

A narrative-based approach

A narrative-based approach to depression

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In the last article in this series, I gave an account of how one might take a narrative-based approach when seeing a patient with a diagnosis of schizophrenia.¹ I described how it might be possible to adopt a consulting stance that pays respect to the patient's own narrative of their experiences, however bizarre this might seem, without diminishing the accuracy or seriousness of the diagnosis. Taking such a stance involves treading a fine line between accepting a diagnosis as something concrete and unalterable on the one hand, and dismissing it as irrelevant on the other. It means acknowledging the validity of two quite different kinds of 'stories' – the patient's own description of their reality, and the professional categorisation of that reality – and holding these two stories in mind so that neither is allowed to disqualify the other.

In this article, I want to examine what it means to adopt this kind of approach in a patient with depression. Here too, one is dealing both with a unique and personal story and with the 'official' narrative about depression that clinicians have to learn in their training. Again, the narrative practitioner's task is to bring together the two accounts of reality in a way that patients will find useful. However, there are also differences where depression is concerned. For example, patients are much more likely to offer their own diagnosis of depression than they are with schizophrenia. They may use the word depression to describe a huge range of subjective feelings, varying in severity from transient disappointment to enduring despair. At the same time, the whole notion of 'depression' as a distinct clinical entity has become contested within the professional community so that it is now possible to find respected clinicians who regard the notion of depression as anything from a straightforward biological illness to an oppressive social construction.² Working within these multiple perspectives, how can one use narrative ideas? The following example, drawn from a variety of cases but merged so as to anonymise them, indicates one way.

Sally B, a single woman in her early forties, attended the surgery about a month ago. She told me that she felt as if 'someone had knocked the stuffing out of her'. Following her exact words, I asked her if anyone had done just that – expecting perhaps that she would tell me about being disappointed in love, or thwarted by someone at work. In fact, she said, it was nothing quite so definite: more a general lack or loss of direction in her life. She told me that she generally enjoyed her work but had been under extra pressure recently because of recruitment problems in her hairdressing salon. Her home circumstances had not changed for many years; she lives with an elderly father who is gradually becoming frail but is still self-sufficient.

Forming a new hypothesis related to her age and circumstances, I asked her about any hopes she might have for relationships and children. She surprised me by saying that she had no real concern about these. The main loves of her life, she explained, were her spaniels, whom she breeds and displays in dog shows. And yet even her dogs, she told me, sometimes irritated her now. At this point in her narrative I chose to ask her about any previous experience she might have of feeling like this. I also introduced some of the standard 'mental state' questions, inquiring into such things as her mood, her eating, her weight, her sleep and whether she had contemplated suicide.

Commentary: What I was mainly trying to do in this particular consultation was to track the patient's own story and encourage her to extend it. Drawing on my own training in family therapy – where narrative ideas have had a strong influence – I explored a variety of hypotheses that I hoped might offer meaning to the patient, but remained willing to drop any that did not take the narrative further.³ At the same time, I was aware of the need for me as a doctor to check the 'facts' from a professional point of view. I tried to interject questions about these facts when they seemed to fit the patient's

own narrative flow, and delayed most of them until I felt I had given her sufficient time to develop her story in her own way.

Having established that she was moderately depressed in the medical sense, I asked Sally B: 'Would you describe yourself as depressed?'. She told me that best friend thought that she was depressed – which was why she had booked to see me – although she herself was not sure. She asked me for my own opinion. I answered that I thought she had some features of depression *from a medical point of view*, but I told her that I was more interested in how she would react to being labelled as depressed. Once again she surprised me by saying that she would find this 'quite a relief': it would make sense of what she was going through, and perhaps also point towards things she could do about it. I pursued this response by asking her what things she thought might help her. I inquired if she had thought, for example, of seeing a psychologist or taking pills.

Commentary: Working within primary care, I find myself increasingly interested in exploring, and using, people's own vocabulary where depression is concerned.⁴ I am generally willing to follow through their own preferences for bringing about change – unless there seems to be a very compelling reason to override these. As a narrative practitioner, I find am less concerned with the absolute accuracy of an ICD or DSM diagnosis than with the therapeutic efficacy of the conversations that a description like 'depression' may generate.

In answer to my previous question, Sally B said she would like to try antidepressant pills but feared becoming addicted. She was also very definite in saying that she did not want to see a counsellor, psychologist or psychiatrist. I gave her a fairly standard medical explanation about antidepressants, including all the usual reassurances and cautions. Nevertheless, I was careful to use phrases like 'this is what doctors usually advise' and 'at least, that is

what psychiatrists recommend these days'. I explained that we have a practice policy of seeing anyone on antidepressants every month – in order to protect ourselves and also to oversee patients who might be vulnerable. She was happy to agree to this.

Commentary: Working within our own familiar medical narratives, we can easily get drawn into the conviction that all our beliefs and rules make perfect sense. Yet if we cannot interweave these official 'scripts' with the stories that patients bring, they may seem arbitrary and even oppressive. In a world where the authority of doctors and mental health professionals can no longer be taken for granted, it can be helpful to label the 'grand narrative' of psychiatry as one perspective rather than as the absolute truth.⁵

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