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A Phenomenological Study to Explore Individuals' Experience of Depression

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Submitted as requirement for a

PhD (Doctor of Philosophy)

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Declaration of own work

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Statement of Declaration

I acknowledge that this work is mine and does not contain unacknowledged work from other sources. This thesis has been submitted in fulfilment of the requirements for an award of Doctor of Philosophy (PhD) in Medicine and Health.

Signature:_____.

Date:_____.

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Abstract

Numerous epidemiological findings suggest that we live in an era that can only be described as the “age of melancholy” in that more and more individuals are diagnosed with depression every year. The aim of this study was to gain a phenomenological understanding of how individuals who experienced depression understood and made sense of their experience of depression through a methodology of interpretative phenomenological analysis. In-depth semi-structured interviews explored the lived experience of depression for eight individuals and identified how social discourses contributed to their understanding. Following rigorous analysis of twelve interview transcripts, data was broken down into four recurrent super-ordinate themes which related directly to how individuals made sense of their experience of depression; The Descent; The Worlds Conversations and Me - Engagement with Social Discourses; Broken Self - Transforming the Self; Embracing myself and my Mind - Transformation of the Self. Further interrogative analysis identified how some social discourses communicated by healthcare professionals, the media and academia, contributed to individuals experiencing an additional layer of distress, namely meta-distress which in essence is distress about distress.

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Glossary of Terms

Phenomenology - Edmund Husserl (1859-1938) stated that the focus of phenomenology is to "return to the things themselves" where its aim is to focus on a person's perception of the world in which they live and what this means to them: a focus on a person's lived experience (Husserl, 1913).

Interpretative Phenomenological Analysis (IPA) - IPA is concerned with the detailed examination of personal lived experience, the meaning of experience to people and how people make sense of that experience (Smith, 2011).

Experience - "Something personally lived through or encountered" (Concise Oxford Dictionary, 1995).

Social Discourse - Social discourse is speech or text communication that involves a social element, a communication that has a social purpose or some kind of distinctively social aspect. It is everything that is said or written in a given society, everything that is printed, or talked about, and represented through electronic and print media (Angenot, 2004).

Preface

Personal Journey

Deciding to undertake research into the way individuals experience depression grew from my personal experience of struggle with self known, the impact social discourses have in how we as human beings relate to ourselves, others and the world we live in and my experiences of working with individuals who experience depression over the past sixteen years. There is arguably a movement to concretize and promote a unified body of knowledge on mental health and mental illness in order to understand mental health difficulties such as depression. I am referring to the biomedical knowledge mental health professionals and academics communicate which is then disseminated by both electronic and print media.

The aim of this unified body of knowledge is to ensure individuals know how to recognise, prevent, and seek treatment (usually meaning professional help) for mental disorders with depression been referred to as a mental disorder. However, this dominant understanding of depression has wider social consequences in that individuals may become hyper-vigilant for what they understand to be symptoms of depression and may identify normal adaptive sadness as depression. Therefore I believed it was timely to explore individuals' experience of depression from a phenomenological perspective in order to explore how various social discourses contributed to individuals' lived experience of depression.

Reflexivity played a significant and necessary role throughout this study. The process of reflexivity ensured that I remained as grounded and aware as I could be of my own

experiences, thoughts, assumptions, beliefs, and knowledge, both professional and personal. Reflexivity also influenced how my experiences, beliefs, assumptions and knowledge contributed to the development of this study. In order to understand the task of interpreting another individual's "lived" experience, reflecting on my own phenomenological experiences became a necessary endeavour as phenomenological enquiry requires a mindset that welcomes a double hermeneutic involvement with individuals' perceptions of their lived experience (Spinelli, 2005). It requires the recognition that reality, as experienced by each individual, is a construct within intentional interpretations. It does not dispute physical reality as separate from our conscious experience of it (Spinelli, 2005). Therefore if I was to bring an unbiased and neutral stance to my role as a researcher I needed to be conscious of those personal life experiences that were likely to impact on my own stance and position in relation to the research topic. While acknowledging that it was not possible to recognise every presupposition, some consideration of my own perceptions of my own subjective 'lived' experiences thus far was necessary in order to understand how my experiences shaped and continue to shape me as a human being, as a healthcare professional and as a phenomenological researcher.

As I began this task, reflecting on my own indissoluble inter-relationship between myself as 'being' and my being-in-the-world, uncovered many of those habituated explanations that become part of our narrative. As a mental health nurse for the past sixteen years and a cognitive behavioural psychotherapist over the past seven years, I have had the privilege of working with individuals in very difficult times in their lives and allowed to enter their world and share in their subjective lived experience of depression. Over the years I have noticed at times at how healthcare professionals and

society in general oversimplify emotional experiences such as depression. I have also noticed the significant impact social discourses such as the biomedical discourse and media discourse have in how individuals experience depression and how these discourses contribute to the meaning they derive from their experience. This resonated with my own personal experience as a gay person who from early adolescence was faced with a social discourse about homosexuality, a discourse that stated that it was abnormal, wrong, disordered, even evil to many and those who were homosexual should be ashamed of who they were. In essence I was to be ashamed of who I was although being gay was not something I choose to be.

It was deemed wrong for many in society at the time and it was illegal to engage in any homosexual acts in Ireland up until 1993. To further reinforce the disgust many (not all) in society had for homosexuality, when the law was challenged in 1983, the Supreme Court in Ireland argued that due to the Christian and democratic nature of the Irish State, criminalisation (of homosexual acts) served public health and the institution of marriage. This ruling communicated very strongly a discourse of unacceptability and contributed to the narrative of homosexuality in society and to those who identified as homosexual. It was not until the case, Norris v. Ireland was taken to the European Court of Human Rights in 1988 that it was overturned as it was in breach of an individuals' human right to privacy. It then took a further five years for the Irish State to decriminalise homosexual acts.

The effect of growing up in a society where many were intolerant and disgusted about homosexuality was significant and one that I have considered a springboard to understanding my own strengths, vulnerabilities and purpose. I remember clearly my

own ‘coming out’ at age 21 years and the phenomenological experience I had. I remember for many years struggling with my sexuality due to (what I now know) what the social discourses (media, biomedical) communicated and the impact these discourses had on my sense of self, my opinion of myself, my self worth and my self concept. So significant the impact, that I had relationships with women for a number of years while always knowing that it did not feel right for me. After all having relationships with women communicated not only to the world but more importantly to me that I was normal, not disordered and not unacceptable. After a number of years of reflecting on my ‘being in the world’, I arrived at the conclusion that no individual should be made feel ashamed for who they happen to be or how they experience the world, therefore I should not be ashamed of who I happen to be. It was only at that point that I considered publically affirming this part of myself. Although I arrived at that conclusion I still took a very measured approach in communicating this hidden part of myself. I firstly told my sister who responded very lovingly and fully supportive so I continued to tell people one at a time.

Being gay and identifying as a gay man has been significant in my life for many reasons; I have a deep understanding of the shame human beings can feel for something that is part of their lived experience; I have a deep understanding of how social discourses contribute to how individuals experience the world they live in and their perceptions and subsequent behaviour; I have a deep understanding of the impact social discourses have in how individuals relate to themselves, others and the world; I have a deep understanding of the depth of human suffering but also how human beings can come through human suffering and thrive in the world; and finally I have a deep understanding of how social discourses change over time and the positive impact

this has on individuals' and society in general. The public narrative, once intolerant, has shifted over the years (in Ireland and many other countries but not all countries) from non acceptance and disgust, to acceptance and an embracing of difference on the whole.

The social discourse has shifted in a positive way in Ireland and many other countries which is welcomed and arguably allows gay people growing up in today's society to be more accepting of themselves. I often hear young people today when asked about their "'coming out"' experience say that they never '"came out"' because they were never "in". I often think how far we have come when I hear this and how the lived experience of being gay is so much more positive. I am very thankful that society has become more understanding and tolerant. This has led to me questioning whether or not if given a choice would I have preferred to grow up as a gay man in today's society or in the society I grew up in. I believe it has been helpful to me as a person to grow up in the times I did as the experiences I had, has defined much of my life direction thereafter influencing many of my life choices, career and world views. My subjective lived experience has shaped the person I am today and I believe I am a much more tolerant, accepting, understanding person as a result. Despite the growth of a more accepting and curious public narrative, I remain sceptical of the labile nature of public narrative and political agenda that can demonise individuals overnight. For example, in more recent times the debate surrounding gay couples' right to marriage equality and same sex adoption has come to the fore and the very same arguments that were expressed not allowing gay people legal recognition of their relationship until 1993 are again surfacing. I am not surprised by this discourse because it appears to me that many in society have difficulty reflecting on their beliefs

and therefore when they are forced to examine their belief, many struggle with that. However I am hopeful that a more accepting, tolerant discourse will again emerge in time as with discussion and debate individuals do come to a more reasoned and informed belief. I am better equipped this time however as I have a strong sense of self now and believe that I am worthy of equality even if there are others who do not believe so.

My lived experience has not gone without its lasting consequences. I have internalised many discourses to some extent which have shaped how I respond to others such as friends, family and colleagues. I have experienced and still experience internalised homophobia, something I am not proud of and feel ashamed when I notice this. I acknowledge it is not possible to grow up exposed to social discourses and not have internalised some of these discourses. I believe that would be impossible and naïve of me and I believe all human beings internalise discourses even those who are fully supportive of gay rights. They too are in some ways homophobic and intolerant at times. I do believe however that through self awareness and reflection I am aware when my internalised stigma, internalised homophobia or internalised shame emerges and I am able to address it much more effectively now. For example, for many years I would ask a very close friend of mine to "tone down his gayness", I would ask why he dressed "so gay and behaved so gay". I did not realise for many years that this was a result of my internalised homophobia and internalised shame along with the experiences of negative feedback from others when I or friends of mine exhibited 'gay behaviour'. I feel ashamed about that now, as a gay person should be able to express who they are just like any other human being. We would never say to a heterosexual man to stop being "so straight" or "tone down your straightness".

I do feel angry at times that this is part of my lived experience and if social discourses had been different I may not have been contaminated with internalised homophobia, shame and stigma. I also feel sad that in recent times again homosexuality internationally has regained much negative attention. Countries such as Russia along with many African countries are introducing new anti gay laws which again ensures that young gay people are being exposed to these discourses. Fortunately in Ireland there is also a discourse of public outrage regarding the re-emergence of hate towards gay people. This may help to reduce the impact of internalised homophobia, shame and stigma for today's young people.

You may be wondering how these experiences contribute to the study I undertook. It is evident by virtue of the stigma associated with experiencing depression (Cromby, Harper, Reavey, 2013) that a similar process occurs for individuals who experience depression or any mental health difficulty for that matter. In my sixteen years working with those who experience emotional distress I have drawn many parallels with my own experience as a gay person living in the world. For the most part individuals would not choose to experience the intense and deep feeling of despair and hopelessness commonly referred to as depression as it is emotionally very distressing. Many individuals I have worked with clearly stated that they wished they never experienced depression. However many say following the experience that it has had some beneficial impact on how they understand themselves and the world they live in. For many if not all they are also strongly influenced by the social discourses surrounding the experience of depression and mental health. For most they are not aware of how internalised stigma and shame contributes to the intensity of their experience. Many are unaware of how much distress is caused by the internalised

social discourses they possess through their exposure to them in their everyday lives through media, professional discourse and societal interactions with one another.

Individuals who experience depression are disadvantaged immediately due to the negative social discourses available to them. For example, I have often heard individuals who experience depression say “I should just get on with it”, “I am being selfish”, and “The men in the white coats will take me away”. These statements reflect internalised social discourses and when an individual experiences depression, they often think the above statements. Therefore it is inevitable that many will feel fear, shame and guilt for their experience. This often results in individuals not sharing their distress with others due to the shame they feel and a belief that they “should just snap out of it”. Human beings do not come into this world with beliefs so they have to acquire them through their lived experience in the world. So if individuals are saying that they should “just get on with things” or “not be so selfish” they clearly acquired those beliefs along their path in life. This leads to individuals hiding their emotional pain or telling very few people. Again like my experience of “’coming out’” as a gay person, individuals who experience depression have a “’coming out”’ in relation to their emotional distress. Depression is a very common human experience, so common in fact that it is often referred to as the common cold of emotional health difficulties. However the manner in which individuals who experience depression relate to their experience would imply that is a very rare experience. I believe this is due to the internalised social discourses which result in internalised stigma and shame which prevents individuals openly expressing their experience. This was also the experience of gay people in Ireland in the past but much less often today.

Deciding to undertake research in the way individuals experience depression grew from my personal experience of struggle with self known (homosexual orientation and what I thought I should be, namely heterosexual); the impact social discourses have in how we relate to ourselves, others and the world we live in and my experiences of working with individuals who experience depression. There is no doubt that my personal experiences have shaped my career path and how I relate and work with those touched by the experience of depression. In many ways it has shaped my life path. It is quietly there in the background; a silent companion influencing my decisions. Ultimately it has led me to this research to explore individuals' subjective lived experience of depression and explore how social discourses contribute to their experience.

Chapter 1

Introduction and Background to Study

1.1 Introduction

This chapter will present the significance, background and rationale for the study which explored individuals' experience of depression. The purpose of the study along with its aims will be outlined. An outline will be presented for each chapter including a rationale for its inclusion in this thesis. A conclusion will bring this chapter to a close and provide the context for subsequent chapters. The impetus for this research study arouse from my interest in mental health, emotional health and depression and from my experience of working with individuals experiencing depression as a mental health professional. Over the years I have noticed the significant impact social discourses have in how individuals' experience depression and how these discourses contribute to the meaning they derive from their experience.

My experience in how individuals understand and work through their unique experience of depression has encouraged me to read further on the role of social discourses and the meaning of emotions in understanding emotional experiences such as depression. For these reasons I became interested in exploring individuals' lived experience of depression. I employed a qualitative approach (Interpretative Phenomenological Analysis) to gain a deeper and contextualised understanding of individuals' lived experience of depression.

1.2 Problem Statement and Rationale for Study

Numerous epidemiological findings suggest that we live in an era that can only be described as the "'age of melancholy"' in that more and more individuals are diagnosed with depression every year (Schotte et al, 2006). Social scientists Horwitz and Wakefield (2007) argue in their book "The Loss of Sadness", that the biomedical discourse from psychiatry has medicalised and pathologised emotions whereby individuals experiencing difficult emotions are labelled depressed based on experiencing certain symptomatology. Discourses within society, the media and medicine have had a significant impact on how people talk and understand emotions, mental health and illness. Some emotional experiences are labelled as abnormal and requiring treatment much more quickly now than previous generations (Schotte et al, 2006).

It is argued that when people are exposed to advertisements, media attention and news stories regarding depressive symptoms they can confuse depression with normal sadness (Horwitz and Wakefield, 2007). Individuals monitor themselves for such symptoms and reframe their own experiences of sadness as signs of a mental disorder and in turn seek professional help for their experiences. Therefore, instead of focusing on what the meaning of their emotion is including their current life circumstances, and addressing these emotions, the individual interprets their emotional experience as a medical condition, namely, depression.

The media have an influence on the everyday lives of individuals and communities. Radio, television, print media along with other systems of representation such as academia, school, art, literature, film and music are all elements out of which we form

identities both as individuals and as communities (Henry and Tator, 2002). These vehicles of cultural production help shape our sense of self, our understanding of what it means to be male or female, mentally well or not. The media hold a mirror in which society can see itself reflected and at times the mirror is severely distorted (Henry and Tator, 2002). Henry and Tator (2002) maintain that the media does not always objectively record and describe reality, nor do they neutrally report the facts and stories. Media discourses are informed by many social discourses such as biomedical discourses and gender discourses among others. However, it is also plausible that some media practitioners socially reconstruct reality based on their professional and personal ideologies, corporate interests, and cultural and organisational norms.

There is arguably a movement to concretize and promote a unified body of knowledge on mental health and mental illness, now generally known as mental health literacy (MHL). The aim of MHL training is to ensure individuals know how to recognise, prevent, and seek help/ treatment (usually meaning professional help) for mental disorders with depression referred to as a mental disorder (LeFrancois, Menzies, & Reaume, 2013). MHL is a form of knowledge that is not necessarily tethered to culture and experience. A report compiled by the Canadian Alliance on Mental Illness and Mental Health (2007), offers the following definition: “Health literacy is defined as the degree to which people can obtain, process and understand basic health information and services they need to make acceptable health decisions. Mental health literacy (MHL) may be understood similarly as knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems. Enhanced mental health literacy is thought to confer a range of benefits: prevention,

early recognition and intervention, and reduction of stigma associated with mental illness" (Bourget & Chenier, 2007, pg 6).

In examining the broader social and political function of MHL work as a regulatory practice, LeFrancois et al (2013) suggest that efforts to homogenize opposing ideologies and culturally diverse ways of understanding, living with, and responding to mental health difficulties such as depression around a central dogma, or set of hegemonic principles, are fundamentally exclusionary and non-democratic (LeFrancois, Menzies, & Reaume, 2013). MHL training for depression might be seen as a manifestation of a collection of ongoing practices through which the "mentally ill" are socially and institutionally identified and managed (LeFrancois, Menzies, & Reaume, 2013). Therefore if only one way of conceptualising mental health and mental ill health is disseminated then that becomes the discourse in society and many individuals are more likely to label their emotional experience through the language and understanding of that particular discourse.

As the incidence of diagnosed depression is rising (World Health Organisation, 2014) it is imperative that further research be conducted in order to explore what contributes to the lived experience of individuals'. Arguably the increase in the incidence of depression could be as a result of movement to concretize and promote a unified body of knowledge on mental health and mental illness (MHL). This may result in individuals understanding their experience of depression from a unified body of knowledge or more specifically biomedical knowledge (biomedical discourse) disseminated through electronic and print media (media discourse). Therefore it was timely to explore how individuals who experienced depression understood and made

sense of their experience of depression. When I reviewed the literature, it also became clear that there was a paucity of research exploring the lived experience of depression using interpretative phenomenological analysis and in particular the impact social discourses have in the meaning making of individuals experience of depression. This thus became the focus of this study.

1.3 Purpose

The purpose of this study was to gain a phenomenological understanding of how individuals' who experienced depression understood and made sense of their experience of depression through a methodology of interpretative phenomenological analysis. It was envisaged that a greater understanding of individuals' lived experience of depression could influence future training and education and inform how clinicians work with individuals experiencing depression. Also it was hoped that this study would contribute to an alternative discourse and paradigm shift in how society and health care professionals conceptualise depression moving from a biomedical understanding towards a more phenomenological understanding of depression.

1.4 Research Aims

The aim of this study was to gain a phenomenological understanding of how individuals who experienced depression understood and made sense of their experience of depression.

1.5 Chapter Map

1.51 Literature Review

The literature review consists of two chapters. The first chapter (chapter 2) of the literature review provides the clinical and conceptual literature pertaining to how mental health and depression is conceptualised and the numerous understandings mental healthcare professionals, academia and society have derived in relation to depression. The following chapter (chapter 3) provides a review of the research literature pertaining to individuals' experience of depression.

1.52 Methodology

Chapter four is an overview of the methodology utilised in this study. The rationale for utilising a phenomenological methodology and more specifically Interpretative Phenomenological Analysis (IPA) is presented. The sampling method chosen, the research instrument used (in depth semi-structured interview), data collection procedures, gaining access to the participants, data analysis, ethical considerations and rigour is presented and discussed. It lays the foundation of how the study was conducted.

