

Postprint: Narrative Medicine Interpretive Model of MUS and the Enabling Mechanism of Narrative Thinking for Holistic Diagnosis and Treatment of MUS

Authors: Yang Xiaolin, Zhang Peng, Zhang Peng

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Abstract

“Medically Unexplained Symptoms” (MUS) has become a significant public health problem. The biomedical interpretive approach to MUS cannot resolve the numerous dilemmas faced by individuals with MUS, and clinically, issues of overdiagnosis and overtreatment are pronounced. This article, departing from the narrative medicine interpretive model for MUS, proposes that the vast majority of individuals with MUS are either individuals with narrative closure (traumatic, doubtful, or elderly types) or individuals with interpersonal narrative rupture. Only general practitioners or specialists equipped with narrative thinking can reduce the overtreatment of MUS and its attendant negative effects while concurrently enhancing patients’ quality of life. Physicians should, on the foundation of proactively establishing robust narrative connections with individuals with MUS, guide patients to actively undertake narrative regulation, assist them in achieving leapfrog growth of the narrative self, and diminish the impact of symptoms on their quality of life. The article advocates for constructing a general practice narrative medicine system, elevating the professional narrative competence of general practitioners, and integrating scales for narrative connection rupture and narrative closure status into the MUS diagnosis and treatment process, thereby effectively enhancing their capabilities in narrative diagnosis, narrative patient education, and narrative healing for “medically difficult-to-explain symptoms.”

Full Text

Preamble

General Practice Consultation Room Study on the Narrative Medicine Interpretive Model for Medically

Unexplained Symptoms and the Empowerment Mechanism of Narrative Thinking in the Holistic Diagnosis and Treatment of MUS

YANG Xiaolin¹, ZHANG Peng^{2*}

¹Research Center of Narrative Medicine, Shunde Hospital, Southern Medical University, Foshan 528000, China

²Huiqiao Medical Center, Southern Hospital, Southern Medical University, Guangzhou 510000, China

Corresponding author: ZHANG Peng, Associate Chief Physician; E-mail: herve_{zhang}@163.com

Abstract

Medically unexplained symptoms (MUS) have become an important public health issue. The biomedical interpretation of MUS cannot resolve the numerous dilemmas faced by individuals with MUS, and problems of overdiagnosis and overtreatment are clinically prominent. This article proposes, from the perspective of a narrative medicine interpretive model for MUS, that the vast majority of individuals with MUS suffer from traumatic, suspicious, professional, or elderly narrative foreclosure, or interpersonal narrative disruption. Only general practitioners or specialists equipped with narrative thinking can reduce overtreatment of MUS and its negative effects while improving patients' quality of life. Healthcare professionals should, on the basis of actively establishing sound narrative connections with individuals with MUS, guide patients to engage in narrative adjustment and mediation, thereby helping them achieve leapfrog growth in their narrative self and reducing the impact of symptoms on their quality of life. This article calls for establishing a general practice narrative medicine system to enhance physicians' professional narrative competencies, and for integrating scales for narrative disconnection and narrative foreclosure into the MUS diagnosis and treatment process, thereby effectively improving their capabilities in narrative diagnosis, narrative patient education, and narrative healing when dealing with MUS.

Keywords

Narrative medicine; Medically unexplained symptoms; Clinicians' narrative competencies; Holistic healing

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1. Narrative Medicine Interpretation of the Frequent Occurrence of MUS

Modern medical developments such as imaging technology, genetic testing, and biotechnology mean that, compared to any previous era in medical history, diseases can be more effectively predicted, diagnosed, treated, and managed. However, ironically, a large number of diseases, pains, and discomforts still fall within the realm of “medically unexplained,” about which medicine knows very little, let alone how to prevent or manage them. These “medically unexplained symptoms” (MUS) or “medically unexplained physical symptoms” (MUPS) have become important public health issues. In clinical practice, physicians frequently encounter patients with various complaints of discomfort that remain undiagnosed even after detailed examinations. Currently, domestic scholars mostly refer to such clinical problems as “undifferentiated diseases” [1], while internationally the term MUS is more commonly used [2].

