendances. Data were obtained from case notes and computer entries.

## Attendance and acceptability

After the first session we asked whether the patient would like to continue seeing us; three patients opted not to continue after the initial session and they indicated that they felt our approach would not help them. The remaining 14 patients attended between one and six sessions – eight patients opting to come for all six sessions and six patients choosing between one and five sessions. For some patients, significant progress was made in a few sessions (see Appendix). Non-attendance was very uncommon. Patients did not express any worries about joint consulting and all 17 agreed to being taped, although only two agreed to filming.



**Figure 1** Referrals to secondary care in the five years prior to the study

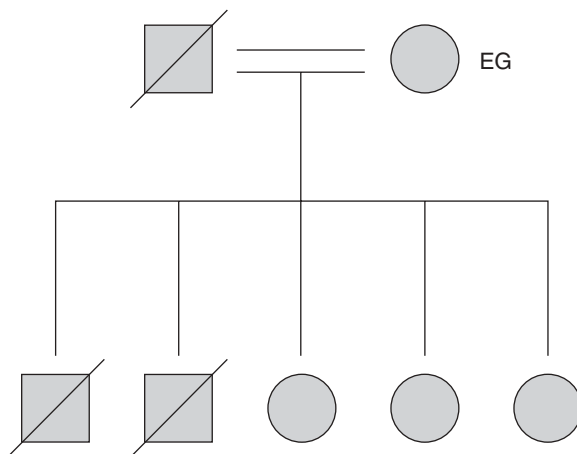
## Tools used during the sessions

### *Genograms*

Our aim was to try and see each patient as part of his or her family rather than as an isolated individual, and the drawing of a family tree in the first session was very useful in achieving this. During this process we learnt about the patient's family of origin, early relations within the family, social context and reasons for coming to England. Although genograms are always powerful tools to open a dialogue, we were unprepared for the extent of the losses people had suffered in their lives. We found that everyone we saw had a history characterised by loss – bereavement, torture, imprisonment, early histories of abuse, violent marriages, separation from children and above all fracture from the community they had grown up to expect to inhabit. Talking about themselves in the context of their families was acceptable to the patients, even when they were describing traumatic events. A sample genogram is reproduced in Figure 2 with an amplifying description.

### *Reflecting partner*

Joint consulting was acceptable for patients and supportive for professionals. It allowed a different consultation to take place – one in which patients'



**Figure 2** Genogram. Mrs EG is a 53-year-old lady who complained of severe whole body pain which was not helped by analgesics, and for which no physical cause had been found. Her husband and one son are missing in Turkey and she assumes that they are dead. Another son was shot dead by police in front of her and she sustained an abdominal gunshot wound while trying to protect him. Her youngest daughter has severe mental health problems. Her two other daughters live in Germany

references to physical symptoms could be acknowledged without an expectation of diagnosis or treatment. The observer could take notes and remember important comments made by the patient. She could indicate the need for a break to consult with the therapist to offer her comments and ideas as to how the consultation could proceed. This proved very valuable in 'changing the narrative' from a list of repeated symptoms to a more open discussion of feelings. At the end of the session, all three professionals could discuss what had happened and plan for the next session. Comments were fed back to patients at the time to maintain the openness of the dialogue and to allow the patient to comment on the session.

### *Reattribution techniques*

These were valuable again in opening up the consultation. Morriss discusses several options for use with patients presenting with psychosomatic symptoms.<sup>9</sup> We found that trying statements such as 'some people think that headaches are caused by stress; what do you think ...' was occasionally successful, as was commenting on non-verbal cues, such as 'you seem very angry about this ...'. The most useful re-attribution technique for us was commenting on patients' manifestations of symptoms while recalling stressful events, for example one patient developed a severe headache in front of us while discussing childhood traumas. Reattribution techniques had been used previously with many of the patients by their own GPs to attempt to introduce a psychological element into consultations, but the direct connection with past family events was a stronger tool. In a study of somatisation and illness meaning among Turkish migrant women in Stockholm, Baarnhielm and Ekbald note how although psychological attribution was rarely acknowledged, verbalising coherent links between bodily symptoms and emotional distress was valued as a tool for recovery by the women.<sup>10</sup> Acknowledgement of patients' pain was very important, and easier to do when there was not the expectation of cure in this setting.

### *Systemic questioning*

Using systemic questions was generally unhelpful with this group of patients. Asking for example, 'what would your husband say if he was here now?' would be met with little response, as would questions such as 'who notices most when you are ill?'. Questions requiring an imaginative answer such as the 'miracle question' of solution focus work were equally unhelpful, as were scale questions which were simply not understood.