1.53 Findings

In this chapter the findings that emerged are presented and subsequently analysed using Interpretative Phenomenological Analysis (IPA). Following a rigorous analysis process of twelve interview transcripts, informed by Smith, Flowers and Larkin (2009), four recurrent super-ordinate themes which related directly to how individuals made sense of their experience of depression emerged. These were:

1. The Descent

"It felt like I was in a world where there was a constant dark black cloud everyday over me … it was just awful…so dark with no way out"

2. The World's Conversations and Me - Engagement with Social Discourses

"… the doctor described it was serotonin in my brain and that because I was just draining myself physically of the chemical that I was so low I wasn't able to reproduce this happy mood, good hormone, chemical or whatever it is. I needed something to take, to boost that again and he said once that was boosted you begin to think clearer"

3. Broken Self - Transforming the Self

"The fear of failure and when that happens, you've failed to keep it together in your body, in your mind everything and (its) just out there … "I'm a failure"

4. Embracing Myself and my Mind - Transformation of the Self

"I live my life now everyday because I was living months in advance, what if, what if and I was getting hysterical and totally putting my body into total overdrive … it's just all about helping yourself".

1.53.1 Finding Meta Distress

An important finding from this study related to the concept of meta-distress. Distress was identified in the studies reviewed but attributed to the experience of depression itself and it was not conceptualised as two layers of distress which emerged in this study. The theme 'The World's Conversations and Me' highlighted how social discourses informed participants understanding of their emotional experience when they received the label of depression. They established a new appraisal of their experience based on noticing symptoms from listening to the radio, reading on the internet or speaking with their general practitioner (GP) and linked this to being depressed. They then arguably experienced another level of distress about being emotionally distressed. I have conceptualised this experience as meta-distress which in essence is distress about distress. These included the distress related to their experience and the meta-distress related to the social discourses that informed their understanding of their experience when labelled depressed.

1.54 Discussion

In chapter six the findings are discussed with reference to the existing conceptual and research literature pertaining to individuals' lived experience of depression. The discussion focuses on three main findings; selfhood; connectedness; and meta-distress. These findings are discussed as they featured strongly in the participant accounts with the finding meta-distress emerging in this study however not identified in the research studies reviewed.

1.55 Conclusion, Personal Reflections and Implications

In the final chapter conclusions are drawn pertaining to the study. Critical reflections and implications for research and mental health practice are discussed. The reflective critique examines my own personal experiences of using a phenomenological method in mental health research as a result of undertaking this study. It is hoped that this study will contribute to the body of knowledge regarding the lived experience of depression and mental health more generally and act as a catalyst for discussion and debate about the issues identified thereby bringing about change in the social discourses regarding the lived experience of depression.

1.6 Conclusion

This chapter has outlined the research topic with emphasis on the significance, background and rationale for the study. The research aims have been outlined. The rationale for the study arose from the gaps in the current research. The gaps identified include: the paucity of research exploring the lived experience of depression using interpretative phenomenological analysis and in particular the impact social discourses have in the meaning making of individuals experience of depression. Furthermore, exploring how social discourses influence the lived experience using interpretative phenomenological analysis had not been conducted to date. Therefore it was useful to examine the influence of social discourses on individuals sense making of their experience of depression using this methodology. Furthermore as the incidence of diagnosed depression is rising it is imperative that further research be conducted in order to ascertain what factors contribute to the experience of individuals with depression in order to identify future training and education needs and contribute to a more informed discourse.

Chapter 2

Literature Review

Understanding Depression

2.1 Introduction

The purpose of the literature review (Chapter 2 and 3) was two fold. Firstly, to review the clinical and conceptual literature pertaining to how the experience of depression and mental health is conceptualised and the numerous understandings mental health professionals, academia and society have derived in relation to depression. Secondly, to review (Chapter 3) studies pertaining to individuals' experience of depression and the way individuals' made sense of their experience.

To locate empirical and conceptual literature around depression the databases CINAHL, MEDLINE, PsychINFO, PubMed, Science Direct and SWETSWISE were used. Key words used included: 'depression', 'sadness', 'concept analysis', 'experience of depression', 'media and depression', 'understanding depression', 'theories of depression', 'discourses and depression', 'gender and depression', 'culture and depression', 'biomedical discourse', 'mental health', 'mental illness', 'emotional health', 'psychiatry', 'critical psychiatry'. Numerous books related to the experience of depression were also reviewed with some individuals writing about their experience from a medical perspective and others from an existential

perspective. The research pertaining to the study came from a variety of disciplines including nursing, medicine, psychology, philosophy and sociology.

I also accessed websites discussing depression throughout the study to gain a greater understanding of individuals' experience of depression. These websites included www.peoplesrepublicofcork.com depression forum, "Depression and my battle with it"; www.depressionforum.org/forums and www.boards.ie depression forum. I was mindful to read and be exposed as much as possible to all understandings of depression as I wished to obtain a holistic picture of individuals lived experience of depression. In doing this I took a mindful approach to the information and experiences of individuals experience of depression so as to reduce any bias I might have. This involved taking a mindful non-judgemental stance when reading and reviewing the literature which involved not making judgements or evaluations based on my own understanding and taking an open mind in that as human beings we all experience events in our lives differently.

An overview of the literature pertaining to nursing, medicine, sociology, psychology, philosophy along with personal accounts informed the written account on understanding depression. I believe it was important to derive understanding from all disciplines not because it represents good research but because it represents the wide opinion, views and beliefs related to the experience of depression as individuals' living in the world find different understandings helpful.

Firstly I will present the incidence of diagnosed depression in society currently to highlight the increasing numbers of people being diagnosed with this difficulty. I also

offer an alternative explanation for the rise in depression diagnoses. Following this, in order to contextualise the study I discuss how culture shapes experience, interpretation, and action and orients people in their way of feeling, thinking, and being in the world thereby contributing to individuals understanding of depression. To further contextualise this study I provide a historical account of how academics, professionals and scholars derived their understanding of mental illness and depression. I believe this is relevant as it provides a critique of the concept of mental illness, depression and psychiatric diagnosis and highlights how early understandings of mental illness became a dominant biomedical discourse and thereby informed the professional, media, and societal discourses that continue today. This understanding is pivotal as it demonstrates how social discourses contribute to individuals' process of making sense of their experience of depression. It also highlights how early understandings such as the biomedical understanding results in individuals framing their experience of depression through this lens.

Following this, I felt it was important to understand more fully the concept of emotion and differentiate between depression and sadness in order to provide conceptual clarity of these two emotional experiences which are often used interchangeably. This is important as it may offer an explanation as to why the incidence of diagnosed depression continues to rise. Arguably part of the conceptual confusion arises from the dominance of the biomedical model in society; thereby becoming the cultural norm for individuals and communities by shaping beliefs, habits and discourse around the experience of depression.

When there is conceptual confusion between the concept of depression and sadness by health professionals and individuals in society, then it is likely that individuals experiencing normal adaptive sadness are being diagnosed or self diagnosing as being depressed thereby further complicating matters. During the literature search I found a concept analysis on depression however I was unable to find a concept analysis on sadness. I therefore examined the literature pertaining to sadness and undertook a concept analysis related to sadness using Walker and Avant (2010) framework for theory construction which outlined its defining attributes, antecedents, consequences, and empirical referents. This provided conceptual clarity and helped differentiate between the two concepts.

Finally I present an overview of the theoretical understandings of depression from a biological, genetic, psychological, sociological, and biopsychosocial perspective. More theories and understandings of depression have emerged over the years due to the emergence and maturing of other disciplines such as sociology, psychology, and nursing and also increased interest in mental health. Furthermore, research skills and competences have expanded to other disciplines resulting in further research being conducted examining many emotional experiences such as depression. This has resulted in other theories of depression emerging which is presented in this chapter. The emergence of these theories has contributed to a discourse in society related to these theories which will be presented. This demonstrates how social discourses emerge from theories of depression and highlights the role of the media in disseminating this information.

2.2 Incidence of Depression

At least 350 million people are diagnosed with depression globally each year (WHO, 2014). Depression is the leading cause of disability as measured by Years Lived with Disability (YLD's) and by 2020 diagnosed depression is projected to reach second place in the ranking of disability (WHO, 2010). According to Aware (2013), an Irish voluntary group which assists those whose lives are directly affected by depression, state that 450,000 people in Ireland are living with depression at any one time. One in five women and one in ten men will be diagnosed with a clinically significant depressive episode during their lifetime (Schotte et al, 2006). A large epidemiological study on depression revealed a 17 % six month prevalence of depression from a sample of 78,000 adults from six different European countries (Tylee, 2000).

The above figures presented would lead us to believe that depression is an increasing mental health problem as the numbers diagnosed every year continues to rise. An alternative explanation might be that due to the increased use and acceptance of a unified body of knowledge on depression which aims to ensure that individuals' know how to recognise, prevent, and seek help/ treatment (usually meaning professional help) for depression is responsible for the rise. As a consequence of a unified body of knowledge disseminated through electronic and print media individuals are internalising this knowledge/ discourse and thereby understanding their emotional experience as depression more quickly. This could account for the continued rise in depression in the world. This internalised unified body of knowledge on depression is shaping our belief system, habits, customs, and discourse for both individuals and communities, demonstrating how cultural understanding impacts on our experience of depression which is discussed further below.

2.3 Cultural Understanding of Depression

The relationship between culture, mental health, depression and distress is ongoing and complex. Defining culture can be difficult and the debates between and within anthropology, psychiatry and psychology continues. Too broad a definition can obscure some of the key differences between people within the same culture, and a too narrow definition can blind us to important similarities (Cromby et al, 2013). Social psychologists Kenrick, Neuberg and Cialdini (2010) define culture as a set of beliefs, habits, customs and discourse shared by people living in close proximity and time. Cultural anthropologists argue that culture shapes experience, interpretation, and action and orients people in their way of feeling, thinking, and being in the world (Jenkins & Barrett, 2004). Therefore the manner in which individuals interpret their lived experience of depression will be influenced by their belief system, habits, customs and discourse which are shared with those living in close proximity and time.

Arthur Kleinman, an American Psychiatrist and medical anthropologist argues that culture is not a "thing", it is "a process by which ordinary activities acquire emotional and moral meaning for participants. Cultural processes include the embodiment of meaning in habits and physiological reactions, the understanding of what is at stake in particular situations, the development of interpersonal connections, religious practices, and the cultivation of collective and individual identity. Culture is inextricably caught up with economic, political, psychological, and biological conditions. Treating culture as a fixed variable seriously impedes our ability to understand and respond" (Kleinman, 2004, pg 952). When studying culture and the experience of depression, attention must be given to more specific domains of family,

religion, ethnicity, class, and gender within the overarching definition of culture, as these can have a dramatic effect on the organisation of emotions, beliefs and norms of acceptable behaviour (Pilgram, 2009). Therefore social discourses related to gender, media, and feminist discourse are all influenced by cultural norms within society at any given time which is discussed further.

In addressing issues of culture in the context of individuals' experience of depression, it is important to explore how particular customs and habits of a given culture contribute to the development of depression as cultural beliefs regarding depression are informed and shaped by professional disciplines that are sanctioned by society to measure and treat depression (Cromby et al, 2013). The introduction of pharmaceutical companies into developing countries, for example, has possibly resulted in an increase in interest in the psychiatric views from developed countries thereby imposing different cultural values and belief systems that may not necessarily be congruent with the culture it enters into (Cromby et al, 2013). The research pertaining to the lived experience of depression from different cultures will be presented in Chapter 3 to highlight how different cultural beliefs, customs and discourse impact on how individuals experience and interpret depression.

A question that arises relates to how these cultural understandings emerged. In order to answer that question, a critique of the historical account of how academics, professionals and scholars derived their understanding of mental illness and depression must be examined. Providing a critique of the concept of mental illness, depression and psychiatric diagnosis highlights how early understandings of mental illness became a dominant biomedical discourse informed by the biomedical model

which is discussed further below. The biomedical model relates to a conceptual model of illness that excludes psychological and social factors and includes only biological factors in an attempt to understand a person's illness or disorder (Ghaemi, 2007).

2.4 Philosophical perspectives of Mental Illness

In order to contextualise the study further I will explore and discuss how early understandings of mental illness and depression became a dominant discourse which informed the professional, media, and medical discourses that continue today. Over the past few centuries the nature and form of mental illness or madness such as schizophrenia, and depression in Western society has been widely debated. A range of theories have been developed and presented, different treatment developed and different 'cures' for illness claimed. So what exactly is mental illness?

In order to explore this concept, one must examine the philosophy of psychiatry, personal narratives and professional views regarding 'mental illness'. Three broad areas of philosophy of psychiatry will be presented and critiqued. These include the scientific underpinnings of psychiatry, the role of values in diagnosis and treatment, and the nature and limits of understanding meaning. The aim is to provide context to this study by gaining a critical understanding of how psychiatry has impacted on how society understands and conceptualises mental illness and emotional experiences such as depression and discuss how this contributes to individuals' lived experience of depression.

At the beginning of the 17th century there was increasing scepticism about the supernatural as an explanation for mental illness or madness. Anatomists were

beginning to develop more detailed understandings of the body and began to understand the body as a machine founded on the operation of two key systems: cardiovascular system and the nervous system (the brain and sense organs). Thus madness was viewed as a failure of the sense organs and the nervous system (Cromby et al, 2013). It was at this time that the term 'neurologie' was coined by Anglican Thomas Willis in his writings 'Anatomy of the Brain' to indicate a physical lesion of the nervous system (Hunter & MacAlpine, 1963). He argued that 'the true and genuine reasons for many of the actions and passions that take place in our body were to be found in the anatomy of the nerves' (Scull, 2011, pp. 32-33).

French philosopher Rene Descartes (1594 – 1650) proposed a distinction between the mind and body, as he declared 'I think, therefore I am' an example of the mind – body dualism (Clarke, 2006). Cartesian dualism held that the immaterial mind and the material body are two completely different types of substances which interact with each other. Scull (2011) argued that Cartesian dualism had a profound influence on medical thought, in that it could justify medicine's jurisdiction over the mad as madness was rooted in the body which was the domain of the physician. Scottish psychiatrist W.A.F Browne concluded that 'derangement is no longer considered a disease of the understanding, but of the centre of the nervous system … the brain is at fault, and not the mind' (Scull, 2011, pp. 37).

Until this time, in most societies, families cared for those afflicted by madness. Then asylums began to emerge more in the housing and feeding of those experiencing mental illness or madness. By the middle of the 17th century, private for – profit institutions were well established in the England and Europe (Cromby et al, 2013).

Here the rich could live in separate houses on the grounds and have their own cooks. However the physicians that delivered care to those within these institutions lacked legitimacy, their competence and motives were questioned and they were figures of fun in the popular press (Scull, 2011). It was a different experience, however, for the poor who were housed in asylums which were much more brutal relying on physical restraint, blood – letting, purges and vomits (Porter, 2002). Porter (1996) argued that punishment was not necessarily the intention of these institutions as official reports also document humane practices alongside the punitive practices, rather, the aim was to segregate the insane to preserve order in society and permit intensive treatment.

The link between madness and the preservation of public order is significant as Foucault (1967) in his book Madness and Civilization argued that by the mid 17th century, in the depths of the age of reason, the mad were separated completely from society. They were confined in asylums along with other outcasts from society such as the poor, the crippled, the aged, petty criminals and so on. Foucault labelled this period as the 'Great Confinement'. Foucault (1967) argued that social forces drove this confinement as an extrajudicial mechanism for getting rid of the undesirables. Confinement ensured that the mad were conveniently available to medical doctors who viewed madness as a natural object worthy of study and then as an illness to be cured while been separated from society.

The 19th century therefore saw the professionalization of those involved with treating the mad in the asylums. The term 'psychiatry' was first coined by German physician Johann Christian Reil in 1808 with psychiatric diagnosis as we understand it today tracing back to the work of another German psychiatrist Emil Kraepelin at the end of

the 19th century (Bentall, 2003). Kraepelin believed that severer forms of madness could be divided, like physical illnesses, into a small number of disorders based on symptoms. In summary, the mainstream assumption in psychiatry, dating back to Kraepelin, is that severer forms of madness are best understood as disease processes. For this reason, enormous efforts have been devoted to trying to define and categorise them in the same way as diseases in other branches of medicine (Cromby et al, 2013) leading to the development of a psychiatric classification of mental disorders based on symptoms, namely, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Therefore with this in mind it is timely to examine the scientific underpinnings of psychiatry and also examine if, what Foucault (1967) refers to as, madness can be deduced to disease processes as suggested by Kraepelin and the discipline of psychiatry.

The factual and scientific underpinning of psychiatry asks the question; Is psychiatric classification valid?' Classification is essential to all sciences and lies at the heart of conceptual judgement, prediction and explanation. It is important to question whether or not psychiatry is a science although it makes sense that if psychiatry wishes to view itself as a legitimate science; it will then attempt to position itself as a science thereby developing a classification system. This would be one way of establishing itself as a legitimate science. One could argue that just because psychiatry has established the "ingredients" of a science that the "ingredients" itself does not necessarily make it a science.

Classifications come in different forms. One that tracks real, objective-underlying similarities in nature is referred to as a "natural" classification. Another is that which

is imposed on us that may or may not be useful for us but which expresses "our" interests. The latter is particularly vivid in psychiatry and concerns the validity of psychiatric classification and diagnosis. Those involved in the anti-psychiatry movement argue that psychiatric classifications are not reflective of genuine medical conditions at all but are reflections of social prescriptions and values. The central concern here is the evaluative aspect of psychiatric classification whether one accepts the anti-psychiatry movement or not (Thornton 2007). The move to operationalise definitions has increased the reliability of the DSM yet the underlying issue of validity of the classification remains. Kupfer et al (2002) questions whether classification should be based on dimensions instead of categories, and whether mental illness can be construed as discrete entities or not. Following World War II the World Health Organisation (WHO) established an International Classification of Disease (ICD) to deal with bodily disorders including psychiatric disorders. However although well received and adopted around the world by government health departments, the psychiatric section was not. Instead most psychiatric institutions, continued to operate with their own systems. This was investigated and it was identified that attempts at a classification based on theories of the causes of mental disorder were to be abandoned, as the theories were not well defined (Mayes & Horwitz, 2005). Therefore one was to rely on what could be directly observed which were symptoms. This resulted in the ICD 8. The current ICD 10 and DSM V are both derived from the ICD 8 and retain its essential basis in symptoms.

Hempels (1994) examines the "valuation" (values in versus values out) argument of psychiatric classification which he believes threatens to undermine the objectivity of psychiatric classification. He suggests that as different people make different value

judgements, then if classifications require value judgements, these classifications will lack reliability. The presence of values in classification is in itself enough to show that the classification lacks validity. A recent development within the World Psychiatric Association (WPA) is the advocacy of a comprehensive model of diagnosis. In doing this they have published a guideline called the "Idiographic (personalised) Diagnostic Formulation" which recommends an idiographic component within psychiatric diagnosis. A narrative or idiographic formulation can be defined as an individual account with first-person and third-person aspects (Phillips, 2005). The account includes the person's story, which may contain formal diagnostic, ICD 10/DSM V aspects along with psychodynamic and cultural dimensions not found in manuals. The clinician will then make a judgement or not regarding the priority of the biological or the psychological in the person's presentation and will structure the formulation accordingly (Phillips, 2005). The WPA suggests that the narrative components in a comprehensive diagnosis are tailored to individual cases. Therefore, if psychiatric diagnosis is to contain a narrative-based, idiographic ingredient, then what comes of its validity?

So can drawing from the philosophy of science assess validity where debate about realism has been more common? Two tests within science for realism include inference to the best explanation and inference to the cause, which can be applied to psychiatric taxonomy (Thornton 2007). Fine (1986) suggests that neither of these can provide an extra theoretical perspective. Therefore there is no theory neutral way to measure validity of psychiatric classification. Finally when questioning validity in relation to the narrative elements of "comprehensive diagnosis" the very idea of an individualistic element goes against the paradigmatic validity of say the Periodic

Table, which is based on general, criterial and nomothetic understanding. The strength of the Periodic Table lies in its ability to prescind (to separate or divide in thought; consider individually) from surface complexity to chart shared underlying structures. In contrast, individualistic understanding in "comprehensive diagnosis" stresses the "surface complexity" which ultimately are the individual features that contribute to a person's life. Therefore how does one apply scientific scrutiny to such accounts.