As a descriptive term, MUS encompasses somatization disorder, hypochondriasis, persistent pain, mood disorders, and some functional syndromes such as fibromyalgia and chronic fatigue syndrome. MUS represents one of the most common problems encountered across all clinical disciplines, particularly in general practice, and is often described as non-specific symptoms, persistent physical symptoms, functional symptoms, autonomic nervous dysfunction, or neurosis [3]. MUS can be viewed as a continuous spectrum ranging from self-limiting symptoms to recurrent or persistent symptoms and symptom disorders. Research has found that MUS also falls within the category of persistent physical symptoms (PPS) [4]. These unexplained diseases share the common characteristic that somatic symptoms lack corresponding pathological manifestations, yet functional impairment may be genuine if patients’ illness experience narratives are authentic.

Medical science emphasizes visualization and evidence-based practice. If existing examinations or scans cannot reveal the presence of a disease or tangible abnormalities (such as nodules, tumors, enlargements, effusions, fibroids, or ulcers), then patients with such diseases lose their sense of presence and feel that no one is listening to their voices. Many are constantly doubted and negated by others because “pain only exists when acknowledged by physicians; patients’ self-reports do not count” [5]. Without medically recognized, visible pathological evidence, patients can only remain in the gray zone of medical skepticism [5]. Medical terminology “constructs a patient hierarchy, with those at the top possessing clear evidence to prove their disease and thus being accepted by the medical field, while those unable to prove their disease remain at the bottom, suffering from medical doubt” [5].

MUS patients may appear in any specialty clinic within medical institutions, but most frequently seek help from general practice, neurology, pain management, cardiology, gynecology, and gastroenterology. Statistics show that diagnosing and treating MUS patients has become a major task for many internists, par-

ticularly in primary care and general practice settings, where over one-third of outpatient referrals belong to MUS patients [6]. Existing literature on MUS has primarily focused on diagnostic reliability, patients' mental health status, benefits of psychological interventions, patients' demographic and social characteristics, and factors affecting the physician-patient relationship [7]. Overall, international research literature on MUS has been increasing in recent years.

Western literature has categorized MUS interpretive models into somatic amplification theory, sensitization theory, sensitivity theory, immune system sensitization theory, endocrine dysregulation theory, signal filtering theory, illness behavior theory, autonomic nervous system dysfunction theory, abnormal proprioception theory, cognitive-behavioral therapy models, and others [8]. Compared to the gradual attention to MUS research abroad, domestic literature remains scarce and has hardly moved beyond the biomedical framework and single-disease interpretive models. In reality, MUS is closely related to patients' illness cognition, family status, emotional regulation capacity, lifestyle habits, personality traits, and quality of kinship connections. From the perspective of the Chinese narrative medicine framework, both physicians and the public can fundamentally transform their understanding of MUS and improve patients' quality of life.

Narrative medicine theory posits that the increasing prevalence of MUS is directly related to two trends in modern medicine: the overreliance on objective evidence and the neglect of patients' subjective illness experiences. Physicians equipped only with evidence-based thinking primarily rely on medications and surgical instruments as treatment modalities, yet individuals with MUS are difficult to cure through these external means. Consequently, conflicts and disputes easily arise between physicians and patients, leading many doctors to avoid such patients whenever possible. Due to the inability to reach consensus with physicians, MUS patients generally report low satisfaction with their medical visits.

This article proposes a new interpretive model within the narrative medicine framework, suggesting that individuals are troubled by MUS fundamentally because they are trapped in certain life stories or life states from which their own energy cannot escape. This state of entanglement is directly related to the individuals being in a state of interpersonal narrative connection disruption. This long-term narrative foreclosure state severely impedes the growth of their narrative self [9]. The vast majority of MUS patients are narrative foreclosure sufferers of different types, including traumatic, suspicious, professional, or elderly narrative foreclosure. The narrative medicine interpretive model for MUS can guide healthcare workers to recognize that they are dealing with patients' concrete illness experiences rather than abstract health concepts, focusing more on the suffering person rather than bodily symptoms. This interpretive model can guide physicians back to the original purpose of medicine: relieving human suffering. Only in this way can the quality of life for MUS patients be improved.

MUS represents a threshold state or intermediate gray zone between health and

disease. In the context of narrative medicine, MUS often serves as a messenger in patients' lives, alerting them that problems have emerged in their life state and requiring them to make active adjustments. This messenger intends for individuals to use the warnings brought by symptoms to initiate active narrative integration, better perceive and understand their life state, make corresponding narrative adjustments, and achieve narrative self-growth. When individuals troubled by MUS lack awareness of narrative adjustment and instead blindly pursue medications and surgical solutions, they miss the optimal opportunity and eventually truly enter a disease state. Conversely, timely and effective narrative adjustment or narrative care from others can enable them to return from the gray zone to the kingdom of health.