## Discussion

Although we had selected frequent attenders for our study it was still surprising to see the high consultation rates of this group, reflecting a patient-led service with a group of people who see themselves as having serious medical problems and who have relatively easy access to primary care – especially when advocates are provided. These were not new arrivals into the UK, and many of their children had been born here. However, they were socially and culturally isolated in three ways: often within the local Turkish/Kurdish community itself, from their family, culture and networks of origin, and from the host culture of east London. The number of secondary care referrals is also of interest as this too has cost implications for the NHS and mostly did not result in a diagnosis or effective management plan. Most of the group had been referred for psychological input previously, including primary care bilingual counselling, mental health team assessment, clinical psychology and psychiatric assessment and treatment. However, either patients failed to engage with these services or the services seemed unsure of how to approach patients who predominantly wished to talk about physical and not psychological issues. As Van der Kolk has demonstrated, the emphasis on characteristics such as intrusive memories and disordered arousal in the diagnosis of post-traumatic stress disorder (PTSD) has frequently led to the exclusion of other disorders such as somatisation and histrionic and borderline personality disorders from being associated with post traumatic stress.<sup>11</sup> Patients in our group tended to be suffering from a cluster of chronic PTSD symptoms which fell beneath or outside criteria for treatment by specialist trauma services. These often included hypo-rather than hyper-arousal, emotional numbing and a sense of helplessness.

No ongoing, long-term psychological support had been offered to any members of the group and thus as so often, primary care continues to have the ongoing task of containing and working with such groups.

We decided to offer 30-minute sessions, as this was an acceptable compromise between the GP's '10-minute' approach and the 'therapist's hour'. Zalidis demonstrates the usefulness of inviting a small number of patients to longer half hour appointments.<sup>12</sup> The attendance patterns of the study group were surprising to us. We had thought that attendance at the sessions offered may be poor, as we were specifically dealing with patients who did not feel that their illnesses had a psychological component and we were only offering that approach. Perhaps the joint presence of a GP and a psychotherapist represented an acceptable compromise for the

patients in this respect. It was interesting to note that patients attending for all six sessions were perceived by the GPs as the most 'difficult' cases and often those where we did not feel we had achieved any impact. However as illustrated in case two in the Appendix, some change in consultation content was achieved.

Cultural differences obviously were of great importance in our study and while we did not set out to address them as a primary issue, inevitably they became so. In fact cultural issues ran throughout the study: trying to work with the cultural differences of our professional backgrounds ran parallel to trying to connect across the cultural differences between us and our clients. The insistence of such patients that the pain is a pain in the body and not to do with psychological pain often leads to a diagnosis of somatisation.

Working in a medical setting, it is easy to protect oneself from realising some of the effects of cultural dislocation in anything other than a generalised way. In the drawing of a family tree and talking about the family structure, we had to see the person as an individual rather than a generic somatising patient. We learnt about the cultural background of each client; their family; the structures for support within Turkish/Kurdish communities; the patterns of physical illness in families and the chain of losses, bereavements, abuse and violence both within the family and towards the community.

As professionals we were affected in different ways. The doctor had to experience a paradigm shift – away from the notion of cure and management, to that of allowing a therapeutic space where something or nothing might happen. She also had to acknowledge the intimacy of her relationship with the patient which is often painful, and an issue that is rarely explored in medical training. Being able to actively change the context in which the consultation was taking place led to increased engagement in the relationship with the patient. Working together also led to a reduced sense of isolation and the possibility of gaining mutual support in difficult situations.

The therapist too had to alter her way of working. It became obvious that these patients could not relate to traditional psychotherapeutic approaches. They were happy to talk about physical pain and often unable to articulate emotional concepts in the way the therapist was used to. They also wanted a direct and meaningful relationship on a concrete and personal level and were uncomfortable if this was absent.

For the advocate, the experiences of our patients were sometimes almost unbearably poignant: she experienced their suffering directly, whereas the therapist and doctor were protected from such

direct contact by virtue of the language barrier. She understood far better than us the cultural background of the patients and could empathise with the patients' experiences. She had to reframe our questions into both culturally and emotionally acceptable ones and also reframe patient comments. One example illustrates this:

one client spent several sessions sitting on the floor wailing and banging her head, pleading with us to do something for her. We noticed the advocate translating less and less of what was said and discovered that the woman was using extremely bad language that was highly offensive to the advocate. She was placed in the difficult position of absorbing the swearing and yet her shame at the language made it impossible for her to translate it for us. She wanted to protect us from it and so chose to say nothing for some time. Her role as the third element, the conduit through which all speech passes was an extremely difficult one.