Finally it is evident that the role of judgement and in particular "having good judgement" plays a part in mental health care. The view is in opposition to codified or algorithmic practice and therefore there is increasing emphasis being placed on codification of psychiatric practice. This is to ensure reliability of diagnosis in psychiatry. This is evident in the rise of structured and semi-structured interview protocols originating within psychiatry. Codification of diagnosis aims to standardise clinical judgements and improve communication between clinicians and research. Codifications also aims to set out an agreed legal framework against which judgements of permissible actions can be made which may lead to the belief that they can capture the nature of skilled clinical judgement itself. In mental health care-making judgements involves a complex inter-relation between factual, meaningful and evaluative aspects. Therefore the overall judgement is based on an appreciation of a complex whole, but this is not to say that the interaction of the factors that make up the whole can be predicted algorithmically. Codification presents a number of risks; abusive practice, if values are squeezed into a constraining framework; misunderstanding, when meanings are treated mechanically and finally, less than optimal evidence based practice, when the element of judgement about the relevance of evidence is downplayed (Thornton 2007).

Following examination of the scientific underpinnings of psychiatry discussed above it would appear that the central aim of psychiatry is to understand the messages and significance of an individual's experiences (idiographic) as well as explaining the aetiology of mental illness such as depression through the development of a psychiatric classification system. In other words, psychiatry aims to understand the relationship between understanding meaning and explaining it through scientific laws. However others such as Thomas Szasz (psychiatrist), Michel Foucault (French philosopher), Pat Bracken (psychiatrist) to name a few argue that psychiatry aims to be paternalistic and exert power over individuals experiencing mental health difficulties. Psychiatry is more concerned about establishing itself as a legitimate science (through psychiatric classification discussed above) and discipline than understanding the unique individual experience of the person (Bracken and Thomas, 2001, & Bracken, 2012).

During the 1960's the fundamental claims and practices of mainstream psychiatry were being challenged by psychiatrists such as R.D. Laing from the United Kingdom, Franco Basaglia from Italy and Thomas Szasz from Hungary who trained and worked in America. This challenge was to become known as the anti-psychiatry movement which viewed psychiatric treatments more damaging to patients than helpful. It considered psychiatry a coercive instrument of oppression due to the unequal power relationship between the doctor and patient and use of a highly subjective diagnostic process (Crossley, 2005).

The term anti-psychiatry was used by David Cooper, a South African Psychiatrist, however the psychiatrists outlined above would not have considered themselves anti-psychiatry. The anti-psychiatry movement claims that mental illness does not exist and is a myth. Psychiatrist Thomas Szasz has put forward a number of explicitly philosophical arguments in support of this movement. He would view this movement in terms of critical psychiatry as opposed to anti-psychiatry. He argues that mental illness is defined by reference to evaluative norms in contrast with physical illness. This is defined as deviation from structural or functional integrity and therefore Szasz argued that mental illness could not be treated like physical illness. His arguments relate to the role of values, such as what is considered a mental illness, in diagnosis and the treatment of mental illness (Szasz, 2010).

The argument regarding the anti-psychiatry movement relates to the nature of mental illness itself. Physical illness involves a deviation from structural or functional integrity and mental illness depends on deviation from evaluative norms (Szasz, 2010). Mental illness therefore cannot be treated by medical means (Szasz, 2010). This is in direct contrast to the biologically minded defences of psychiatry offered by Kendell (1975) and Boorse (1998). The first line of argument for the existence of mental illness is based on the reality of illnesses of the body and brain. An illness of the body leads to an illness of the brain. For those who regard mental symptoms as signs of brain disease the concept of mental illness is unnecessary and misleading (Szasz, 2010). He argues that if people suffer from disease of the brain, in essence a neurological disorder, then that is how it should be phrased. The idea that mental illness is sui generic (a form of illness like physical illness but essentially and distinctly mental) implies that one views mental illness as a “deformity of the

personality". This explains human disharmony or more generally life problems. This implies that punitive mental illness is the same thing as a form of behaviour, a form of mental illness behaviourism (Szasz, 2010). If mental illness is defined in terms of certain sorts of behaviour then the connection between it and those forms of behaviour is necessarily not contingent (Thornton, 2007). Thus if mental illness is supposed to cause the behaviour and it does not, is there mental illness?

Szasz (2010) argues that those who subscribe to the idea of mental illness also insist that it can be addressed using medical measures yet these are designed for treating bodily illness. He does acknowledge the presence of contemporary human problems but does not believe mental illness exists. It's the labels society gives to the human problems that concern him (Szasz, 2010). This is evident in the many names the experience of depression has been given over the years such as melancholy, depressive disorder, reactive depression, and major depression. In contrast to Szases views, Christopher Boorse and Robert Kendell defended the idea of mental illness. Kendell (1975) argues that an increased mortality rate and reduced fertility rate implies "biological disadvantage" therefore any condition that leads to "biological disadvantage" is an illness. The criterion is therefore value free and purely factual so if a condition increases mortality and reduced fertility then it's an illness (Kendell, 1975). This approach faces a 'dilemma' as it is possible for a person to be ill without this leading to increased mortality and reduced fertility (Thornton, 2007). Boorse (1998) presents a value free, purely descriptive account of disease. He argues that to understand mental health one should be informed by root notions of health in general, drawn from physical medicine. He distinguishes between disease and illness unlike Kendell (1975). Disease is a more fundamental notion and is value free where illness

is a disease that is “serious enough to be incapacitating” and “undesirable for its bearer” (Boorse 1975).

Fulford (1999) offers a useful perspective on Szasz’s values-based critique of psychiatry and Kendell and Boorse’s values-excluding defence. Both parties agree that mental illness is conceptually problematic where physical illness is conceptually simple and also value free. Kendell argues that they fit his preferred criteria of increased mortality rate and reduced fertility. Fulford (1999) argues that both mental illness and physical illness are both value terms. He goes on to say that if illness (generically) is a value term and if mental illness is more overtly value-laden than physical illness, this is neither because (as Szasz argued) mental illness is a moral, rather than a scientific concept, nor (as Kendell and Boorse argued) because psychiatric science is a less advanced science than physical medicine.

He attempts to provide more clarity in relation to both arguments and highlights that psychiatry is concerned with areas of human experience and behaviour such as emotions, desire, volition, and belief, where people’s values are highly diverse (Fulford, 1999). The idea that illness comprises an internally generated failure of ordinary doing explains its value-ladenness because the ineliminable concept of failure (of ordinary doing) itself suggests an ineliminable (negative) value judgement. This is true for both physical and mental illness. There is general agreement about the values concerned with physical illness, but wide disagreement over those concerned in mental illness (Fulford 1999).

Pickering (2006) criticised Fulford's analysis and attempted to explain why there is continuing disagreement about the status of mental illness including depression despite careful analysis. He argues that a fundamental flaw exists because of a shared dependence on what he refers to as the "likeness argument". The likeness argument is supposed to resolve the status of mental illness by demonstrating that putative mental illness is sufficiently like illness. However it does not achieve this. The likeness argument fails to settle the matter due to two questionable assumptions; that there are features of human conditions such as depression, which decide what category these conditions are a member of and that, with respect to the presence of or absence of these features, a condition such as depression, is describable independent of the category it is assigned to (Pickering 2006).

The ascription of features to conditions – putative illness - depends on an overall category – illness or not – into which they are placed. He argues that the behavioural features of alcoholism, for example, can equally be described in terms of moral weakness or of causally determined pathological behaviour. The features themselves cannot be used to determine to which overall category the condition belongs. Therefore the likeness argument is questionable and fails to resolve the different views/ arguments of both parties (Pickering, 2006). In conclusion, while "value theorists" argue that mental illness such as depression is essentially an evaluative notion, their "values out" opponents argue that it is a matter of the plain facts to be analysed, using the notion of biological function.

The final area that emerged in exploring philosophy of psychiatry relates to the nature and limits of understanding meaning. Psychiatry unlike other areas of medicine,

concerns meanings as much as physiological facts. As stated earlier, psychiatry aims to understand individuals such as those experiencing depression as well as attempting to explain mental illness. However understanding meaning is a different kind of intelligibility from framing causal, aetiological explanations. Philosophical analysis aims to provide a way of interpreting or making sense of expressions of mental illness and depression. Understanding meaning from a cognitive approach such as Beck's cognitive theory of depression attempts to explain the content of mental states. Internal information, carrying states of the brain or nervous system are postulated which are processed by sub-personal modules. A person therefore has the capacity to think thoughts by the processing of internal mental representations. There are two main approaches to meaning taken in psychology; cognitivism and discursive psychology. Cognitivism which gained prominence in the 1960's was a response to Skinner's behaviourism which was the dominant approach in psychology at the time, examines the approach to meaning by treating the mind on the model of an information-processing computer (Richelle, 1995). Cognitive psychology developed by George Miller, Eugene Galanter, Donald Broadbent and later Ulric Neisser attempts to provide scientific explanations of how the brain carries out complex mental functions such as vision, thinking and memory (Richelle, 1995, Parkin 1996). Reasons are a species of causes and intentionality is explained as an essentially causal notion.

Another approach to understanding meaning is through discursive psychology which was developed during the late 1980's and 1990's by Derek Edwards and Jonathan Potter at Loughborough University in England. This approach places meaning in the public world and views meaning as essentially sharable. It also places meaning in

nature. The discursive approach claims that meanings are caused by social factors and constructionism, which is one way to discharge that obligation. An advantage of the discursive approach from a philosophical perspective is that it addresses the concern about privacy of meanings and mental states by placing them in the public domain (Thornton, 2007).

This is in contrast with the cognitivist approach where a number of problems arise as mental states within cognitivism are constructed as internal states within a person. A difficulty which arises is that of others' minds; how do we know/ understand what mental states others are in if all we have to base our judgements on are outward appearances. Furthermore, how are we to know/ understand others' meaning if meanings are an internal matter? Finally if our mental states are internal states then how can they reveal themselves to the outer world? These are some of the difficulties that arise from the cognitivist approach. The discursive approach claims that psychological phenomena are not merely caused by social factors, but also constituted by them, rather than constituted by factors within the skull (Harre and Gillett, 1994). Discursive psychology is usually taken to be constructionist which implies that mental meanings are constructed in ongoing social interaction. Constructionist forms of discursive psychology view meaning as an ongoing product of conversations.

Cognitivism and discursive psychology are the two main theoretical approaches within psychology. Although they offer contrasting approaches as discussed, they share a common aim. This involves explaining meaning or intentionality in more basic non-meaning presupposing terms. An alternative to this is to embrace meaning and intentionality as features of the world, which are natural in their own right

(Thornton, 2007). This is referred to as non-reductive or relaxed naturalism that involves two aspects. People possess abilities that can be moulded into an appreciation of meanings through suitable education and training. In other words we can make judgements about what others mean and can in turn, judge how to use language appropriately. Thornton (2007) believes this cannot be reduced to mere mechanisms. This view also claims that the world itself contains not just those features that can be explained using nomological causal explanations of the realm of law, but also the meaning-laden phenomena of the space of reasons. Therefore psychiatry needs to embrace an augmented sense of nature or the world, in other words, a relaxed form of naturalism.

Finally a cognitive approach seeks to explain intentionality whereas philosophy elaborates the idea that a mental state means what "causes" it in the brain or the nervous system of the person. Therefore meaning is a kind of causation (Thornton 2007). This has been explored in depth with regard to delusions (Maher, 1999) however can be applied to the experience of depression or any emotional difficulty. Maher (1999) states that we experience "primary feelings of significance" in our everyday lives. We refer to these as "feelings of awareness"; "mood"; "atmosphere". He refers to these as an "experience" which informs us that something significant or important has occurred whatever it is. Inferences can be drawn from these experiences and he argues that the same kind of phenomena exists in psychopathology. It was from this that he developed his model of delusion, which broadly argues that the processes by which deluded persons reason from experience to belief are not different to those of non-deluded persons. The major difference that appears between delusional and non-delusional beliefs is the nature and intensity of the

phenomenological experience that is been explored (Maher 1999). This is also evident in how healthcare professionals such as general practitioners, psychotherapists, psychologists and psychiatrists respond to individuals who describe experiencing depression after the death of a loved one. Very often, healthcare professionals do not view their experience as depression but a normal response to a loss. Whereas the concept of loss can also apply to the loss of a job, a relationship, ones sense of self, thereby representing similar emotional symptoms. However healthcare professionals are more likely to conceptualise the symptoms of depression associated with the loss of a relationship or job as depressive disorder more quickly. This suggests that understanding is ongoing but sometimes, it can be an impossible task. Therefore the clinician has to make a series of interpretative judgements taking broad account of the life of the individual. These judgements can aid in at least partial understanding of the person as a whole while at the same time taking account of their psychopathological experiences. Therefore the basic unit of meaning is the life of the whole person. Therefore within the discipline of psychiatry, be it schizophrenia or depression, there is no quick route to bypass the need for good and sensitive judgement.

In conclusion, providing a critique of the literature pertaining to the philosophy of psychiatry in understanding mental illness and psychiatric diagnosis highlights how early understandings of mental illness became a dominant biomedical discourse and thereby informed the professional, media, and societal discourses that continue today through the development of the DSM and ICD 10. Within philosophy of psychiatry, three broad areas were presented and critiqued. These included the factual and scientific underpinnings of psychiatry, the role of values in diagnosis and treatment; the nature and limits of understanding meaning.

From reviewing the arguments above it is evident that the concepts of mental illness are complex and influenced by value judgements by those who diagnose mental illness such as depression. As discussed, early attempts to conceptualise mental illness through a framework of understanding physical ill health was over simplistic and deductive. Psychiatric diagnoses such as depression are influenced by the social norms of society at any given time as argued by Foucault (1967). This involves the beliefs and discourse individuals and communities have at that time, in essence the cultural values (cultural understanding) of society which involves what is acceptable or unacceptable, important or not important, right or wrong, and so on in society. It highlights how early understandings such as the biomedical understanding results in both health professionals and individuals framing the experience of depression through a biomedical lens thereby impacting on individuals' understanding and experience of depression and accounts for the continuing rise in diagnosed depression every year. It also demonstrates how social discourses such as the biomedical discourse contribute to individuals' process of making sense of their experience of depression. Furthermore as discussed value judgements and their impact on diagnosing depression is complex due to the increasing multi-cultural society we live in. Therefore as health professionals come from many different cultural backgrounds and have various training and individual lived experiences of depression, all of these will impact on the value judgements they make about depression and the individual experiencing it. Other value judgements that will also come into play will be gender and age, all social discourses which will be examined further. Therefore providing a historical account of understanding mental illness and depression contextualises the

study and highlights the complexities in attempting to define the experience of depression. I will now present the different understandings of depression.

2.5 Understanding Depression

There are many theories that attempt to explain the experience of depression. These include; biological, genetic, psychological, social and the biopsychosocial diathesis–stress model of depression, which aims to provide a constructive conceptual framework to understand depressive complaints, vulnerability, and stress taking into consideration the psychological, biological, social and environmental demonstrating how all factors can contribute to individuals experiencing depression. I will now present the different understandings of depression in the context of what has been discussed above, namely how culture and historical understandings impact on how both professionals and individuals understand the experience of depression.

Firstly however I will differentiate between the experience of depression and sadness in order to provide conceptual clarity for these two emotional experiences which are often used interchangeably. By doing this an explanation as to why the continual rise of the incidence of diagnosed depression becomes apparent. Arguably part of the conceptual confusion arises from the dominance of the biomedical discourse in society; thereby becoming the cultural norm for individuals and communities by shaping beliefs, habits and discourse around the experience of depression. Furthermore by exploring the concept of sadness more fully will allow for differentiation between sadness and depression allowing for further exploration of the term depression. It will also clarify both terms and inform the research study more fully.

Attempts have been made to understand and define the parameters of the concept of depression. Depression is defined from many perspectives; biomedical, psychiatrically, sociologically, and psychologically. Although there are many ways of defining and understanding this common human experience, the biomedical explanation remains dominant in society and is what is communicated most by the media. During the literature search I found a concept analysis on depression written by a nurse researcher who broadly conceptualised depression as a dysphoric mood marked by feeling of sadness, helplessness, worthlessness, loneliness, and often guilt (Subu, 2006). Her definition of depression identified the emotions and the phenomenological experience of worthlessness and hopelessness many individuals experience. However when we examine Winokur's (1981) definition of depression, it is described from a biomedical perspective. Depression is a state of mind and body which is characterized by a change in mood towards being miserable, worried, discouraged, irritable, unable to feel emotion, fearful, despondent, hopeless, or down in the dumps. Furthermore, he continued that this state of mind, however, is not enough for the diagnosis of depression. The person with depression must have a cluster of associated symptoms, which occur over a period of time and are associated with the mood. Such symptoms include poor appetite or weight loss, trouble sleeping, tiredness or fatigability, agitation, slowness in thinking and motion, a loss of interest in usual activities, a decrease in sexual drive, feelings of self-condemnation, difficulty concentrating, thought of death or suicide, and perhaps suicide attempts (Winokur, 1981).

Wolpert (2001) writes about his personal experience of depression and described his experience as disabling. He stated that it was indescribable where one entered a world with little relation to the real one and described the experience as the worst experience in his life, even worse than the death of his wife from cancer which he described as shameful. His description demonstrates the enormity of his experience and also demonstrates how his relationship with himself and the world changed so significantly. Finally John Stuart Mill (1962), a British philosopher, political economist and civil servant wrote that Coleridge's (1802) poem 'Dejection: An Ode' was an accurate description of his experience of depression.

> A grief without a pang, void, dark and drear,
> A drowsy, stifled, unimpassioned grief,
> Which, finds no natural outlet or relief
> In word, or sign, or tear.
>
> (Samuel Taylor Coleridge, 1802)

From the descriptions above, it is evident that individuals described the experience of depression differently emphasizing the complexity of the experience. Wolpert's (2001) description is very relational based where Winokur's (1981) description is based on symptomology and Mill's (1962) best described his experience through poetry again emphasizing the unique nature of this idiographic emotional experience.

It is evident from above that how individuals experience and describe their phenomenological experience of depression differs from person to person. Exploring

the concept of sadness more fully will allow for differentiation between sadness and depression allowing for further exploration of the term depression.

2.51 Differentiating between Sadness and Depression

Horwitz and Wakefield (2007) argue that psychiatry has medicalised and pathologised emotions such as sadness; in effect, confusing normal adaptive sadness with depression. Emotions are defined as "tendencies to establish, maintain, or disrupt a relationship with the environment so that emotions might be defined as action readiness in response to emergencies or interruption" (Frijda, 1987, pg 71). This definition suggests that emotions are ways in which individuals deal with the people and events they encounter in the social world as they react to complex social situations. Thus emotions are ways of coping and adapting to the social situations that life presents (TenHouten, 2007). Emotions and feelings are often used interchangeably, however they are different.

Defining the term emotion allows further exploration of two related concepts; depression and sadness so as to provide greater conceptual clarity of these two related but different concepts as they are often used interchangeably. The medicalisation of sadness in psychiatric diagnoses has had broader cultural consequences. When people in society are exposed to advertisements, media attention and news stories regarding depressive symptoms they can confuse normal sadness with depression and monitor themselves for such symptoms and therefore reframe their own experiences of sadness as signs of mental disorder and in turn seek professional help for their experiences (Horwitz and Wakefield, 2007).

With successive editions of the DSM being published, the experience of sadness has been broadened into new forms of disorders (Haslam, 2005). As a result, the DSM may inaccurately pathologise many normal psychological variations of emotion such as sadness and as a result the prevalence of depression would appear inflated (Kutchins and Kirk, 1997). This view is supported by Horwitz and Wakefield (2007) who argue that up to 25% of people diagnosed with depression may in actual fact be experiencing normal sadness. Therefore it is not surprising that by 2020 diagnosed depression will be the second leading cause of disease burden as defined by the DSM (World Health Organisation, 2010).