MUS frequently occurs after major traumas (childhood abuse, war trauma, disaster trauma) [11] or major life events (bereavement, breakup, unemployment, disability, business failure, marital failure), or during major life transitions when individuals endure excessive stress, tense interpersonal relationships, and other significant adjustment periods. MUS patients can only receive correct diagnosis, treatment, and care within the narrative thinking framework of physicians, while patients themselves must use their symptom suffering as an opportunity to restart their stalled life narrative process through self-narrative adjustment and narrative intervention from physicians and loved ones, thereby cultivating their own narrative adjustment capacity and achieving leapfrog growth in their narrative self, which ultimately leads to symptom relief and elimination.

MUS frequently occurs in children, adolescents, and women. Traditional Chinese medical literature mentions that widows, unmarried women, young boys, and frustrated individuals require emotional diversion and self-resolution rather than relying entirely on herbal medicine. If physicians only know how to respond with medications, they will treat these people as difficult cases and their symptoms as refractory diseases, unaware that such patients must be treated through the power of persuasive conversation [12]. From the perspective of narrative medicine, children and adolescents are in the early developmental stage of their narrative self, with very weak self-narrative adjustment capacity. When their narrative self maturity is insufficient to handle various events requiring response at their life stage, they adopt avoidance attitudes toward certain life events rather than actively confronting them to directly enhance their narrative adjustment capacity. When narrative self maturity does not match their life stage, even seemingly minor events may be perceived as major traumatic events. When such traumatic events occur, the "Broca's area" in the left hemisphere responsible for language shuts down [17], and only when sensing the goodwill and warmth of narrative connection from others can this trauma storytelling function be reopened.

Narrative medicine proposes that many MUS patients are traumatic narrative foreclosure sufferers [9], suspicious narrative foreclosure sufferers, elderly narrative foreclosure sufferers [13], occupational narrative foreclosure sufferers [14], or other single-identity narrative foreclosure sufferers [15]. Atypical chest

pain in cardiology, irritable bowel syndrome in gastroenterology, fibromyalgia in rheumatology, chronic neck and back pain in orthopedics, psychogenic non-epileptic seizures (PNES) in neurology, and chronic pelvic pain in gynecology are highly likely caused by narrative foreclosure. Some individuals diagnosed with epilepsy are typically told to undergo at least two years of medication treatment, yet drugs and physical therapy obviously have limited effectiveness. The MUS population is often subjected to excessive medical treatment for diseases that essentially do not exist. The evidence-based thinking approach leads physicians and MUS individuals to completely overlook the true healing method: reactivating individuals' intrinsic narrative adjustment capacity on the premise of repairing narrative connections with significant others.

Building a narrative community with seeking physicians and surrounding loved ones constitutes the foundational condition for overcoming MUS troubles. Dr. Varila, an oncologist and bestselling author, proposed that when emotions and feelings are hidden or suppressed, they can lead to gastritis, gastric ulcers, and unexplained spinal pain. Over time, these problems may even deteriorate into cancer. Finding a confidant to share one's pain story can dissolve adverse symptoms [15]. It can be said that MUS is primarily related to poor subjective narrative adjustment capacity and blocked narrative self-growth, while interpersonal narrative connection serves as the most powerful remedy for these problems. Patients with such symptoms can be followed long-term by general practitioners who comprehensively grasp major life events before and after illness onset and collaborate closely with various specialties, while using narrative concepts to guide patients out of their symptomatic predicament and help them understand their life stories from a more comprehensive perspective.

2. Physician Narrative Thinking and Holistic Diagnosis and Treatment of MUS Patients

With social progress and development, people's life rhythms accelerate and social competition intensifies, leading to increasingly younger MUS patients and rising overall prevalence rates. The symptoms of most MUS patients show no significant improvement after conventional medical treatment because the root of MUS patients' symptoms lies in crises encountered by the narrative self and serious problems with self-narrative adjustment capacity, which cannot be relieved through medications or surgical instruments. The realization of their holistic healing depends on physicians' clinical narrative thinking. Narrative thinking refers to a practical wisdom that skillfully shifts perspectives to perceive the life circumstances of self and others, and actively utilizes accumulated narrative capital to respond, reflect, and empower individuals differently according to their specific situations. It represents a mode of thinking corresponding to scientific, evidence-based, and technical thinking.