## Conclusion

Thirty-minute sessions with the GP and therapist were acceptable to this group of patients and produced successful interventions.

There were significant effects of the study on us as practitioners. Working together contributed to us all feeling less 'burnt out' and more creative in our work with this difficult group. We felt that the basic tools we used could easily be employed by other primary care practitioners wishing to explore similar ways of working, but this would be contingent on having professionals interested in joint working who are accessible within primary care.

The theoretical construct of a split between psyche and soma was mirrored in our attempt to work across the boundaries of medicine and psychotherapy. We learnt too much about our patients, and the culture from which they came, to accept our initial diagnosis of somatisation in the same straightforward way. We discovered that linking the body and mind in such a diagnosis often benefits the practitioner but does not seem to make sense to people coming from a culture and frame of reference in which the two cannot be separated.

In analysis of consultation rate differences at six months, a significant fall in consultation was demonstrated. However, further analysis of long-term figures would be needed to give a more accurate picture of any change in consultation patterns and this was not a main concern of this study. Patient numbers in this study were small and this obviously limits the interpretation of results. However, we feel that the results may raise some issues of relevance for future research projects within primary care looking at refugee mental health.

## ACKNOWLEDGEMENTS

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## CONFLICTS OF INTEREST

None.

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## Appendix: case studies

The following case studies were chosen because they illustrated different patterns of attendance for the sessions and different presenting problems. In the first, the patient attended only twice. In the second the patient attended all six sessions and would have continued if more sessions had been offered. The third patient attended our session once, but was then referred on to a more appropriate service, where she has been seen regularly.

### Case study 1

DA was a 28-year-old man referred by his GP because she felt that she was not able to help his presenting problem further. Mr A felt that he had a bad smell emanating from his stomach and despite many GP and hospital investigations and treatments this had not improved. He did not feel that this represented a symptom of depression, and attempting to pursue this was unfruitful. He felt that everyone around him noticed the smell and he wanted a cure. In our first session, Mr A was very quiet and said little. He did however tell us about his childhood, which was dominated by being teased by other children as he had a shortened leg due to polio. He said that although he had worked in the past, he now felt that he was 'too old' to find employment. He agreed to a second session but we wondered whether he would attend. Unprompted by us, his wife accompanied him in the second session where she immediately talked about his loss of self-esteem, his worry about being able to support their young family and their housing difficulties. Both of them cried and turned to each other for support. We talked about their distress and offered practical help and advice about housing and finances. When asked whether she noticed the smell, Mrs A looked surprised and replied 'of course not'. A third session was not booked as Mrs A was about to give birth and we felt that some conclusion had been reached. We offered to see them if needed but they have not contacted us and DA has not consulted about the problem since.

### Case study 2

AS is a 66-year-old lady referred to us because of frequent consulting without apparent reason. She described severe pain all over her body and said

that she was extremely ill. Investigations of her symptoms had not provided any diagnosis, nor did painkillers help at all. She had been offered psychological help in the past and had had courses of antidepressants without any benefit. Her GP felt helpless and 'burnt out' by her frequent attendance. Mrs A was always very early for her appointments – often by more than one hour – but spoke very little during the sessions. She appeared profoundly depressed and seemed unable to articulate her feelings. The sessions were marked by long periods of silence where Mrs A would look distraught. Like several other patients in this study, she was illiterate, and so we could not ask her to write about how she felt outside the sessions. This had proved a valuable tool with other patients who found talking difficult. However, when we asked her about dreams, she readily described a recent nightmare. She said that she was trying to reach the surgery to see her GP, but was prevented from doing so. This caused her great anxiety. We were able to talk about this and she was keen to reassure us and her own doctor that she knew we were trying to help. She said that she saw the surgery as a place of safety, and her relationship with her GP as a trusting one. This was the importance for her and she was distressed to hear that we felt we were not helping her. At the end of the six sessions she embraced us formally one by one and it seemed as though we had shared an intimacy that we had not at the time recognised.

### Case study 3

This lady arrived at the first session accompanied by her three-year-old daughter. She had been referred because of frequent attendance complaining of various pains without any diagnosis being identified, and which had not responded to any symptomatic treatment. We explained the nature of the sessions and began to ask her about her past. She immediately began talking about having been sexually abused as a child. She had obviously decided to disclose this prior to arriving, and talked at length about it. It was interesting that this lady had already had individual counselling with a Turkish-speaking therapist and some joint sessions with her husband, but she had not disclosed the abuse during these sessions. It seemed that offering the space, again with no fixed agenda, allowed her to decide to use it. We told her that it would be better for her to carry on seeing the therapist in separate sessions without her child being present, and she has done so.