Considering the apparent confusion between the concept of sadness and depression I examined the concept of sadness using the process of concept analysis, as outlined by Walker and Avant (2010) in an attempt to clarify this concept by outlining its defining attributes, antecedents, consequences, and empirical referents (Table 1.0). The aim of this analysis was to reduce conceptual confusion pertaining to the concept of sadness and to highlight the differences between sadness and depression so both concepts could be viewed and conceptualised as two related, but distinct entities. Horwitz and Wakefield (2007) highlighted the dangers inherent in defining sadness too simply and the need to understand and respond to it in a more complex way. This may lead to a re-evaluation of the concept of sadness and along with it, many basic assumptions about human emotion.

Sadness was described in individuals for a long time before the term depression was introduced (Mouchet-Mages & Bayle, 2008). For example, melancholia as outlined by Hippocrates was defined as a state of persistent fear and sadness. Furthermore,

sadness figured prominently in the Christian monastic understanding of the spiritual life. Evagrius of Pontus, a fourth century monastic writer considered *lupe* or sadness important enough to include it in his list of eight principle thoughts with which he believed the monk must contend to find his way to God (Burton-Christe, 2009). The concept of sadness never really disappeared but became subsumed into other ideas and forms of discourse, such as *acedia* (an undesirable trait of character acquired in the course of living a life) melancholy, and the most common expression today, depression (Daly, 2007).

Within contemporary psychotherapeutic discourse sadness has come to be identified with depression thereby medicalising a normal human emotion (Greenberg, 2010). Within healthcare discourse, especially psychiatric and psychological discourse, sadness becomes a symptom rather than an experience to be probed for its own value. Hippocrates in the fifth century B.C., defined sadness as a distinct disorder; “If fear or distress last for a long time it is melancholia”. Therefore melancholia is defined as a state of persistent fear and sadness (Horwitz and Wakefield (2007). A century later Aristotle distinguished between normal and pathological mood states. The distinction in ancient definitions of melancholia was between states of sadness without cause and with cause where without cause was referred to as a mental disorder now more commonly know as depression. Ancient Greek and Roman physicians would not consider symptoms of depression that occurs with cause such as bereavement, rejection in love, and economic failure as signs of illness. They referred to this as sadness, a normal human emotion occurring in the context of their life experiences (Daly, 2007).

Many authors have defined sadness and identify the need to distinguish the concept of sadness from depression. Gramling (1997) defines sadness as “a pervasive feeling of disillusionment and unhappiness that influences the meaning of life events and decision making” (Gramling, 1997, pg 312). Existential psychotherapists view a client’s sadness as “originating from conflicts brought about by how it is for the client to exist in the world” (Spinelli 2002, pg 252). Pridmore (2009) echoes Gramling (1997) definition and defines sadness as an undesired emotion, which accompanies undesired events, such as loss of a valued object or individual or failure to achieve a desired goal. In relation to sadness, one accepts a painful fact of life as something that is beyond our capacity to change and does this without self-pity (Broch Pierrakos, 1996). It is experienced, as a healthy growing pain free from hopelessness and one is aware that it will eventually pass and believes this. Although the boundaries between sadness and depression are sometimes vague, there are phenomenological features that help us distinguish these two concepts (Pies, 2008). I examined the concept of sadness using the process of concept analysis to clarify this concept by outlining its defining attributes, antecedents, consequences, and empirical referents (Walker and Avant, 2010) outlined in Table 1.0 below. I present the concept analysis in Table format for comparative purposes as it highlights the differences between the concepts of sadness and depression.

Table 1.0 Concept Analysis: Sadness

Sadness	Depression
Defining Attributes Defining attributes are a cluster of attributes most frequently associated with the concept, which helps differentiate the concept from others similar or related to it (Walker and Avant, 2010). Sadness is an emotion with its own particular and unique expression (serves to communicate to self and others that something is wrong and facilitates the slowing down of body and mind, thus providing time for reflection thereby allowing the person to acquire new learning and move forward) (Izard, 1991). The defining attributes related to sadness can be identified as understanding and accepting of one's current circumstances or new circumstances, an acknowledgement of pain and the individual's ability to overcome and move towards acceptance, experiencing feelings of helplessness however continuing to hold on to feelings of hopefulness (Broch Pierrakos, 1996), remaining connected to others (Pies, 2008) and not becoming emotionally blunted or numb and finally a belief that one day it will end (Gramling, 1997) and it is within their capacity to overcome and grow from the pain experiences (Pies, 2008).	Depression involves a complex combination of emotions, physiological states, memories, thoughts and images (Izard, 1991). With depression although the outer circumstance may be the same, the experience of pain is due to other reasons other than the outer circumstance and the feeling is linked to frustration and hopelessness. Depression evokes ambiguous confusing feelings, which the person is unaware of. The feelings of loss trigger some unresolved, festering inner conflict, which may lead to an individual believing that they are unable to cope, thus causing depression (Broch Pierrakos, 1996). With depression one feels outcast and alone and not connected to others (Pies, 2008). With depression there is a sense it will last forever (Gramling, 1997). The person experiencing sadness accepts the loss and feels helpless, whereas the person experiencing depression feels hopelessness and the loss is generalised.

Antecedents Antecedents are events or incidents that must occur prior to the occurrence of the concept and are factors that precede or cause the concept (Walker and Avant, 2010). The antecedents of sadness can be outlined under the following headings: social and cultural, interpersonal factors/ psychological, and biological. *Social and cultural:* cultural differences, racism, isolation, lack of support and intergenerational and gender conflict (Tilbury, 2007, Fozdar, 2009), unemployment, family breakdown, death, separation, culture shock, prejudice and discrimination, immigration (Fozdar, 2009, Horwitz and Wakefield 2007). *Interpersonal factors/ psychological:* age, not being married, disharmony in a marriage/ relationship, breakup of a romantic relationship, expectations from life as an adult not been met (Gramling and McCain, 1997, Horwitz and Wakefield, 2007), been attacked or rejected by peers, loss of a loved one, disappointments and aggression to peers (Berti et al, 2000), loneliness (Gramling and McCain 1997, Silverstein et al, 2010). *Biological:* With regard to biological variables, this can be divided into two aspects; the first arises when there is a threat to bodily integrity such as an illness or a disability as identified by Berti et al (2000) and Fozdar (2009), and secondly where the neurocircuitry of the brain demonstrates biological differences in brain activity between normal and	Gramling and McCain (1997) viewed sadness as a developmental phenomenon of young adulthood, which was diminished or resolved by the early to mid-thirties. However those who were unable to do so experienced a shift from sadness to depression. Also other factors associated with difficulties in resolving sadness and thus contributing to depression included sexual abuse, problematic relationships in childhood, and inadequate relational contexts in adult life. Therefore sadness can be a developmentally derived antecedent to depression. Saarni (1999) in her book "The Development of Emotional Competence" supports this finding and believes that individuals who are unaware or avoid acknowledging their emotions including sadness results in a reduced ability to manage their emotions in a constructive way. Consequently when an individual experiences a negative emotional state, it is likely to persist or result in more adverse outcomes such as depression and anxiety.

spontaneous sadness and clinical depression (Najib et al, 2004, Mayberg et al, 2005, and Pies, 2008).	
Consequences Consequences are those events or outcomes that happen after the occurrence of the concept (Walker and Avant, 2010). The consequences pertaining to sadness can be divided into two categories: adaptive or helpful and maladaptive or unhelpful. *Adaptive or helpful:* sadness as an experience can be helpful and advantageous in a number of ways. It can prevent immediate future losses by inciting action, it can aid in eliciting help from others when needed (social support), or it may inspire a reassessment of major life strategies to necessitate change (Nesse, 1999, Izard, 1991). Furthermore, Broch Pierrakos (1996) argue that it can be an enriching experience leading to increased personal growth and awareness. *Maladaptive or unhelpful:* Gramling and McCain, (1997) identified sadness as a developmental phenomenon of young adulthood, which was diminished or resolved by the early to mid-thirties. However those who were unable to do so experienced a shift from sadness to depression.	Individuals who conceptualised their sadness as a lost battle or an entity out of their control viewed their experience as abnormal and a sign of depression (Silverstein et al, 2010). Depression is commonly believed to exist on a continuum from "the symptom of ordinary sadness through depressed mood to the syndrome of clinical depression" (Gramling and McCain, 1997, pg 313). Saarni (1999), Henretty et al (2008), and Silverstein et al (2010) found that individuals who were unaware or avoided acknowledging their emotions including sadness resulted in a reduced ability to manage their emotions in a constructive way resulting in more adverse outcomes such as depression and anxiety.

Empirical Referents Empirical referents are categories used to measure a concept or determine its existence in the real world (Walker and Avant, 2010). In other words, armed with these indicators, it would be possible to see "beyond a shadow of a doubt" if the concept was present (McKenna, 2003). In some cases, the empirical referents will be the same as the defining attributes (McKenna, 2003). The empirical referents for sadness include an understanding of the context of the distress, acceptance of their current/ new circumstances, tolerance of distress, feelings of helplessness and hope, belief that the pain/ sadness will pass. It also includes willingness by the individual to "listen" to what their emotion is attempting to communicate to them or others and "hear" their emotion and begin to respond to it in a way that allows them to move forward with their lives in a more fulfilling way.	With depression there is a sense that the experience will last forever, there is a sense of hopelessness and a belief that the individual is helpless to do anything that will bring about change. With depression although the outer circumstance may be the same, the experience of pain is due to other reasons other than the outer circumstance and the feeling is linked to frustration and hopelessness. The feelings of loss trigger some unresolved, festering inner conflict, which may lead to an individual believing that they are unable to cope, thus causing depression (Broch Pierrakos, 1996). With depression one feels outcast and alone and not connected to others (Pies, 2008).

In conclusion, the concepts of depression and sadness have been examined and discussed in order to provide conceptual clarity for these two concepts which are often used interchangeably. With the experience of sadness, there is an understanding of the context of the distress, an acceptance of their current/ new circumstances, a tolerance of the distress, feelings of helplessness and hope, and finally a belief that the pain/ sadness will pass. It also includes willingness by the individual to "listen" to what their emotion is attempting to communicate to them or others and "hear" their emotion and begin to respond to it in a way that allows them to move forward with their lives in a more fulfilling way. With depression there is a sense that the experience will last forever, there is a sense of hopelessness and a belief that the individual is helpless to do anything that will bring about change. With depression although the outer circumstance may be the same, the experience of pain is due to other reasons other than the outer circumstance and the feeling is linked to frustration and hopelessness. The feelings of loss triggers some unresolved, festering inner conflict, which may lead to an individual believing that they are unable to cope, thus causing depression (Broch Pierrakos, 1996). Furthermore when individuals experience depression one feels outcast and alone and not connected to others (Pies, 2008).

Exploring the concept of sadness more fully allows for a differentiation between the concepts of sadness and depression. The concept analysis outlined above provides greater clarity regarding the experience of sadness and depression. However, the dominance of the biomedical discourse in society arguably does not differentiate between the two concepts and thereby uses both interchangeably. This then becomes the cultural norm for individuals and communities by shaping beliefs, habits and

discourse around the experience of depression. I will now present the different theories of depression that attempt to explain the aetiology of depression and discuss the social discourses that have emerged as a result of these theories.

2.52 Understanding Depression - Theories of Depression and Related Social Discourses

Various theoretical models have also been used to explain depression based on biological, cognitive, interpersonal, and life-events research (Gotlib and Hammen, 2002). Akiskal (1995) argues that all these models belong to the class of diathesis-stress models which argues that a genetic predisposition or a particular cognitive style, a biological dysfunction, or a social skills problem, make individuals vulnerable to depression when they are confronted with a distressing life event. The theories are presented to provide a comprehensive overview of the different theoretical understandings of depression. The emergence of these theories has contributed to the development of social discourses which will be discussed in relation to the theories presented. The purpose of examining the theoretical literature pertaining to social discourses of depression was to provide an overview of how social discourses contribute to individuals understanding of depression whether conscious or unconscious. Individuals encounter many social discourses through their everyday engagement in the world and their lives from once they are born including medical, media, cultural, gender among others through their exposure to medical conversation/ professional opinion, and social interactions via social conversation, radio, television, print and social media. This demonstrates how social discourses which emerge from the theories of depression contribute to individuals' understanding of depression.

2.52.1 Discourse

Henry and Tator (2002) state that discourse is the way in which language is used socially to convey broad historical meanings. It is language identified by the social conditions of its use, by who is using it and under what conditions. They argue that language can never be neutral because it bridges our personal and social worlds (Henry and Tator, 2002). Therefore social discourses relates to how language/ knowledge and social understanding is constructed by individuals' in society via mediums such as the radio, print media, and social media who produce, reproduce, and disseminate information related to the experience of depression through language and discourse. According to Angenot (2004) social discourse includes speech or text communication that involves a social element, a communication that has a social purpose or some kind of distinctively social aspect. It is everything that is said or written in a given society, everything that is printed, or talked about, and represented through electronic and print media.

There are many social discourses in operation in the world we live in including biomedical discourses, gender discourses, media discourses, and many more. Social discourses contribute to individuals' understanding and experience of depression. I will now present the different theories of depression and discuss what social discourse emerged from these theories.

2.52.2 Biological and Genetic Theories

Biological theories or the biomedical model argue that depression is a result of biological disturbances of the biochemical, neuroendocrine, immune, or

chronobiological systems (Schotte, 2006). One of the most notable biological explanations regarding the aetiology of depression relates to the theory that depression is a result of a serotonin imbalance in the brain. However there are two monoamine theories of depression. The first suggests that depression is caused by a central deficiency of catecholamines, principally noradrenaline while the other implicates deficient serotonin activity. However there is little empirical evidence underlying these ideas (Nelson et al, 2005).

The origins of the monoamine hypothesis lay in the astute clinical observations that the monoamine oxidase inhibitor (MAOI) isoniazid, and the tricyclic antidepressant (TCA), imipramine were useful in treating depression (Healy, 2002). Prior to this there were no effective medications to treat depression. Subsequent work in animals showed that both MAOI's and TCA's potentiated the function of monoamines which led to the theory that depression was caused by a monoamine deficiency such as serotonin deficiency (Healy, 2002). At the time there was no good neurobiological understanding of depression therefore this idea was intriguing and potentially testable. This explains why the monoamine theory of depression has had such a big impact on psychopharmacology.

Coppen (1967) proposed the serotonin imbalance theory of depression at a time when direct investigation of the living human brain was not possible. It was apparent even at this early stage that assessing serotonin abnormalities in individuals with depression was challenging for several reasons. There was an inconsistency of findings from different laboratories as well as the problem of taking into account biochemical effects of current and previous antidepressant medications (Pariante et al, 2009). With

the development of neuroendocrine challenge techniques, assessment of serotonin function could be carried out in unmedicated individuals experiencing depression. Furthermore using brain imaging techniques enabled a more direct investigation of serotonin receptors in the living human brain (Grasby, 2002). However the data from this work was contradictory showing that even using state of the art imaging to measure serotonin receptors in unmedicated individuals, classified with reliable diagnostic systems, was insufficient to overcome clinical heterogeneity or technical variability between different laboratories (Bhagwagar et al, 2007). Therefore the serotonin deficiency theory does not plausibly provide an explanation for the aetiology of depression.

Alternatively, Mazure et al (2000) found that the majority of first episodes of major depression were preceded by an acute stressful experience or adverse life event however the importance of life events diminishes as the number of depressive episodes increases. Furthermore dysfunction of stress response systems such as the corticotrophin-releasing factor (CRF) system and the hypothalamic-pituitary-adrenal (HPA) axis are thought to be important factors in the neurobiology of depression. Gold et al (2002) found that the concentration of cortisol, the end product of the HPA axis, was increased in the blood and urine of individuals with major depression. Furthermore the concentration of CRF is increased in the cerebrospinal fluid (CSF) of individuals with depression as compared to controls (Nemeroff et al 1988). Basal HPA axis function is determined by both environmental and genetic factors. Stressors such as child sexual abuse can produce lifelong disturbances in HPA axis function (Heim et al 2001; Tyrka et al 2008), which can lead to individuals' experiencing depression later in life.

Nesse (2009) maintains that biological traits as a cause of depression need both evolutionary and proximate explanations and that neuroscience can never provide a full biological explanation for depression, it can only explain mechanisms. He argues that proximate explanations based on brain mechanisms are insufficient, as every trait requires an evolutionary explanation also. Furthermore he argues that diseases do not have evolutionary explanations, however evolution can provide an explanation to why some aspects of the body are vulnerable to failure. Finally he maintains that many symptoms such as fever, pain and negative emotions are not usually the result of bodily defects, they are adaptive responses shaped by natural selection. Therefore the brain mechanisms that regulate these responses are vulnerable to dysregulation (Nesse, 2009).

Much neuroscience research views depression as a "brain disease". Drawing an assumption that depression is a brain disease limits scientific progress in a number of ways (Kendler, 2005, & Moncrieff, 2007). First, it implies that genetic and brain variations that predispose individuals to depression are abnormalities, when in fact they may be neutral, or ever advantageous, in certain environments. Furthermore it neglects the role of life events and other causal factors that may lead to an individual experiencing depression. It also implies that depressive symptoms are pathological, distracting attention from the task of identifying the function of the emotion of feeling low or depressed. Finally, diagnostic criteria based only on symptoms encourage studying depression as if it is one condition with a single aetiology, although it can have many different aetiologies (Antonijevic, 2006, Keller and Nesse, 2005, Kendler, 2005).

In contrast, an evolutionary perspective acknowledges that symptoms of depression can be either normal or abnormal depending on the situation (Horwitz and Wakefield, 2007), that numerous factors may combine leading to an individual experiencing depression and finally that different depressive symptoms may have been shaped to cope with different precipitating situations (Keller and Nesse, 2006). Klinger (1975) argued that mood was an adaptation to regulate goal pursuits. He found that rapid progress towards a goal results in mood elevating which in turn motivates continued effort and risk taking. On the other hand when efforts to reach a goal are failing, mood becomes low motivating the individual to pull back to conserve resources and reconsider options. If conditions do not improve and no other strategy is viable, low mood disengages motivation from the unreachable goal so efforts can be turned to more productive activities. If the individual continues to pursue an unreachable goal, ordinary negative effect can escalate into depression.

An example of an unreachable goal may be an individual's wish to please everyone all the time. Goals include many different things such as getting a job, getting a spouse to be affectionate, pleasing a parent, becoming recognised as a poet and so on. Giving up such a goal can mean giving up what gives meaning to a person's life and social identity. Individuals differ in their ability to disengage from unreachable goals and those individuals who are more capable of disengaging are less prone to experiencing depression (Wrosch and Scheier, 2003).

According to Claes et al (2009) a large number of family and twin studies have identified the importance of genetic factors in the vulnerability for depression.

Sullivan et al (2000) found that in first-degree family members with depression, the risk to develop major depression is increased by a factor of almost three. A meta-analysis of twin studies identified that about 40% of the liability to develop depression is accounted for by genetic factors (Kendler et al 2006). Hettema et al (2006) with a research population of 15,000 Swedish twins identified a set of common genes increasing vulnerability for high neuroticism, depression and anxiety disorders. Another set of genes was involved in the risk for major depression and anxiety thereby implying that there are no genetic factors that solely increase the risk for major depression. Therefore researchers should search for genes increasing the risk for both depression and anxiety. The search for such genes should take into account impaired stress coping mechanisms (Claes et al, 2009). They hypothesise that there are potentially four genes; CRF receptor 1 (CRFR1) gene; Arginine Vasopressin 1b receptor (AVPR1B) gene; Glucocorticoid receptor gene (NR3C1) and the co-chaperone protein FKBP5 gene, that contributes to individuals developing depression (Claes et al, 2009). However they acknowledge that the research pertaining to these genes is limited with few studies conducted. They believe that the evidence is greatest for the FKBP5 gene where four large studies have been conducted. They also acknowledge that further studies are needed to determine the significance of genetics in the development of depression.