Clinical narrative thinking is an interpersonal interaction model in which physicians apply narrative thinking to clinical patient education, disease disclosure, clinical diagnosis and treatment, and clinical decision-making [15]. When fac-

ing increasing numbers of MUS patients, physicians must first realize that establishing interpersonal narrative relationships, rather than evidence-based relationships between doctor and disease, constitutes the essential element and cornerstone for efficiently managing and addressing MUS individuals' symptoms. Therefore, hospitals must first cultivate physicians' narrative thinking holistically and create a safe narrative environment that encourages patients to share their life stories and experiences [19]. Physicians should use important information obtained beyond the biomedical domain through narrative interaction with patients to provide targeted, concrete explanations for symptom causes in patients' own life-world language, and point them toward new strategies for self-symptom management and self-narrative care.

2.1 Physician Narrative Thinking and MUS Occupational Narrative Foreclosure

Individuals consist of multiple identities, playing different roles in different contexts. However, occupational narrative foreclosure sufferers confine themselves solely to their occupational identity, treating external evaluations of their professional identity as the sole source of satisfaction, denying the existence of other identities, and unwilling to develop their life stories beyond their profession into areas such as daily life, family, or love. These workplace individuals devote most of their energy and resources to external matters that provide quick feedback or benefits. This single-identity narrative foreclosure is detrimental to health; only by skillfully shifting identities and establishing narrative connections with self, family, colleagues, workplace service recipients, and society can one achieve both success and health [14]. For such foreclosure sufferers, MUS serves as a warning signal, because most will not change their rigid life trajectory unless they encounter certain life events that, under the guidance of wise individuals, stimulate internal reflection and epiphany.

Dr. Xiao Zhou, a 36-year-old physician working in Zhuhai, began experiencing inexplicable bodily discomfort in early March 2024—daytime fatigue and headaches, nighttime insomnia and irritability—constantly suspecting something was wrong with her body. Yet this occurred less than two months after her annual comprehensive physical examination at her workplace. To confirm she had no health problems, she underwent multiple examinations at her hospital, with all data and imaging reports showing normal results and yielding no diagnosis. However, her subjective symptoms progressively worsened, forcing her to seek help from a psychiatrist at her own hospital. Unacquainted with this doctor previously, after disclosing her colleague status, the psychiatrist immediately administered scales and informed Dr. Xiao Zhou that the results indicated moderate depression, prescribing two medications—one for sleep assistance and one psychotropic drug.

After the consultation, Dr. Xiao Zhou felt she hadn't truly received medical care. This reflects the current situation in many domestic psychiatry departments, where this specialty that should least be evidence-based has become evidence-

based. Psychiatrists no longer listen to patients' illness experiences but use absolute biomedical cognitive frameworks to interpret and address diseases. As a physician herself, Dr. Xiao Zhou found this incredible and did not follow the medical advice. Later, she drove for over an hour to Shunde to consult another doctor reportedly successful in treating many similar patients. After inquiring about Dr. Xiao Zhou's recent work situation, this physician posed two questions that didn't require immediate answers: "Are you married?" and "Has any immediate family member, such as siblings or parents, experienced any major events?" He also prescribed medication but told Dr. Xiao Zhou that drugs could only temporarily relieve symptoms and should not be taken long-term, emphasizing that to overcome her current state, the more important task was to 重新认识 herself.

During the drive back, these two questions kept circling in Dr. Xiao Zhou's mind: At 36, she remained single, with romance and marriage never prioritized; among four siblings, one sister had committed suicide after being diagnosed with stage III ovarian cancer at year-end, and one brother had recently been diagnosed with diabetes. Yet due to busy clinical work, she had only briefly confronted these family tragedies without taking time to fully face them with other family members, let alone accompany them...She realized that since graduating from medical school, she had been passively swept up in medical affairs, busy daily, having escaped and missed too much, yet these unaddressed matters continued to affect her subconsciously.

After returning to her hospital, Dr. Xiao Zhou arranged her department work, took several days off, returned to her hometown, gathered with her siblings, and learned that her sister had been unhappy in marriage. With their parents deceased and herself working away from home, she had been unable to connect with her sister, who faced marital breakdown alone. Combined with the ovarian cancer diagnosis, her sister felt life was meaningless and chose suicide. Dr. Xiao Zhou realized that if she didn't transform her own life state, she would be the next to suffer from serious illness. Subsequently, she repaired intimate connections with family members, established daily narrative connections with siblings and their children, and learned to balance work with personal life.