It is evident that the biological and genetic theories of depression are not conclusive requiring further research. However these theories are still communicated through the media contributing to the biomedical discourse evident today in society. According to McPherson and Armstrong (2009), individuals may self diagnose as depressed before they meet with their primary care physicians. This is perhaps an indication of the

dominance of the biomedical discourse in society and the ease of access to information via social media. The diffusion of health and medical information on the internet means that information that once was only available via consultation with medical professionals is now readily available along with being able to take self-directed diagnostic tests via the internet (Nettelton and Burrows, 2003).

Kokanovic, Bendelow, and Philip (2012) found a dissonance in lay accounts of being diagnosed with depression where individuals resisted and challenged the medicalised discourse of depression by emphasising the social context of their distress, coupled with their desire for more guidance from their physicians on their problems with everyday life. They embraced aspects of the medical discourse on depression by characterising their distressing emotions as something that was wrong with them, safeguarding their right to medical treatment thus incorporating a medical diagnosis of depression into their life story (Kokanovic et al, 2012).

Participants moved inside and outside the medicalised discourse on depression when describing their emotional distress which may indicate that there is a degree of recognition amongst contemporary individuals that disappointment and dissatisfaction are a part of normal everyday life (Kokanovic et al, 2012). However individuals found it difficult to deal with their distress without accessing support from their physicians even though they reported frustration with the limitations of the biomedical model.

2.52.3 Social Theory

In order to fully understand how society influences individuals' understanding, one needs to understand the theoretical position of social constructionism. There is no

doubt that emotional or mental distress such as depression exists in many forms however what is contested is the view that depression can be categorised as a disorder in isolation from the illness experience of those who experience it, and from the social, cultural, political, and historical landscape in which labels are assigned to such experiences.

Social discourses of depression makes the connection between the individual and the social as it acknowledges that the experience of depression is both a language and a lived experience and therefore cannot be treated as an entity outside the discourses in which it is constructed (Masse, 2000). Therefore individuals' lived experience of depression is grounded in social context thereby contributing to their understanding and experience of depression.

Beliefs about health and illness which are contingent on their social, cultural and historical context relate to the theoretical position of social constructionism (McClusky, 1997). Definitions of health and illness, perceptions of their causes, and accepted ways of maintaining and restoring health are socially constructed according to this theoretical position. According to Nettleton (2006) in social constructionism all knowledge, including biomedical knowledge is socially constructed. Social constructionism positions the social context itself at the centre of meaning making with the focus on the "knowing" which is created through shared production (Burr, 2003). With social constructionism there is an assumption that human beings rationalise their experience by creating a model of the social world and how it functions and secondly it acknowledges that language is the essential system through which humans construct reality (Leeds-Hurwitz, 2009). Berger and Luckmann (1966),

both pivotal in the development of the theory of social constructionism argued that all knowledge, including the most basic, taken-for-granted common sense knowledge of everyday reality, is derived from and maintained by social interactions. When people interact, they do so with the understanding their common knowledge of reality becomes reinforced (Berger and Luckman, 1966). In other words social constructionism assumes that understanding, significance, and meaning are developed not separately within the individual, but in coordination with other human beings. As the data from this study aims to tell us something about people's involvement in and orientation towards the world and how they made sense of their experiences, social constructionism is best situated to contribute to understanding how individuals made sense of their experience of depression.

The dominant model in modern societies for understanding and interpreting health and illness including depression is often the biomedical model where health is viewed simply as the absence of disease, with disease or illness such as depression being reduced to a discrete biological abnormality within the body. This relates to the promotion of a unified body of knowledge on mental health and mental illness, known as mental health literacy (MHL) discussed earlier. However MHL is a form of knowledge that is not necessarily tethered to culture and experience. (Bourget & Chenier, 2007).

There are however alternative social explanations that may explain the aetiology of depression. In many societies depression is associated with impoverishment, rural-urban migration, marginalisation, domestic violence and overwork (Das et al, 2007; Hanandita & Tampubolon, 2014; Tampubolon & Hanandita, 2014, WHO, 2008).

Empirical findings from developed countries suggest that, for most mental health difficulties including depression, the association between low socioeconomic status and psychiatric morbidity is strong and significant (Kessler, Chiu, Demler, & Walters, 2005). It has also been found to be true in low income countries (Das et al, 2007; Hanandita & Tampubolon, 2014; Tampubolon & Hanandita, 2014).

George Brown (1978), a medical sociologist established the crucial role social factors have in the aetiology of depression. Brown & Harris (1978) argued that depression was not just another public health problem but a link between many kinds of problem-those that may lead to it and those that may follow-and that it held a pivotal position in understanding what was wrong with a society. While sadness, unhappiness, and grief are inevitable, this is not true of depression (Brown and Harris 1978). Evidence has since accumulated that depression acts in this way because its origins are closely linked to the quality of core social roles (Brown, 2002).

Brown & Harris (1978) original account of the origins of clinically relevant depression among non-elderly women in South London showed that certain kinds of life events, and to a lesser extent long-term difficulties played a significant role in onset of depression. There was a much higher rate of depression among working-class women, but this only occurred among those with children at home (Brown and Harris 1978). Another study conducted later concentrated on working-class women with a child living at home (Brown 1989). The study was longitudinal and of the 404 women first seen, 303 were contacted again a year later, omitting those with depression at first contact. The findings concerning life events occurring during the follow-up year are typical. One in 10 developed a depressive disorder in the year after

they were seen, and 29 of the 32 who did so had a severely threatening life event not long before. The distinctive feature of the majority of provoking life events was the experience of loss or disappointment broadly defined to include threat of or actual separation from a key figure, an unpleasant revelation about someone close, a life threatening illness of a close relative, a major material loss, and miscellaneous crises such as being made redundant after a long period of steady employment (Brown & Harris, 1978).

Another important factor contributing to depression in Brown & Harris (1978) research involved events that carried a long term threat. For example, women not involved in a significant intimate relationship (husband or partner) when a major difficulty in their life arose led to a greater chance of them experiencing depression. They also found that women with children from working class backgrounds were four times more likely to develop depression compared to women from middle class backgrounds. According to Brown & Harris (1978), the reasons for the increased risk of depression amongst women from working class backgrounds was due to the fact that these women experience more severe life events and major difficulties, especially when they have children such as problems concerning housing, finance, and relationship difficulties with their husbands. From reviewing Brown and Harris (1978) work it becomes evident that life events in people's social world also contribute to the experience of depression. Although Brown's research first highlighted the impact socioeconomic factors play in the development of depression, further research conducted since then continues to demonstrate the strong link between socioeconomic factors and depression (Das et al, 2007; Hanandita & Tampubolon, 2014; Tampubolon & Hanandita; 2014; Kessler, Chiu, Demler, & Walters, 2005). Social

factors need to be considered in the aetiology of depression in light of the research discussed above.

2.52.4 Psychological Theories

Other theories utilised to conceptualise the experience of depression include cognitive and interpersonal models. Beck et al (1976) cognitive model proposes that depression is a cognitive problem dominated by a negative evaluation of the self, others and the world. Beck's cognitive theory of emotional disorders (Beck, 1967; 1976) asserts that emotional disorders are maintained by a "thinking disorder" in which anxiety and depression are accompanied by distortions in thinking. At a surface level this dysfunctional processing manifests as a stream of negative automatic thoughts (NATs) in the individuals's consciousness. Distortions in processing and NATs reflect the operation of underlying beliefs and assumptions stored in memory. These beliefs and assumptions represent knowledge stored in memory and are referred to as schemas. Once these schema are activated they influence information processing, shape the interpretation of experience, and affect behaviour. Cognitive theory argues that the constellation of core beliefs and assumptions that individuals develop in their early chilhood or as a result of major life events are critical to understanding later perceptions of events, and their associated behavioural and interpersonal strategies.

An individual's affect and behaviour are largely determined by the way in which he/she structures the world (Beck, 1976). He states that in order to help a depressed person, we need to 'get inside their conceptual system & see the world through their eyes' (Beck, 1976, p. 15). The cognitive model of depression posits three specific concepts to explain the psychological make-up of depression: the cognitive triad;

schemas and cognitive errors (Beck, Rush, Shaw & Emery, 1979; Beck, 1970). Depressed people have negative views of themselves, their world & their future. The individual's understanding of a situation is distorted to match the activated underlying dysfunctional cognitive pattern or schema. Systematic cognitive errors further uphold the person's dysfunctional beliefs in the face of disconfirming evidence. Cognitive therapy for depression uses behavioural and cognitive strategies to bring to awareness and test the individual's specific misconceptions, dysfunctional assumptions & behaviours. This helps the individual see and potentially overcome his/her problems (Beck, Rush, Shaw & Emery, 1979).

Interpersonal models relate several levels of social functioning to depression (Coyne, 1976; Joiner, 2002; Markowitz, 1999). The first relates to vulnerability as a result of interpersonal factors. The second relates to the social skills and behaviour of individuals with depression and finally, the third relates to the effect of depression on social interactions and relations as discussed below.

Object Relations Theory (ORT) of depression is associated with a continuing pattern of poor attachment that is laid out in childhood and continues into adulthood (Herbert et al 2010). ORT evolved from traditional psychoanalytic theory to become an influential school of thought in its own right. Herbert et al (2010) state that while there is no single object relations theory of depression, there does exist an overarching theme that is present in all object relations theories of depression. Many of these theories argue that depression stems from a feeling or fear of the loss of an important and loved object, which is fostered in childhood and then repeated by later peer relationships (Kaslow and Magnavita, 2002). The object loss theory of depression

refers to traumatic separation of the person from significant objects of attachment. There are two important issues to note here; loss during childhood as a predisposing factor for adult depression and separation in adult life as a precipitating stress. The first issue assumes that a child has formed a tie to a mother figure by 6 months of age, and if that tie is ruptured for any reason, the child experiences seperation anxiety, grief, and mourning. This can then affect personality development and lead to depression in adult life (Kaslow and Magnavita, 2002).

Ussher (2010) argues that competing biomedical, sociocultural and psychological models adopt a realist epistemology and a discourse of medical naturalism to position depression as a naturally occurring pathology, caused by biology, cognitions, or life stress. Ussher (2010) further states that feminist critics argue that this medicalises women's misery, legitimises expert intervention, and negates the political, economic and discursive aspects of experience. Ussher (2010) argues that psychology offers an alternative perspective which has equally not escaped feminist scrutiny. For example in recent years cognitive behavioural therapy (CBT) has made some inroad into the dominant medical discourse with CBT being recommended by many government agencies in the treatment of depression. Marecek (2006) argues that many psychological theories of depression have been dismissed for being over-generalised and over-simplified or for being based on a positivist epistemology that positions individuals' distress as symptoms of an underlying disorder (Stoppard 1999). Critics argue that both biomedical and psychological discourses of depression decontextualise what is often a social problem, simply acting to legitimise expert intervention, whilst negating the political, economic and discursive aspects of the experience (Lafrance 2009).

2.52.5 Biopsychosocial Diathesis–Stress Model

Schotte et al (2006) believes that the theories presented above contribute to our understanding of depression however when taken individually these theories are fragmentary and reductionistic which I agree with. They argue that clinicians need to take into consideration biological, individual psychological factors as well as social, environmental, and stress factors in order to conceptualise depression from a biopsychosocial paradigm. They propose a biopsychosocial diathesis–stress model of depression, which aims to provide therapists, clients, and their environment a constructive conceptual framework to understand depressive complaints, vulnerability, and stress. They present a model consisting of the concept of psychobiological vulnerability, which is determined by risk factors of a biogenetic, psychological, somatic, and societal nature and by protective factors. Furthermore they argue that when life events with a stress-inducing value interact with this vulnerability, an individual becomes distressed which in turn affects the individual's resilience and leads to symptoms of depression. The pathogenesis of depression is symbolized by a negative downward loop, in which interactions among symptoms, vulnerability, and stressors drive the individual toward a depressive condition.

The notion of vulnerability needs to be considered from both the psychological (mind) and the biological (brain and body) view where both systems are essentially and irreversibly linked (Schotte et al, 2006). Kendler et al (1995) argue that genes, biology, psychology, and stressors need to work in ‘‘harmony’’ to provoke a depressive episode. The Kendler model states that the risk for a depressive disorder is the result of three broad, interacting pathways that reflect internalising symptoms (neuroticism and early onset anxiety disorders), externalizing systems (conduct

disorders and substance misuse), and psychosocial misfortune in the various phases of life. Genetic risk factors for depression appear to contribute to the three paths. Schotte et al (2006) argue that these findings illustrate the complex interweaving and interactions of psychosocial and genetic vulnerability factors.

Research shows that psychologically traumatic experiences also lead to significant and often permanent dysregulations of many aspects of biological functioning: HPA axis, stress parameters, heart rate, neurotransmitters, and hormonal and immunological parameters as discussed above (Heim et al., 2001; Ladd et al., 2000; Van Voorhees and Scarpa, 2004). Furthermore, a striking illustration of how closely psychology and biology are linked is the finding that effective psychological interventions influence various aspects and parameters of biological functioning (Brody et al., 2001; Thase, 2001). In summary, numerous paradigms emphasize the interrelatedness of the psychological and the biological. An individuals emotional life, self-image, and one's being are all governed by biological processes, but biological functioning is equally influenced by what one experiences or has experienced (early life experiences, trauma, major life events), by how one feels, and by what one believes he or she is (Schotte et al, 2006).

2.6 The Influence of the Media

From reviewing the different theories of depression it is evident that social discourses emerge which are informed by the theories presented above. The media have a strong influence on the everyday lives of individuals and communities. Radio, television, print media along with other systems of representation such as academia, school, art, literature, film and music are all elements out of which we form identities both as

individuals and as communities (Henry and Tator, 2002). These vehicles of cultural production help shape our sense of self, our understanding of what it means to be male or female, depressed or not. Henry and Tator (2002) believe that the media does not always objectively record and describe reality, nor do they neutrally report the facts and stories.

The media discourse on mental health/ ill health and depression contributes to how individuals in society understand and derive meaning from the experience of depression. Much has been written in the media about mental health that can only be described as a false and misleading construction of mental health and mental ill health (Rowe, Tilbury, Rapley and O Ferrall, 2003). So stigmatising, it is said, is the effect of negative media coverage that there is growing pressure for more accurate and less stereotypical reporting of mental illness (Clarke 2009, British Psychological Society 2000). Numerous studies have examined the contribution the media discourse has on understanding the experience of mental illness (Johansson et al, 2009 Rowe, Tilbury, Rapley & O Ferrall 2003, Sieff 2003, Ward 1997, Rose 1998, Parslow 2002, Francis et al 2004).

Johansson, Bengs, Danielsson, Lehti and Hammarstrom (2009) metasynthesis highlights the media's influence in how society understands mental health and in particular depression. They found that there were differences in the recognition of depression, the understanding of the reasons for depression and the contextualisation of depression. They identified that although women and men described different symptoms and reasons for falling ill, these gendered expressions were not always acknowledged in articles coming from western medical settings. Participant

interviews and media reports repeatedly referred to the sudden onset of depression in men and the gradual onset for women. For men the onset was dramatic in the physical symptoms being experienced whereas depictions of women described a slow "cracking façade". This is a reflection of male and female stereotypes with men being active, aggressive and extroverted and women being passive, sensitive, and introverted (Johansson et al, 2009).

They also identified that individuals with depression relied on medical expertise in recognising depression. They argue that this is an important and difficult commission of trust for clinicians with implications in how depression is understood either as a diagnosis or as psychosocial suffering and who decides this. They question if the disparities between patients and experts' understanding of depression contribute to sliding diagnostic criteria and medicalisation of human distress (Johansson et al 2009).

Another finding related to accounts of causality and their consequences. Lay discourse as to why men and women fell ill was gendered. Environmental reasons were identified for men whereas personality was emphasised for women. This finding reinforces the idea that innate factors account for the differences in rates of depression in women and men. They found that this biological understanding was also reported in the media and to some extent adopted by individuals who experienced depression. Shame was identified in lay discourse and it was found that men in particular were diffident about a diagnosis for fear of being stigmatised. However some believed that obtaining a diagnosis of depression allowed them to offload the shame and guilt. Adopting biomedical explanatory models may result in both individuals' with

depression and physicians contributing to the medicalisation of depression by understanding psychosocial stress such as grief and sorrow as intrinsic biological deficiencies that can be pharmacologically treated (Johansson et al, 2009). It is widely accepted that multifactoral and contextual influences ought to be integrated into the medical understanding of depression (Kendler, Gardner & Prescott 2002). Therefore there is a need to develop a pragmatic and integrative model for understanding sex, gender, and cultural aspects in depression if we are to understand this human experience more fully.

However according to Clarke (2009) a paucity of research studying how the media discourse impacts on individuals' understanding of depression has been published which led to their research exploring the portrayal of depression in men's magazines between 2000 and 2007. Findings suggest that depression in men's magazines is encapsulated in stereotypical male discourses of success at work, ignorance of feelings, reluctance to seek help. Depression was also largely described as having a biochemical and/ or genetic cause. Only a few articles mentioned the possible effects of socio-economic and gendered experiences of maleness or masculinity. The magazine portrayal emphasised that men are not to have feelings and in particular negative feelings and if they do they should not seek help through psychotherapy It was communicated that men must be highly successful at work or sport, even celebrated, and if hit with depression which is portrayed as a biological disease then they need to be treated actively and aggressively with antidepressant medication prescribed by a doctor (Clarke 2009). It was also noted that men's experience of depression contrasted greatly with women's experience (Clarke, 2009). Women were described in the media, usually by inference, as both weak and "using" men through

their demands that they be highly successful at work and financially. Men were also described as engaging in violent behaviours when experiencing depression.

The magazine portrayal of depression suggested that for men to acknowledge depression they had to repudiate their claims to hegemonic masculinity, which according to Gray, Fitch, Fergus, Mkyhalovskiy & Church (2002) is primarily characterised by relations of dominance, actively performing through competition, aggression, bodily strength, stoicism, heterosexism, homophobia and misogyny (Clarke, 2009). Clarke (2009) suggests that men experiencing any emotional difficulty such as depression prevents the characteristics of hegemonic masculinity especially aggression, competition and stoicism therefore threatening men's mental health.

All the articles within this review related to successful men either occupationally or in sport and "the type" of man that experienced depression were identified as CEO's or Nobel Prize winners. This representation ignores the fact that men who are more socially disadvantaged experience depression more (Clarke, 2009). However another message of the media in this study was that depression could happen to anyone although paradoxically, the latent message implicit was that it would not happen to the readers of the identified magazines in this study as they were from middle class backgrounds with high earnings thereby emphasising that success is in some way protective against depression. Finally, Clarke (2009) found that the medicalisation of male health was reinforced through the adoption of the medical model of emotional expression through the emphasis on treating what was referred to as a real disease through pharmaceuticals.

Alternatively, Gattuso, Fullagar, and Young (2005) examined how women's magazines in Australia constructed depression and how media discourses widened the boundaries of what was understood to be depression in the context of Australian policy on depression namely the National Action Plan for Depression (2000). They found that although depression literacy literature privileges biomedical and psychological expertise in explaining depression and promoting help-seeking behaviour, the magazine discourses foreground an individualising discourse of depression as a problem of self-management.