One doctor merely prescribed medication based on scale data, while another, through two questions that didn't require immediate answers, prompted her to engage in life narrative integration, recognize and adjust her life state, achieving symptom relief and simultaneous narrative self-growth. This case demonstrates that to enhance holistic healing outcomes for MUS patients, psychiatrists must break free from the biomedical model framework, actively establish physician-patient narrative connections, and engage in narrative intervention. Additionally, specialists most frequently consulted by MUS patients—including general practice, neurology, gastroenterology, cardiology, and psychiatry—must possess clinical narrative thinking and provide narrative care within the narrative community constructed with patients, guiding their narrative self-growth.

2.2 Physician Narrative Thinking and MUS Traumatic Narrative Foreclosure

The life health narrative concept holds that if infants and children experience bereavement, bullying, emotional abuse, caregiving neglect, witness conflicts and violence, or indirectly perceive trauma experienced by significant others, these traumatic experiences affect not only psychological dimensions but also severely impact physiological manifestations, with chronic disease symptoms or medically unexplained symptoms appearing during adolescence or adulthood. These experiences are termed “adverse childhood experiences” (ACEs) or “early adverse life events” (EALs). Such traumatic experiences increase the likelihood of individuals suffering from medically unexplained functional neurological symptoms (FNS) during their life course [20], correlate directly with the severity of functional somatic syndromes (FSS) such as fibromyalgia, chronic fatigue syndrome, somatic disorders, and irritable bowel syndrome [21], and are directly associated with chronic pelvic pain syndrome in women [22].

Research has found positive correlations between childhood unexplained functional abdominal pain and adult chronic pain with parental maladaptive parenting styles (low care and high protection) during childhood [23]. In the narrative medicine context, these findings strongly correlate with weak parent-child narrative connections and lack of narrative caregiving awareness. These poor family narrative ecologies likely increase children’s future risk of developing chronic pain. Therefore, besides patients receiving narrative care and guidance on narrative adjustment capacity when seeking medical help, more parents in families must transform their parenting styles, pay attention to subtle changes in their children, establish intimate narrative connections with them, and create better family narrative ecologies to prevent the possibility of MUS.

Shortly after the Life Health Narrative Center opened in 2020, several parents brought children aged 8, 9, or even over 10 who still wet the bed. In modern medical contexts, bedwetting is often medicalized as a disease considered solvable through examinations, prescriptions, and injections. However, most children’s bedwetting problems are not physiological in origin—not brain problems nor urinary system issues. Such non-physiologically caused bedwetting often stems from caregivers’ maladaptive parenting styles or unaddressed traumatic experiences in early childhood that lacked positive attention and effective emotional response from caregivers.

At the narrative center, we conducted extended conversations with these children and parents separately, listening to their family stories before and after bedwetting began. We found these children either grew up in single-parent families, experienced long-term separation from parents, underwent sudden death of close relatives, had experiences of suddenly moving to unfamiliar places, or were even beaten and scolded by parents or grandparents for bedwetting. Through extensive investigation, the narrative center discovered that parental quarrels or divorce, sudden death or injury of relatives, long-term separation from parents

living in different locations, moving to unfamiliar places, nighttime frights, and parents' frequent punishment and humiliation of bedwetting children all cause and exacerbate bedwetting or plunge children into narrative foreclosure states.

Additionally, fibromyalgia among adult MUS symptoms often emerges after individuals experience unbearably stressful events, including car accidents, surgeries, childbirth, physical overload from overwork, long-term stress states, psychological trauma, or experiences of abuse or sexual assault.

2.3 Physician Narrative Thinking and MUS Illness Anxiety Narrative Foreclosure

In the narrative medicine context, practitioners have found that MUS individuals often do not have just one specific symptom but feel troubled by multiple symptoms, experiencing extreme panic as a result. These symptoms often undergo a “somatic amplification process” in illness anxiety narrative foreclosure sufferers. When individuals encounter events difficult to handle in their life course, the weakness of their narrative self prevents somatic stress responses from dissipating on their own, transforming into entangled symptoms. After developing certain bodily sensations, individuals concentrate almost all their attention on these sensations. They develop certain cognitions and attributions that further amplify perception of these bodily signals. This amplification creates a vicious cycle where symptoms are continuously reinforced by individuals' doubts [8], leading MUS individuals to experience a series of more severe and disruptive bodily sensations.