They argue that the increased reference to depression in magazines is evidence that the term is being more widely applied than in the past and that depression is becoming a more common descriptor of certain emotional experiences and dilemmas of feminine identity (Gattuso, Fullagar, and Young, 2005). Furthermore, they suggest that policy is influencing media reporting on depression and public awareness in everyday life. They however found that while there was an increase in the items related to depression following publication and implementation of the policy on depression (2000), the information contained in the articles was not necessarily congruent with how depression literacy was framed within the policy. In contrast to depression literacy discourses that emphasise reliance on professional expertise, the discourses in these magazines invited women to imagine themselves as responsible for self-managing depression and building supportive relationships. Gattuso, Fullagar, and Young (2005) argue that such a belief system can lead to an isolating individualism that leads to a less effective resolution of distress, and can exacerbate women's tendency to blame themselves for not managing the increasing complexity of their lives. It is further argued that this results in an individualised discourse of

inadequacy as the reason for depression. Therefore it is understandable that women come to accept the formulation of depression in terms of illness and treatment with antidepressant medication. The biomedical model promises to exercise the sense of shame associated with not being a good enough woman to "get over it" through one's own actions which Rowe et al (2003) also found in their study.

Although this study identified the contribution of a number of strategies for the management of depression and identified that biomedical and psychological discourses are legitimated within policy frameworks, they found that social structures and processes that contribute to emotional distress such as depression were absent from magazine discourses. Gattuso, Fullagar, and Young (2005) argue that although the media reflects cultural values, they also shape them and that critical analysis of media discourses can contribute to a rethinking of the nature of depression literacy for women.

Rowe et al (2003) investigated representations of depression in the print media (magazines and newspapers) over the course of one year. Three key discourses were identified – the biomedical, the psycho-social and managerial discourse. All discourses were presented as a means of normalising depression by presenting it as beyond the control of the afflicted individual either due to faulty brain chemistry or the product of social conditions. Representations of depression in the media were found to be heavily invested with medical or disease related terminology and scientific jargon along with depression being characterised to many medical disorders such as diabetes or hypertension and therefore in need of research and treatment by medical professionals. Terms such as illness, treatment, patients with depression and

patient management construct depression within an “objective” medical discursive field. The term “clinical research” according to Rowe et al (2003), further acts to produce images of white coats, laboratories, and randomised control drug trials. Furthermore they found that different degrees of agency were ascribed to individuals with depression and medical professionals. GP’s “treat” depression and “manage patients”. These idioms portray the individual as powerless with their agency explicitly denied (Rowe et al, 2003). They are expected to passively accept the biomedical diagnosis and treatment by virtue of the status of the professionals they engage with.

Another discourse that emerged was related to the psycho-social discourse which emphasises psychological and social reasons for unhappiness and focuses on the human experience of depression. Rather than focusing on professionals, clinicians and researchers, the focus is on social aspects within the person’s life such as life circumstances, social, cultural, and political factors that impact on life and contribute to emotional distress. The media portrayal of psycho-social factors used softer language with the use of emotion words more common. Social and individual factors were identified as contributing to depression such as work stress, lack of role models, unhappy childhoods, bereavement, relationship breakdowns, marital difficulties, redundancy, lack of access to education, drugs and alcohol, loss of social connections, and unemployment. A connection between increased rates of depression and increasing social difficulties of modern life was a common theme.

The media has a significant influence in how individuals and society understand the experience of depression as they disseminate the information and theories that emerge

from researchers. Therefore if there are dominant ways of conceptualising the experience of depression which is disseminated by the media then that becomes the discourse in society and many individuals are more likely to label their emotional experience through the language and understanding of that particular discourse. That alters the phenomenological lived experience for many individuals who experience depression in a negative way.

2.7 Conclusion

The purpose of Chapter 2 in the literature review was to examine and present the clinical and conceptual literature pertaining to how depression and mental illness is conceptualised and the numerous understandings mental health professionals, academia and society have derived in relation to the experience of depression. Firstly I presented the incidence of diagnosed depression in society currently to highlight the increasing numbers of people being diagnosed with this difficulty. Following this, in order to contextualise the study I discussed how culture shapes experience, interpretation, and action and orients people in their way of feeling, thinking, and being in the world thereby contributing to individuals' understanding of depression. To further contextualise this study I provided a historical account of how academics and professionals derived their understanding of mental illness and depression through a critique of the concept of mental illness, depression and psychiatric diagnosis. This highlighted how early understandings of mental illness became a dominant biomedical discourse and thereby informed the professional, media, and societal discourses that continue today resulting in individuals framing their experience of depression through this lens. This demonstrated how social discourses contributed to individuals' process of making sense of their experience of depression.

The critique presented highlighted how psychiatry and psychiatric classification has impacted on individuals' understanding of mental illness and depression. It is argued that psychiatry has medicalised and pathologised emotions and individuals experiencing difficult emotions are labelled depressed based on experiencing certain symptomlogy. Society, the media and medicine have had a significant impact on the social discourse of emotions and mental health and illness. It appears that as a society we are "jumping" to label our emotional experiences as abnormal and requiring treatment much more quickly now than previous generations. It is plausible that this is due to the medicalising of emotions and the search for treatment to "extinguish" the "unwanted" symptoms such as painful feelings, difficulty sleeping and so on associated with our emotions. Therefore it is important to be aware of this debate to put the current study in context.

Following this I felt it was important to understand more fully the concept of emotion and differentiate between the emotional experiences of depression and sadness in order to provide conceptual clarity. This offered an explanation as to why the incidence of diagnosed depression continues to rise. Conceptual confusion arose from the dominance of the biomedical model in society; thereby becoming the cultural norm for individuals and communities by shaping beliefs, habits and discourse around the experience of depression. With conceptual confusion between the concept of depression and sadness by health professionals and individuals in society, it is likely that individuals experiencing normal adaptive sadness are being diagnosed or self diagnosing as being depressed thereby further complicating matters.

Finally I presented an overview of the many understandings of depression based on biological, genetic, psychological, sociological, and biopsychosocial theory. More theories and understandings of depression have emerged over the years due to the emergence and maturing of other disciplines such as sociology, psychology, and nursing and also increased interest in mental health. I examined the theoretical literature related to the social discourses that have emerged due to the various theoretical understanding of depression and finally discussed the influence the media has in disseminating the information related to the different theories of depression.

The next chapter of the literature review examines the research literature pertaining to individuals' experience of depression. To summarise the first chapter of the literature review provides context related to the clinical and conceptual understandings of depression, while the next chapter presents a critique of the research literature pertaining to individuals' experience of depression.

Chapter 3

Literature Review

Individuals' Experience of Depression

3.1 Introduction

Chapter two of the literature review examined the medical and conceptual literature pertaining to the concept of depression. This chapter critically reviews and evaluates studies which have examined individuals' experience of depression. Given the focus on this individual experiences, qualitative research literature has been examined in this area.

3.1.1 Search Strategy

Research conducted in the past fifteen years was included in the search, using the following databases: CINAHL, MEDLINE, PsychINFO, PubMed, Science Direct and SWETSWISE. Key words used were: 'depression', 'experience of depression', 'understanding depression', 'phenomenology and depression'. A total of 352 articles were located, of which 13 were identified as relevant. Further search limits include all full text research articles published in English between 2000 and 2015 including both male and female participants.

Three used a phenomenological approach (Smith and Rhodes, 2015; Smith and Rhodes, 2010; Aho, 2013), seven a grounded theory approach (Clarkem, 2006;

Schreiber, 2001; Fancher et al, 2010; Hussain and Cochrane, 2002; Brownhill et al, 2005; Chuick et al, 2009; Emslie et al, 2007), one a discursive approach (Burr and Chapman, 2004), one a narrative approach (Robertson et al, 2005), and one a qualitative gender analysis approach (Danielsson and Johonsson, 2005). A number of books such as malignant sadness by Lewis Wolpert related to the experience of depression were also reviewed with some individuals' writing about their experience from a medical perspective and others from an existential perspective. This review draws on literature provided by a wide range of disciplines including nursing, medicine, psychology, and sociology.

3.1.2 Emerging Themes

A limited number of studies exploring the experience of depression using interpretative phenomenological analysis (IPA) were found (Smith and Rhodes, 2015; Smith and Rhodes, 2010). Exploring depression using this methodology has only begun to emerge in the last few years. Exploring the phenomenological research related to the lived experience of depression highlighted the various elements that underpin this experience. They involve a qualitative shift in the overall structure of experience, encompassing the body (embodiment), mood, selfhood, temporal experiences, interpersonal relationships (connectedness), and spatiality. From reviewing the limited number of phenomenological research studies, the above structures became evident. These were also evident in examining the other qualitative studies which utilised different methodologies. The material in the chapter is therefore organised and structured under the following themes: selfhood, mood and embodiment, spatiality, connectedness, temporality, gender and culture.

3.2 Selfhood

The phenomenological changes that an individual experiencing depression undergoes are profound. A discussion paper written by Ratcliffe et al (2013) states that first-person reports of depression often describe "a kind of all-enveloping affective change that permeates every aspect of experience" and is often described as akin to inhabiting a "different world, a suffocating, alien realm that is isolated from the rest of social reality" (Ratcliffe, Stephan, & Varga, 2013, pg 10). Therefore the experience of depression is not merely a heightening of certain emotions while others are diminished.

Although much has been written about the phenomenology of schizophrenia, there has been comparatively little phenomenological research on the experience of depression (Ratcliffe, 2015). Ratcliffe (2015) argues that the reason that less phenomenological research has been undertaken on depression is due to the assumption that depression involves intensification or proliferation of commonplace feelings, emotions and moods, such as sadness, hopelessness, and guilt. Therefore, according to Radcliffe (2015), in order to understand the phenomenological experience of depression, all one has to do is to imagine a pronounced experience of sadness, hopelessness, and guilt. However, Radcliffe (2015) argues that the experience of depression differs radically from many people's mundane, everyday experience. Phenomenological research, he adds, can further researchers and clinicians understanding of this experience.

The experience of depression impacting on selfhood may seem like a rather self-evident claim. Many diagnoses such as depression found in the DSM V are

established by checking symptoms and behaviours that are very clearly related to issues of selfhood and personality (Svenaeus, 2013). The disease model of depression does not capture the way in which depression shows up as a creature invading the self and taking control over it, an account found in most reports given by individuals who experience depression. According to Svenaeus (2013), depression is much more of an illness than a disease, in that it shows up on the same phenomenological level of experience as the self when it makes itself known. The disease model does not capture the way in which depression is acknowledged by the person experiencing it as something belonging to their identity (selfhood) (Svenaeus, 2013). Depression, therefore, appears to be an illness of the self, robbing an individual of the manner in which they relate to themselves and changing their identity.

A number of studies identified how the experience of depression impacted on the individuals' selfhood (Aho, 2013; Rhodes and Smith, 2010; Smith & Rhodes, 2015; Schreiber, 2001; Fancher et al, 2010; Robertson et al, 2005). Aho (2013) integrated personal narratives with the methods of phenomenology in order to draw conclusions about what it means and what it feels like to be depressed. This paper drew from autobiographical accounts of depression from noted literary figures (Dorman, 2001; Kaysen, 2001; Solomon, 2001; Stenke, 2001; Styron, 1990; Wurtzel, 1995) as well as experiential reports from medical sociologist David Karp's (1996) study, Speaking of Sadness. Aho (2013) found that depression becomes something of a destiny, preventing the person from being open and free to access a range of alternative self-interpretations, identities, and possible ways of being-in-the-world. This was also echoed in Rhodes and Smith (2010) study which utilised Interpretative Phenomenological Analysis (IPA) to explore the experience of depression from the

view point of one individual (Paul). The findings suggest a profound and near total change in the participant's experience of self. Before experiencing depression, he worked, felt competent, and was sociable. Paul contextualised his experience of depression by identifying a number of long-term difficulties such as a struggling business, working excessively long hours, and problems with alcohol. He felt vulnerable and weak as a man thereby identifying how his sense of self and masculinity was affected. Furthermore, Paul commented numerous times on death and dying suggesting a fundamental transformation of the self. He had to remortgage his home to pay for the tax bill and expressed to his wife "bye, bye life" (Rhodes and Smith, 2010, pg 402) thereby merging two conceptual areas (dying and remortgage) into one complex emotional experience.

Robertson et al (2005) conducted their study "Narratives of Depression" with the aim to explore depression from the perspective of self-identified depressed people as expressed in their narratives which also identified how the self was impacted. Their results identified individual experiences of depression and also how they coped with their depression. Their experiences involved attaching negative meaning to life experiences; to future experiences; negative limiting language drawn upon to express life narratives; and subjugating socio-political narratives which impacted on the sense of self and identity. With regard to the attachment of negative meanings to life experiences, they found that participants not only attached negative meaning to their depression but also to many areas of life experiences. For example hurtful experiences were interpreted negatively, without possible positive aspects being considered. Furthermore their experiences were interpreted as devastating and debilitating. They found that rejection was experienced in an overwhelmingly negative manner, and

personal criticisms were accepted as true, instead of being rejected in favour of less negative meanings for example “People were starting to despise me for my image, so I began to fit into my image” (Robertson et al 2005. pg 337).

These narratives present a mind-set stuck in the past and not having an attitude of “letting go” and “moving on” (Robertson et al, 2005). Life narratives give meaning (which contributes to a sense of self) and inform our present and by re-authoring more positively would enable individuals to “move on”. This is in essence gaining a new sense of self and identity. The negative meanings attached to future experiences suggest that the dominant life stories of people will shape their future, and that future events anticipated impact on the life narrative. Therefore if the future is envisaged with hope, then the narrative will be more positive. If there is little hope then the narrative will be more negative for example “I don’t see any future, I don’t go forwards, but I go backwards”.

Schreiber (2001) identified how women’s selfhood was impacted in exploring women’s experience of depression, the recovery process, management of depression and strategies used and women’s experiences of treatment of depression. The findings in this study included the presence in women of an internal dialogue; oppression and marginalisation of women’s experiences; the impact of violence in women’s lives; the roles of treatment and learning; and hope of recovery. With regard to “internal dialogue”, many women spoke of dialogues within themselves concerning their understandings and actions. When doing this participants’ described their understanding of societal or significant others expectations of them, and the moral judgements contained within, resulting in a contrast with the women’s own sense of

coherence. Once aware of the competing voices within, women reflected critically on what seemed to have been a wholesale adoption of the 'me' at the expense of honouring their internal sense of salience and meaning (Schreiber 2001).

Therefore moving from depression to recovery involved making sense of the internal messages and coming to conclusions or actions that felt right for the individual even if it involved questioning the status quo. The internal dialogue highlighted the (over) socialized ways in which women invalidated their own needs in favour of the needs of others (Schreiber, 2001). As a result this can lead to their own marginalization within society as well as alienate themselves from their own needs.

Another important finding relates to "Hope of Recovery" also evident in other studies (Robertson et al 2005, Clarke 2006, Hussain and Cochrane 2002, Burr and Chapman 2004). Participants acknowledged that they had moved far in relation to recovery and began seeing themselves as vulnerable to depression and seeing it as part of who they are but not feeling controlled or defined by it (selfhood). They described embracing their humanity and reclaiming the self that was somehow lost along the way. This to the participant was recovery (Schreiber 2001). This echoes Svenaeus, (2013) description that depression is an illness of the self, robbing an individual of the manner in which they relate to themselves and changing their identity which is clearly evident in the above studies.

Another important factor in how individuals make sense of their experience of depression related to their cultural beliefs regarding depression. Irrespective of where an individual is from in the world societal and cultural beliefs impact on an individual's meaning making and therefore their sense of self and identity as these

beliefs invariably contribute to their understanding of the self when experiencing depression. An exploration of Vietnamese American patient's experience of depression found that participants viewed emotional difficulties or illness as a reflection of poor moral character, spiritual weakness or improper upbringing by the family thereby impacting on their sense of self and identity (Fancher et al, 2010). Therefore when experiencing depression, these beliefs come into play and impacted on their sense of self further. It is evident from reviewing the studies above that the experience of depression has a profound impact on how an individual relates to the self impacting on their sense of self and identity. It also highlights the role gender, societal and cultural beliefs play in constructing an individual's sense of self.

3.3 Mood and Embodiment

When one considers depression from a cultural perspective, different views become apparent. In the predominant culture of the western world depression is regarded as a disorder of mood and affect on the one hand, and a distortion of cognition on the other. Disturbances of bodily experience and of social relations are regarded as secondary to the primarily 'inner' and individual disorder (Fuchs, 2013). However, other cultures such as those from a Vietnamese community understand the experience of depression differently and not as a separate individual experience but as part of a social community. Therefore, disorders of mood are conceived less as intra-psychic, but rather as bodily, interpersonal, or atmospheric processes (Fuchs, 2013). Feelings that are characteristic of depression include sadness, boredom, and anxiety (mood). Phenomenology explores how one's mood alters one's way of being-in-the-world (Merleau, Ponty, 2013). Moods open up a world to human beings in which things

matter to them in different ways and colour the way everything appears to the self and therefore, impacts how an individual experiences their world (Svenaeus, 2013).

Moods are also strongly linked to bodily sensations and are embodied in their very essence (Ratcliffe, 2008). For example to feel anxious is a profoundly bodily experience. Moods are basic to our being-in-the-world, since they open up the world as meaningful, as having significance (Svenaeus, 2013). Moods in the context of a diagnosis of depression can be seen to be destructive rather than productive life experiences. From a phenomenological perspective however, moods can be productive by allowing an individual to see things in new and richer ways. However it needs to be balanced so as an individual does not fall into a bottomless pit of darkness (Svenaeus, 2000). Therefore, moods such as anxiety, boredom, grief and sadness are constitutive of our being-in-the-world, but they can also develop into pathologies such as depression (Svenaeus, 2013). In the latter case, the self is no longer capable of engaging in a normal being-in-the-world and our being as worldly situated selves rests essentially on the attuned understanding of the body.

Fuchs (2013) in his discussion paper Depression, Intercorporeality, and Interaffectivity expands further on Svenaeus (2000, 2013) outlined above in that he argues that depression is not an ‘inner’ psychological or mental disorder, but a ‘detunement’ of the lived body that normally mediates our participation in a shared space of attunement. The corporealized, constricted body loses its affectability and emotional resonance. This in turn undermines individual’s existential feelings of being-with, resulting in a general sense of detachment, separation, or even expulsion. Fuchs (2013) argues that the typical cognitive symptoms of depression are only a

result of this basic bodily alteration. The question then arises for clinicians and academics to why psychopathology has traditionally disregarded this bodily basis for depression and focus on individual psychological symptoms instead even though somatic symptoms of depression are found in most people experiencing depression. The reason is that psychiatry still has no concept of the lived body, or of the organic unity of the embodied person (Fuchs, 2013). Furthermore, the traditional dualism of mind and body has only been replaced by a reductionist monism which now regards the brain as the true heir of the soul which again disregards the living unity of the organism (Fuchs, 2011). Therefore whether depression is attributed to the soul or the brain, in both cases, it is disconnected from the body with the embodied experience of depression at best regarded as secondary 'somatisation' (Fuchs, 2013).

The studies discussed below highlight the embodied experience of depression although participants often did not attribute the embodied experience as part of their experience of depression. However by experiencing the physical representation of depression permitted them to seek help for example through their GP. Therefore the embodied experience acted as a legitimate reason to seek medical intervention. Smith and Rhodes (2015) exploring individuals' experience of first episode depression using IPA found that depression involved a questioning of the self that was embodied. The experience of depression involved a major diminishing of the life world with relational, corporeal, and temporal depletion. This depletion was accompanied in each case by occasional extreme emotions, frenzied thoughts, and confused sense of self. The aim of this study was to focus on a detailed description of the immediate experience of depression in terms of core felt features. It also aimed to explore participants' understanding of their depressive experience in the context of life events

if relevant at onset, as events unfolded, and the complex interplay of personal and interpersonal experience in the present. All participants viewed preceding events as crucial in understanding how their depression began and developed.

The corporeal (embodiment) depletion was experienced by many participants as a felt sense of emptiness. The accounts were embodied with one participant who lost her son describing that she lost part of herself and her heart. Another participant described not being part of her body when experiencing depression. Furthermore, the affective and cognitive turmoil was experienced physically with some participants describing that their body and self had been left bruised, exhausted, and disorientated. The consequences became very physical with one participant who lost his family expressing that his face displayed the shame and blame. These descriptions clearly demonstrate how embodied participant's experience was (Smith and Rhodes, 2015).

The embodied experience of depression is experienced in many different ways. A study of 66 South Asian women living in the UK conducted by Burr and Chapman (2004), argue, on the basis of women's accounts of their experiences of depression, that "depression is "embodied", that is, it is grounded in the materiality of the body which is also immersed in subjective experiences and in the social context of women's lives" (Burr and Chapman 2004: 433). The participants in this study constructed depression in five different but related ways; as a subjective, psychological discourse relating to a sliding scale of emotions, a discourse of coping and endurance in overcoming their feelings of depression for example "I think if you want to cope it's all right". Depression was viewed as a biochemical construct (PND and PMT), participants described a mind/body dualism describing physical

"symptoms" as distinct from their feelings of depression demonstrating the embodied experience of depression. Finally, whilst women did not reject depression as an illness, they projected the idea that depression was not "real" onto Asian people and the community rather than personally owning these ideas (Burr and Chapman 2004). Participants viewed physical problems as legitimate and real and therefore attending the GP was appropriate, however a psychological problem was not legitimate and was therefore a non-medical problem, therefore a GP visit was not appropriate. It is evident from this study that cultural beliefs influenced how the participants of this study understood the experience of depression which subsequently impacted on their behaviour of attending a GP.

Furthermore the participants described feeling 'down', 'low' therefore 'mood' was viewed on a sliding scale and that the further 'down' feelings travel the more depressed women felt (Burr and Chapman, 2004). They also described a sense of powerlessness and hopelessness and feeling they did not have personal control, also evident in other studies (Robertson et al 2005, Clarke 2006, Burr and Chapman 2004).

The participants reported biological causes for their depression namely post natal depression (PND) and pre-menstrual tension (PMT). An interesting finding emerged which involved the belief that "unless it's physical it doesn't really exist" and "it's (depression) not considered an illness" (Burr and Chapman 2004). This belief may explain why discussing and accepting PND and PMT is easier as it is believed to be caused by biochemical/ biological abnormalities. The authors also found that depression affected women's overall physical well-being. These effects included:

inability to sleep; poor appetite; comfort eating; crying; fatigue; nausea and vomiting; generalised aches and pains in the joints; headache; asthma attack and painful periods.

Participants made a distinction between medical and psychological advice and felt a GP would not provide the latter. Participants stated that visiting a GP for physical problems mentioned above was appropriate whereas discussing psychological or emotional difficulties was "moaning" (Burr and Chapman 2004). Finally, Fancher et al (2010) study discussed above which explored the experiences of "Depression with Vietnamese American Patients" found that Vietnamese Americans may believe that mental illness results from metaphysical imbalances. They often used traditional methods first for example herbal and folk medicine (Fancher et al, 2010). They also held a number of beliefs about medication; it works quickly; it has many harmful side effects; long-term use is harmful to the body and finally Vietnamese tolerate less medication than Caucasians. Finally, participants felt that western providers of mental health did not fully understand their culture and this posed as a difficulty for them (Fancher et al 2010). Their cultural beliefs discussed in the studies above did not prevent individuals experiencing depression however it did influence the meaning they attached to the experience and their decision to seek help or not. It also highlights how the embodied experiences of depression led to seeking help however the embodied experience was not attributed to depression itself. Finally the embodied experience of depression legitimised participants to seek treatment as outlined above.

3.4 Spatiality

Spatiality relates to how one's understanding of places and of space is affected by the situation (Merleau Ponty, 2013). A number of studies identified how participants

understanding of places was affected due to experiencing depression (Smith and Rhodes, 2015; Burr and Chapman, 2004; Clarke, 2006; Aho, 2013; Schreiber, 2001). Aho (2013) found that the experience of depression disrupts everyday experiences of spatial orientation and mobility making it difficult for the person to move and perform basic functional tasks, resulting in a collapse or contraction of the life-world. The experience of depression also creates an atmosphere of emotional indifference that reduces the person's ability to qualitatively distinguish what matters in his or her life because nothing stands out as significant or important anymore. Depression is therefore distinct from other feelings in that it is not directed towards particular objects or situations but to the world as a whole.

The experience of depression impacting on one's understanding of place and of space is brought about by a person's capacity to experience significance in their life evident above however depression is also described by others as a place. A study which explored the lived experience of women experiencing mild to moderate depression found that women experienced depression as a place (Clarke, 2006). The study was very much grounded in the social factors underlying women's' experience of depression and was interested in exploring the impact of gender and power imbalances underlying women's unequal and hence unhealthy position in society. Increasingly more women work outside the home and therefore are juggling multiple roles (Clarke 2006). Furthermore women according to Taft (2003) are more likely to experience emotional, physical and sexual abuse thereby resulting in women experiencing depression. These experiences can lead to depression with women viewing depression as a place.

The participant's experience of depression as a "place" was conceptualised as somewhere in between life and death. Clarke (2006) found that rather than thinking about depression as something they have within them, some women saw depression as something external to themselves. Robertson et al (2005) refers to this concept as "Externalisation" and relates to White and Epson's (1990) writings on the practice of "externalising" within narrative therapy. This creates relief from the immensity of problems and encourages them to deal with the problems. Clarke (2006) also mentions the use of language, similar to what Robertson et al (2005) found in their study. This study demonstrates how one's understanding of places and of space is affected and how the experience of depression is distinct from other feelings in that it is not directed towards particular objects or situations but to the world as a whole.

In Burr and Chapman's (2004) study some participants described a sense of dissociation from the world "There is a detachment from the outside world", "I am in my thought". However this appears to be different from the concept of "externalisation" (Robertson et al 2005 and Clarke 2006) as "externalisation" is viewed as something helpful in order to remove yourself from the problem in order to solve or manage them. This finding however appears to be a state not entered into voluntarily or knowingly and further demonstrates how the experience of depression is not directed towards particular objects or situations but to the world as a whole.

3.5 Sociality or Connectedness

Sociality relates to how an individual's relationship with others is changed by the situation (Merleau, Ponty, 2013). A conceptual paper written by Ratcliffe (2014) discussed the phenomenology of depression and the nature of empathy. He argued

that depression impacted on an individual's capacity for interpersonal relatedness that mutual empathy depends upon. Therefore the individual experiencing depression feels cut off from other people, and may remark on their indifference, hostility or inability to understand. Empathy is therefore, not principally a matter of stimulating another person's experience, it is better conceived of as a perception-like exploration of others' experiences that develops progressively through certain styles of interpersonal interaction (Ratcliffe, 2014). Our experience of other people consists, in part, of a felt openness to the possibility of being affected by them in certain ways. It is this openness that is lacking in depression (Ratcliffe, 2014). The experience of depression therefore impacts on this openness which can also be understood as a loss of connecting with those around them which was evident in many studies reviewed (Rhodes and Smith, 2010; Smith and Rhodes, 2015; Burr and Chapman, 2004; Clarke, 2006; Schreiber, 2001; Fancher et al, 2010; Hussain and Cochrane, 2002).

Rhodes and Smith (2010) study discussed above identified how Paul described his experience through the use of imagery where he found himself in a pit or hole, his hands tied with no escape which was a reoccurring image for him. Being in a pit with his hands tied demonstrates his inability to escape. This image also suggests being abandoned according to Rhodes and Smith (2010) which highlights how his relationship with others was affected. He also described the impact negative thoughts had in his experience. An inability to stop negative thinking is attributed to damaging his relationship with his wife (sociality). Paul discovered that he was becoming less human and more mechanical, like a robot thereby impacting on his relationship with others (Rhodes and Smith, 2010). Smith and Rhodes (2015) later IPA based study, discussed earlier, found a diminishing of the life world with relational depletion, in

other words their ability to connect with those around them. The relational (sociality) depletion described a loss of access to key people in their lives with the resulting aloneness conveyed in powerful existential terms. Participants also described feelings of isolation however could see the connections available to them highlighting their struggle of wanting to be connected but also wanting to be alone. They described being disconnected and seeing this as harmful but not being able to connect (Smith and Rhodes, 2015).

Other studies identified how connecting with others was helpful (Clarke, 2006; Robertson et al, 2005). Therefore those experiencing depression often feel and do isolate themselves from others, it is the connecting to others that aids in their recovery. Robertson et al (2005), discussed above, found that some participants used externalisation as a means to cope. This for some was achieved by "talking to someone". Externalisation allowed individuals to view their problems objectively and from outside themselves. As a result the individual feels less paralysed by the problem, seeing it as something outside them to be tackled as opposed to an inner crippling force.

Furthermore, in Clarke's (2006) study, participants identified the group (well-being group) a place where they could share their feelings, and develop a sense of connectedness. This sense of human connectedness was consistently reported by the participants as something that they valued most (Clarke, 2006). This connectedness was described in terms of confiding, belonging, being supported and encouraged. On the other hand it was aspects of their relationship with themselves (self-exploration, their level of self esteem and self-care) that women highlighted as factors in

promoting their well-being and not their relationship with others. Women in this Clarke's (2006) study then developed their "self" in different ways and at different times, some through the relationship they hold with themselves and others through the relationship they hold with others. This also relates to selfhood but could also be understood in terms of individual's connection with themselves, the relationship individuals forge with themselves which in essence impacts on the relationships individuals forge with those around them. Connectedness to others is contingent on connecting with oneself implying that selfhood and sociality are interconnected and have a symbiotic relationship.

Relationships with others, be it with society in general or with significant others (connectedness), impacts on the experience of depression evident in Schreiber's (2001) study. Internalised expectations from society, bolstered by significant others (relationship with others), had the impact of reinforcing the status quo marked by a constricted set of behaviours allowable for women (Schreiber, 2001). This leads to beliefs for women regards being selfless, self sacrificing, making others look good, not showing vulnerability, being productive and being strong (Schreiber 1996; Schreiber, Stern and Wilson 2000). As a result of these beliefs, women are severely limited in realising their true self or enacting their full parenthood as they feel/ believe they must live up to these expectations or suffer untoward consequences. When unable to live up to these expectations, an overwhelming sense of inadequacy prevails. For women to move from this the participants' described challenging their understanding of what it means to be a good woman. This was achieved by attending to their internal dialogue, cease judging themselves and allowing themselves to be imperfect and vulnerable (Schreiber 2001). This further highlights the process of

individuals connecting to themselves through challenging their beliefs thereby facilitating them in connecting to others.

3.6 Temporality

Temporality relates to how one's sense of time, biography, and duration is affected (Merleau Ponty, 2013). This finding emerged explicitly in one of Smith and Rhodes' (2015) study. Temporal depletion, participants described, related to how their lived experience impacted on their present and future, as well as perceptions of the past. Participants described how their lives changed forever and that all before their experience of depression was a waste with their whole life now forever tarnished (Smith and Rhodes, 2015). Participants also described their lives as being over and finished. This may have being a major contribution to thinking about suicide because, if life is empty or over psychologically, it could appear that it might as well be ended literally (Smith and Rhodes, 2015). This study demonstrates how participants experience of time is affected which is a common experience in depression as discussed earlier in relation to differentiating the experience of depression and sadness.

3.7 Gender and the Experience of Depression

It is evident from some of the studies reviewed above (Schreiber, 2001; Clarke, 2006, Roberttson et al, 2005) that much research has been conducted exploring women's experience of depression. However a number of studies have also been conducted examining depression from a male perspective. These will now be reviewed. According to Honkalampi et al (2000) men are less able to identify and express their feelings and are hypoemotional. Studies have found that men express their experience

of depression by engaging in risk taking behaviours such as anti-social behaviours, aggression, violence, self-harm, suicide, sexual encounters, drink driving, gambling, road rage, and drug and alcohol abuse (Bennett and Baumen 2000, Blair-West et al 1999, Degenhandt et al 2001, Moller-Leimkuhler 2003).

A qualitative study by Brownhill et al (2005) explored men's experience of depression and found that gender differences did not affect the experience of depression but in the expression of depression. A convenience sample was used and included both male and female teachers and students from four sites within 3rd level educational institutions. Data was collected through the use of focus groups (14 in total) with 77 men and 25 women. Content analysis was applied to the data to examine similarities and contrasts between men and women (Brownhill et al 2005). From this study, they found that men experiencing depression and the emotional distress that accompanies this manifested it in avoidant, numbing, and escape behaviours, which could lead to violence, aggression, and suicide. They found that gender differences did not appear to affect the experience of depression but in the expression of depression. This finding is not only evident in studies looking at women's experience (Robertson et al 2005, Clarke 2006, Schreiber 2001) but also in studies looking at culture and the experience of depression (Francher et al 2010, Burr and Chapman 2004, Hussain and Cochrane 2002). The above studies like Brownhill et al (2005) found that irrespective of gender or culture, all participants had similar experiences of depression yet they expressed it in different ways.

To clarify this further men's understanding of depression involved a complex interaction between the experience of emotional distress and their response

(expression) to that distress (Brownhill et al, 2005). Furthermore they found that if men's responses to the emotional distress were ineffective then some men would employ risk-taking behaviours outlined above. They described this as emotional release through physical means or the release of built up negative emotion. The themes identified in this study included "Avoiding it" (avoiding problems or issues by not thinking about them, forgetting or distancing or distracting themselves); "Numbing it" (use of drugs or alcohol); "Escaping it" (spending longer at work, extramarital affairs); "Hating me, hurting you" (injurious behaviour towards self, aggression, crime) and finally "Stepping over the line" (Self harm behaviour or suicide) (Brownhill et al 2005).

The women in this study also described men's experience in similar ways such as viewing men with depression as avoiding, numbing and attempting to escape from problems. They felt that men suppressed their emotions (men also described this), which could lead to violent or aggressive behaviour. This further demonstrates how the experience of depression for both men and women is similar however the expression of the experience of depression differs. Brownhill et al (2005) argue that both men and women experience depression similarly in relation to the DSM criteria however men's expression of depression is more complex. Men's expression of depression appears to be hidden in antisocial and risk taking behaviours including drug and alcohol use, self-harm and suicide. These risk-taking behaviours (risky sexual encounters) act as an escape ("escaping it"), as an indirect expression of anger or as control over another person ("hating me, hurting you") and as a diversion ("avoiding it") or to relieve tension ("numbing it"). Finally Brownhill et al (2005)

argue that the gender differences in depression appear not to lie in the "experience" of it but in the "expression" of depression.

Chuick et al (2009) explored men's experience of depression, using a grounded theory methodology. They used interviews to collect the data of 15 men between the ages of 24 and 75 years who described experiencing depression. This study aimed to elucidate the participants' signs and symptoms of depression, their help-seeking processes and their experiences with recovery. The findings were categorised into ten main themes: transition, adjustment, loss; typical, atypical symptoms; aggravating factors; mitigating factors; short term remedies; long term remedies; trial and error; effects of masculinity; recognising depression in men; and suggestions for men. Findings described the relationship between men's experience of depression and a significant change in their lives and their adjustment to this change (transition, adjustment, loss). Also they found that men described lack of interest in pleasurable activities, sleep/ appetite disturbance and thoughts of death (typical, atypical symptoms). Men stated that their depressive symptoms were aggravated by environmental factors and their own maladaptive reactions (aggravating factors). These included substance abuse and infidelity, a finding also presented in Brownhill et al (2005) study.

Another theme, "mitigating factors" described factors that reduced the intensity of depressive symptoms such as treatment, been able to express safely their feelings when they become overwhelmed and feeling normal by recognising others facing similar struggles. Clarke (2006) in her study with women experiencing depression described this as "connectiveness", a finding significant to both men and women. "Short term remedies" was another finding related to various attempts to address their

feelings of depression. These included substance abuse, infidelity, avoidance and focusing excessively on work again similar to findings in Brownhill et al (2005) study. “Long term remedies” were solutions utilised to cope with depression successfully and those included medication, therapy (individual, group, and couple) and religious counselling. Chuick et al (2009) maintained that a fey factor to the success of the long-term solutions was the ability of the participants to increase the level off responsibility they took for resolving their issues.

Another theme that emerged found that men tended to go through a process of trying many different short term remedies for coping with their depression until a successful remedy was found (“trial and error”). Finally in relation to “Effects of masculinity”, men felt that depression was not a socially accepted issue for men, that it was inappropriate for men to seek help, support was lacking and that men experiencing depression were perceived as weak. Chuick et al (2009) concluded that men reported both typical and atypical symptoms of depression, a cyclical often escalating pattern of depression was revealed which required external intervention usually by a significant other and finally, men described the impact of traditional masculine socialization on their reluctance to talk about or obtain help for their depression.

It is argued that the ways in which men and women express emotional distress differ (Chuick et al 2009, Burr and Chapman 2004, Brownhill et al 2005, Fancher et al 2010, Schreiber 2001, Clarle 2006). Women express emotional distress more often and therefore are more likely to be diagnosed with depression while men do not and hide their depression thereby leading to under diagnosis of depression (Brownhill et al 2005). Pollock (2009) found that those experiencing emotional distress suppressed

their emotions during medical consultations because they were trying to "maintain face" and confirm to "the socially sanctioned role of the good and uncomplaining patient in order to retain the social esteem and goodwill of others" (Pollock 2009 pg 175). Emslie et al (2007) explored men and women's experiences of depression and engagement with health professionals. They utilised a modified grounded theory approach. 22 women and 16 men in the UK participated in in-depth qualitative interviews who identified themselves as having had depression and were recruited through general practitioners, psychiatrists and support groups. They aimed to explore the impact of gender on the mental health of men and women.

They found both gender similarities and gender differences (Emslie et al, 2007). They identified that both men and women found it difficult to recognise and articulate mental health problems and this in turn led to difficulties communicating with health professionals. Another similarity included the relationship both men and women held with professionals. Some valued a close personal relationship with professionals while others felt that this personal relationship was a barrier to communication and preferred talking to a "stranger". Both men and women discussed the need to have some rapport, connection, or to click or gel with their GP and those providing talking therapies. This relates to Clarke (2006) findings of "connectiveness" and its value in recovery from depression. Another important factor identified was the importance of continuity of care in building personal relationships and the difficulty in having to repeat their stories to different health care professionals. Differences in accounts of men and women experiencing depression also arose. One difference involved the emphasis on communication in that women feeling listened to was viewed as valuable. For men more emphasis on the ways health professionals enabled them to

talk about their emotional distress was important (Emslie et al 2007). These findings again highlight that both men and women experience depression in much the same way however they express their experiences differently. Another finding in this study related to personal relationships with health professionals. A minority of participants found it easier to communicate with someone they did not know, as they did not wish to reveal their "weaknesses" to a "friend" because pride or fear it would damage their relationship and therefore found it easier to discuss their emotional difficulties with a "stranger".

Finally, Emslie et al (2007) study further supports the findings of a study conducted by Danielsson and Johonsson (2005) who also found that the experience of depression for both men and women was similar however how they expressed their experience differed. They utilised a qualitative approach and conducted in-depth interviews with 18 participants diagnosed with depression (ICD 10 criteria) of different ages and social status. Data was analysed using grounded theory. The findings emerged under four main themes: branded with demands; bodily expressions; gendered vocabulary of mood; and self-effacing or self-aggrandizing language (Danielsson and Johonsson 2005).

With regard to "branded with demands" all participants had a perception of high demands and expectations on them either in the home or at work. However the way in which men and women conveyed these demands differed. They found that although commitment to work or family or both was gendered it was also influenced by socio-economic status. For example women with poor education viewed the family as foremost whereas middleclass men either well educated or well paid viewed work as

foremost. On the other hand highly educated women and men with low income resembled each other in their dual commitment to both family and profession (Danielsson and Johonsson 2005). In relation to physical symptoms, the study found that men called attention to them more intensely than women did. They also found that women had a greater variety of words and metaphors to describe their mood than men had ("gendered vocabulary of mood"). Men expressed their emotional distress in terms of aggression similar to studies conducted by (Emslie et al 2007; Chuick et al 2009; and Brownhill et al 2005).