Ms. Huang, a retiree, presented to a general practice clinic with a two-year history of unexplained chest tightness, dizziness, migratory headaches, and weight loss. She had visited several renowned tertiary hospitals domestically, undergoing multiple comprehensive examinations and evaluations in neurology, rheumatology, respiratory medicine, cardiology, and psychology departments. However, no clearly abnormal indicators were found, preventing definitive diagnosis. After nearly two years of empirical drug treatment, her weight continued to decline progressively. The patient consequently worried about having a serious illness, subjectively feeling her symptoms were multiplying and worsening, leaving her anxious all day with disturbed sleep and appetite. Through patient guidance, the general practitioner opened the “floodgates,” and the patient narrated her marital and life story to the doctor.

It turned out that her marital relationship had been disharmonious for years, with a long-term cold war between the couple. After their child's birth, they had no sexual life for over 30 years. In her family of origin, her father had a violent temperament, resulting in her timid, weak personality and fear of expressing her feelings and emotions. The patient finally told the doctor that among all the hospitals she had visited, no doctor had ever seriously listened to her story—only ordering examinations and psychological assessment scales before prescribing medication. After telling her story this time, she immediately felt relieved and

stated she would strive to change her life circumstances, persuade her husband to attend consultation together, and aim to live better for the rest of her life. After several follow-up visits, Ms. Huang' s headache symptoms disappeared, and other symptoms significantly alleviated.

From these cases, the most critical step in guiding patients out of MUS troubles is “acknowledging the suffering MUS brings to individuals” and “being willing to listen to and guide subjects in sharing their trauma stories.” If physicians focus only on symptoms without exploring the stories behind them and their deeper causes, they can hardly truly understand patients' doubts, let alone heal them. Most physicians sought out by such MUS individuals are perplexed and can only attempt treatments targeting superficial symptoms—addressing the “branch” or “attacking the flow” rather than the “root” or “tracing the source” —thus missing the optimal opportunity for MUS individuals' narrative self-growth. Some physicians, fearing they might be perceived as incompetent if they cannot provide a diagnosis, force themselves to offer far-fetched diagnoses, resulting in misdiagnosis, overdiagnosis, and overtreatment.

To efficiently address the growing number of MUS individuals, the fundamental measure for current medical practice is to assess physicians' narrative literacy and guide them to recognize the important value of professional narrative capacity and narrative thinking for holistic healing. Additionally, integrating narrative foreclosure status scales into the MUS diagnosis and treatment process can help MUS patients become aware of their own life narrative styles and conditions, guiding them to actively engage in life narrative integration and adjustment. Narrative integration itself is, in a sense, a harmonizing process that integrates discordant, difficult-to-explain stories into a coherent, harmonious life narrative through review and reflection [24]. In other words, everyone' s life narrative process is a continuous tuning from discordance to harmony, with each narrative integration achieving leapfrog growth in the subject' s narrative self.

Positive interpersonal narrative connections themselves possess pain-alleviating effects [25]. Contrary to the suffering produced by narrative disconnection, physicians equipped with narrative integration concepts can generate pain-resistant effects by guiding patients to repair their life stories. Narrative medicine enables physicians to find a deeper connecting force rooted in shared human experiences. Once this interpersonal connection is established, a healing relationship can be built, which not only helps understand patients' suffering and achieve holistic healing but also assists both parties in constructing complete selves through narrative interaction [26]. Many patients, through physicians' narrative care and narrative intervention mediation, change their life states. When patients' quality of life improves, the medical quality of hospitals consequently enhances.

Currently, compared to research on other diseases with corresponding clear evidence, holistic diagnosis and treatment of MUS has not yet formed a mature system, and corresponding clinical elective and required curricula are lacking. Physicians with backgrounds in general practice or other specialties do not pos-

sess systematic narrative thinking and have insufficient capacity to identify and respond to MUS. Therefore, given the current situation of MUS, work priorities for the next three years should focus on continuing education and training for physicians' professional narrative competencies. Building upon evidence-based thinking training, we should enhance clinical doctors' narrative thinking and holistic diagnosis and treatment capabilities, using integrated models to address difficult conditions troubling MUS patients and alleviate their suffering. MUS calls for more humane medical services, necessitating timely research that uses the current social narrative ecology surrounding MUS as an entry point to study stress and coping mechanisms from a comprehensive perspective.

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