Finally both men and women described low self-esteem. Women especially those with low education, resorted to self-effacement while men on the other hand called attention to their former competence in heroic terms ("self-effacing or self-aggrandizing"). However below the surface of this men felt a feeling of not been good enough. Danielsson and Johonsson (2005) argue that gender is one factor of importance however social class and background also plays a role in people's experience of depression. It is evident from the studies discussed above that gender plays a significant role in how the experience of depression is expressed, not that men and women experience depression differently. The difference in how the experience of depression is expressed contributes arguably to the higher incidence of diagnosed depression in women.

3.8 Culture and the Experience of Depression

A number of studies discussed above (Fancher et al, 2010, Burr and Chapman, 2004, Hussain and Cochrane, 2002) explored depression with different cultural groups. I will therefore discuss further the contribution culture has in the experience and

expression of depression. It is important to explore the cultural impact, pertaining to individuals' experience of depression as culture affects mental illness with respect to the ways individuals experiencing emotional difficulties describe symptoms, the meaning they impact on their experience and how they make sense of their experience (Kleinman et al, 1978). The views presented in these studies would correlate with some of the philosophical views of mental illness put forward by Thornton, (2007), and Szasz (2010) outlined in chapter two of the literature review. On the other hand the experience of depression could be related to "Stigma and Face" presented in Fancher et al (2010) study where culturally depression is viewed in a negative way. Fancher et al, (2010), exploring the experiences of individuals from the Vietnamese American community with a diagnosis of depression found that this group may deny the signs and symptoms of their experience (understood as mental illness) to preserve their public appearance and save face for themselves and their families. The importance of including family members in medical care decision making and in thinking about depression as a disruption of social group functioning rather than as an individual mental health problem was emphasised by these participants.

Burr and Chapman (2004) in their analysis revealed a discourse of "legitimate illness" which is bound with a moral agenda for appropriate and socially acceptable behaviour, again related to visiting a GP for a physical problem and not a psychological or emotional difficulty. From these findings Burr and Chapman (2004) argue that South Asian communities "somatise" emotional distress, a view supported by other studies (Kawaishi, 1992; Gaw, 1993; Hussain, 1997) because they have difficulty in expressing distress in psychological or emotional terms. While acknowledging the cultural component in this study Burr and Chapman (2004)

acknowledge that all participants were mostly UK born therefore it would be anticipated that women would be socialised into western understandings of depression. They argue that white British men and women may show the same mix of physical and emotional symptoms, however from this study it is clear that women made strategic choices in how they presented their symptoms as "legitimate" and for gaining access to what they believed to be appropriate health care (Burr and Chapman 2004). Therefore this could imply that regardless of culture, socio-economic background and gender, how we experience depression may be the same however, how we express our experience of depression differs depending on the factors outlined above and in particular culture in the study presented.

Hussain and Cochrane (2002) also explored Asian women's (UK based), beliefs on the causes and cures of depression. The study consisted of ten Asian women experiencing depression and three of their carers. Each participant was interviewed about their beliefs around the causes and treatment of depression. Those participants experiencing depression had received treatment from mental health services for a clinical diagnosis of depression within the last year. The findings fell under three core categories: conflicting cultural expectations, "English people don't understand our way of life"; distinctions between psychosocial, spiritual and physical health problems, "Finns (evil spirits) can cause you to be sad or very withdrawn and doctors won't be able to find a cure"; and finally communication problems (general and cultural specific), "I could talk to a Hindu or a Christian and know about their beliefs but I still wouldn't know what it would be like to be one". Hussain and Cochrane (2002), findings initially revealed that a primary causal factor was based on culturally-specific distinctions of spiritual, psychosocial and physical health problems. Much

was based on their spiritual beliefs and the fact participants felt that non-Asian mental health staff would not understand their spiritual beliefs thereby; they would not share them for fear of ridicule or judgement. This study clearly highlights how their relationship with professionals was affected as they believed that they would not understand their cultural beliefs however they did not have any factual evidence to support this assumption.

Finally it is evident from the studies presented above that individuals' from some cultures and religious beliefs do not view depression as an illness in the same manner as they view physical illness. They situate their understanding of depression within their own cultural, value and belief system. They do not seek medical intervention for depression as a result of their cultural belief system. Therefore how they express their experience of depression differs due to their cultural beliefs.

3.9 Conclusion

In conclusion the purpose of examining the literature related to individuals' experience of depression was to gain a comprehensive overview of the studies which explored individuals' experience of depression. This review drew on literature provided by a wide range of disciplines Nursing, Medicine, Psychology and Sociology. Studies from different methodologies including phenomenology, grounded theory, narrative approach, discursive approach and gender analysis were presented. A limited number of studies exploring the experience of depression using interpretative phenomenological analysis (IPA) were found (Smith and Rhodes, 2015; Smith and Rhodes, 2010). Exploring the phenomenological research related to the lived experience of depression highlighted the various elements that underpin this

experience such as embodiment, mood, selfhood, temporal experiences, interpersonal relationships (connectivity), and spatiality. This chapter was presented under the themes that emerged from the qualitative research reviewed such as selfhood and embodiment along with examining and critiquing the research literature with respect to gender and culture. The rationale for this was to explore the experience of depression and ascertain how culture or gender impacted on the experience of depression. From reviewing the literature using phenomenological understanding it became evident that irrespective of culture and gender, the experience was often very similar however the expression of depression differed depending on culture and gender. Examining the research studies through the lens of phenomenology allowed this differentiation to become clear.

It was also important to explore the cultural impact, pertaining to individuals' experience of depression to determine if western views of depression had impacted on how individuals' experienced and understood depression. A number of studies explored individuals' experience of depression from a cultural perspective or acknowledged the impact of culture in relation to experiences of depression (Burr and Chapman 2004; Fancher et al 2010; Hussain and Cochrane, 2002). The findings presented constructed depression in five different but related ways; as a subjective, psychological discourse relating to a sliding scale of emotions, a discourse of coping and endurance in overcoming their feelings of depression for example "I think if you want to cope its all right". Thirdly, depression was viewed as a biochemical construct (PND and PMT) and participants described a mind/body dualism describing physical "symptoms" as distinct from their feelings of depression. Finally, for some communities (Asian communities) psychological problems were not legitimate and

were therefore a non-medical problem, therefore a GP visit was not viewed as appropriate. This is interesting for a number of reasons. Firstly, it may imply that western cultures have medicalised depression as a way of understanding it whereas Asian communities view it differently and have not medicalised it.

While these studies highlight the specific cultural needs of Vietnamese American individuals and Asian communities, there are similarities with other studies discussed (Robertson et al 2005 and Clarke 2006) that highlight the importance of socio-cultural factors. Therefore this could imply that regardless of culture, socio-economic background, gender, how we experience depression is the same however, how we express our experience of depression differs depending on the factors outlined above and in particular culture in the above studies. Another important finding, found in many studies related to a sense of human connectiveness which was consistently reported by the participants as something that they valued most. The participants described a sense of confiding, belonging, being supported and encouraged as significant in their recovery.

Although Honkalampi et al (2000) argued that men are less able to identify and express their feelings and are hypoemotional. Studies exploring men's experience of depression found that gender differences did not appear to affect the experience of depression but in the expression of depression. This finding was not only evident in studies looking at women's experiences (Robertson et al 2005, Clarke 2006, Schreiber 2000) but also in studies looking at culture and the experience of depression (Francher et al 2010, Hinlen et al 1998, Burr and Chapman 2004, Hussain and Cochrane 2002). It is evident from reviewing the above studies that irrespective of gender or culture,

individuals have similar experiences of depression yet they express it in different ways and by examining the literature through the lens of phenomenology this became apparent.

Chapter 4

Methodology

4.1 Introduction

This chapter provides an overview of the methodology utilised in this study. Firstly, justification for choosing a qualitative approach for this study will be discussed. Following this the rationale for choosing a phenomenological methodology and more specifically Interpretative Phenomenological Analysis (IPA) will be presented. Research methods refer to the tools, techniques or procedures used to gather evidence. These include the sampling method chosen, the research instrument used, data collection, gaining access to the participants, data analysis, ethical considerations and finally rigour, all of which will be explored and presented in this chapter. It will lay the foundation of how the research study was conducted.

4.2 Aims of Study

The literature review presented the various understanding of depression such as biological, psychological, sociological and cultural. It was apparent that individuals' experience of depression was a deeply personal, complex experience informed by different life experiences such as current life events, gender, relationships (personal, family, work) and the media. From reviewing the literature it became evident that various discourses also impact on individuals' lived experience of depression. The rationale for the study arose from the gaps in the current research. The gaps identified

include: a paucity of qualitative studies exploring how discourses impact on individuals' lived experience of depression and the meaning they foreground. In addition exploring how social discourses influence the lived experience using interpretative phenomenological analysis had not been conducted. Therefore it was useful to explore the influence of social discourses on individuals' making sense of their experience of depression using this methodology. Furthermore as the incidence of diagnosed depression is rising it is imperative that further research be conducted in order to ascertain what factors contribute to the experience of individuals' with depression in order to identify future training and education needs. This informed the aims of the study.

The aim of this study was to gain a phenomenological understanding of how individuals' who experienced depression understood and made sense of their experience of depression. This was achieved by obtaining an in depth description of individuals' lived experience of depression, exploring how individuals understood their experience of depression, exploring what depression meant to individuals' and exploring the conceptual world of the individual who experienced depression. Finally how various social discourses contributed to their understanding and lived experience of depression was explored.

4.3 Research Design

A qualitative approach and more specifically, an Interpretative Phenomenological Analysis (IPA) methodology was chosen for this study for a number of reasons. It is widely accepted that both qualitative and quantitative research has a purpose and place in understanding the social world (Davies et al, 2002). According to Silverman

(1994) and Mason (1996) qualitative research represents a diverse set of philosophies and techniques that underpin research practice in the human sciences. Biggerstaff and Thompson (2008) argue that as healthcare professionals become more aware of the potential of qualitative approaches such as IPA, they can value more the real contribution that such research makes in understanding healthcare and illness from the individual's perspective. Qualitative methods are the methods concerned with the naturalistic description or interpretation of phenomena in terms of the meanings these have for the people experiencing them (Langdridge, 2007).

Qualitative methodologies have increased in popularity in psychology in recent years as a result of growing dissatisfaction with quantitative methods among sections of the psychological community (Langdridge, 2007). Some criticisms of the cognitive perspective, which focuses on how people retrieve information and how they use this information to solve problems, involves questions about the realism (an assumption that there is a real knowable world out there that we can study) and essentialism (the belief that there is an essential given core to people that makes them what they are once and for all) of the cognitive approach to psychology (Langdridge, 2007). This positivist approach (cognitive perspective) to research is based on the philosophy that people's preconceptions need to be set aside in order to identify objective facts based on empirical observations that are context free. The focus is purely deductive and is concerned with quantifying observable behaviour so as to establish generalisable laws from a sample to the wider population from identified statistical relationships between dependent and independent variables (Ackroyd, 2004).

The question arose regarding studying individuals' lived experience within the social world using the same principles and procedures as the natural sciences, namely a positivist approach. Joseph, et al (2009) questions the appropriateness of the natural sciences model for the study of society and mental health. Langdridge (2007) argues that the failure of many cognitive researchers to take into account the way in which knowledge is a product of both history and culture (constructed through language and our ways of speaking and writing about events) provokes considerable doubt about the findings from this perspective. As a result of this, researchers have looked for alternative ways of producing knowledge and investigating human nature. Qualitative methodologies take a critical stance towards knowledge and recognise the influence of history and culture and appreciate how we construct such knowledge intersubjectively (between people) through language (Langdridge, 2007). Individual's lived experience is better understood through an interpretive and idiographic perspective as not all that we wish to explore is observable thereby bringing understanding to individual experiences. By exploring idiographic (unique and individual) interpretations using qualitative research methods, a researcher gains insights into subjective meaning making rather than objectifying the unique relationship between individuals' and their world.

As nomothetic (effort to derive laws that explain objective phenomena in general) empiricism came under increased criticism during the 1980's and 1990's, two relatively new philosophical positions, relativism and realism were being utilised with increased frequency (Easton, 2002). The critical relativist approach explores multiple realities through a discursive construction of reality which involves deconstructing expressions and conversations as a way of understanding social interactions (Edwards

and Potter, 1992). All knowledge is relative to its time and place with concepts such as right and wrong, goodness and badness variable according to situation and culture. A critical realism approach on the other hand, is a very different approach with critical realists viewing critical relativists as socially restrictive, inhibiting exploration into what goes on inside the person. Critical realists focus on subjective interpretation of phenomena, language systems, meaning systems, symbolism, and the interaction between them. This inductive focus stands in contrast to the deductive focus of positivism that objectively observes the relationship between cause and effect. The critical realist seeks an interface between the natural and social worlds that is forever changing. Research adopting this approach is concerned with the individual experience expressed through talk, understanding, describing, interpretation, and meaning making. Critical realists acknowledge the importance of alternative subjective positions and different ways of making sense of the world (Blaikie, 1991) and thus draw on interpretative qualitative approaches such as phenomenology, IPA, ethnography and hermeneutics (Blaikie, 2000).

It was clear that as this study was exploring the lived experience of individuals' who experienced depression, a qualitative approach was most appropriate. As it is not possible to objectively measure or quantify experiences, a quantitative approach would have been inappropriate for this study. Qualitative research rather than quantitative research methods allow the researcher to study events in the social world from the perspective of the person as a subject, as opposed to the person as an object (Clarke, 1999). Therefore different qualitative approaches were considered including grounded theory, ethnography, discursive enquiry (Denzin & Lincoln, 2005) and

phenomenology, in particular interpretative phenomenological analysis (IPA) (Smith, 2013).

Grounded theory is concerned with a systematic generation of theory from systematic research through the analysis of data (Denzin & Lincoln, 2005) and as I aimed to explore individuals experience and understand the meaning of their experience and not develop theory, grounded theory was not appropriate for this study. Ethnography involves the study of people and cultures and is an appropriate methodology to use when describing how a cultural group works by exploring their beliefs, language, behaviours and other issues such as power and dominance (Denzin & Lincoln, 2005). As this study aimed to explore individuals subjective lived experience and understand the meaning of their experience this methodology would not address the research question. Discursive enquiry explores the role of language in participants descriptions of events and conversations (Denzin & Lincoln, 2005) whereas phenomenology including IPA explores how people ascribe meaning to their experiences in their interactions with their environment (Smith, 2013). Therefore IPA concurred with the current study as I wished to explore and make sense of individuals making sense of their experience of depression.

4.31 Phenomenology

Following identifying a qualitative approach and more specifically IPA as the most appropriate methodology to answer the aims of the study, it was important to gain a greater understanding of phenomenological philosophy and phenomenological psychology. Phenomenological philosophical was a movement that began in the early 1900's beginning with Edmund Husserl (1859-1938) and then developed further by

Martin Heidegger (1889-1976). The founder of phenomenology, Edmund Husserl (1859-1938) stated that the focus of phenomenology is to "return to the things themselves" where its aim is to focus on a person's perception of the world in which they live and what this means to them: a focus on a person's lived experience. Phenomenologists resist the subject-object dualism that is central to positivism and the scientific project, where one sees the world as it really is and the world as it appears through perception (Biggerstaff & Thompson 2008; Langdridge, 2007).

Phenomenologists maintain that it is illogical to think of objects in the world separately from subjectivity and our perception of them. An object only enters our reality when we perceive it to have entered and become conscious of it. Our perception varies depending on context, the position of the perceiver in relation to the object and the mood of the perceiver, among other things. There is no once and for all knowledge to be found about a real knowable world. There is only our perception of the world and how this is experienced, recognised and the meaning of this will differ for different people and even the same person but in a different context (Pringle et al 2011, Biggerstaff & Thompson 2008 Langdridge, 2007). In other words phenomenological philosophy is the study of structures of consciousness as experienced from the first-person point of view. Phenomenology studies the structures of various types of experience ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, including linguistic activity. The central structure of an experience is its intentionality, its being directed towards something, as it is an experience of or about some object. (Husserl, 1913/ 1952). The basic intentional structure of consciousness is found in reflection or analysis which involves further forms of

experience. Thus, phenomenology develops a complex account of temporal (within the stream of consciousness) and spatial awareness, awareness of one's own experiences (self-consciousness), self-awareness, embodied action, awareness of other persons (in empathy, intersubjectivity), linguistic activity (involving meaning, communication), social interaction, and everyday activity in our surrounding life-world (in a particular culture) (Zahavi, 2012).

Phenomenological psychology refers to the use of phenomenology to study the necessary and universal structures of experience. Phenomenological psychology in essence utilises phenomenological methods to gain insights regarding topics related to psychology. Langbridge (2007) explains that "when applying phenomenological philosophy to psychology, we aim to focus on people's perception of the world in which they live and what this means to them: a focus on people's lived experience" (Langbridge, 2007, p.4). Furthermore, Giorgi (1997) argues that phenomenological psychology offers a way to access often difficult and complex human experiences.

There are two approaches to phenomenological psychology broadly speaking: descriptive and hermeneutic (interpretative) (Boden & Eatough, 2015). According to Giorgi (2009) within descriptive phenomenology in psychology "the situations to be described are selected by the participants themselves and what is sought is simply a description that is as faithful as possible" (Giorgi, 2009, p.96). Furthermore Giorgi (2009) acknowledges "the fact that the descriptions come from others could be challenged from a phenomenological perspective … but the descriptions provided by the experiencers are an opening into the world of the other that is sharable" (Giorgi, 2009, p.96).

However hermeneutic (interpretative) approaches such as IPA are more interpretative and less focused on description although they do incorporate description. A significant difference between IPA and Giorgi approach is that Giorgi is attempting as close a translation as possible of Husserl's phenomenological method, while IPA draws from a wider corpus of phenomenology and is not attempting to operationalise a specific version of it in that IPA is avowedly interpretative (Smith, Flowers & Larkin, 2013). Descriptive phenomenological psychology such as Giorgi's method is primarily concerned with developing accounts of commonality in experience so that a complete and integrated eidetic picture of a particular phenomenon can be built up. Hermeneutic (interpretative) approaches such as IPA, by contrast, has the idiographic aim of providing a detailed analysis of divergence and convergence across cases, capturing the texture and richness of each particular individual examined (Smith, Flowers & Larkin, 2013).

Therefore phenomenology as a research methodology aims to employ a set of methods to enable researchers to elicit rich description of experiences and/ or narratives of experiences. These methods aim to illuminate the lived world of the participant and also, possibly, the lived world of the researcher, along with others who have, or may in the future, experience something similar (Bradford, 2010).

Phenomenology is not a consistent body of thought, and there are many variations with implications for the way in which one might build upon these ideas depending on the approach utilised. The phenomenological focus on experience is key for all phenomenological approaches, and so is the discussion of intentionality and the

correlation between the way the world appears and our experience of it which are relevant to all methods of phenomenology. Edmund Husserl (1913) understands intentionality not in its usual sense, of intending to do something but instead, it refers to the fact that whenever we are conscious, it is always to be conscious of something. There is always an object of consciousness so for example when we see something it does not appear to be in our heads as a projection on the occipital lobes of our brain, but rather out there in the world.

Phenomenology focuses on the way consciousness is turned out on the world, as it intentionally relates to objects in the world. It is this consciousness of the world, and more specifically the relationship between a person's consciousness and the world, that is the study for phenomenologists. It is not concerned with understanding cognition and attempting to look inside people's heads in order to develop understanding. Instead the intentional correlation leads to a focus on the experience of things in their appearing and the way in which they appear to us as we focus our attention on them in consciousness. Therefore the mind is not viewed as something private to the individual but instead recognised as something intrinsically public (Husserl, 1913/ 1952).

Although the discussion of intentionality is pivotal to all phenomenological approaches, not all approaches employ the "epoche", phenomenological reduction or imaginative variation. Husserl (1859-1938) understands "epoche" to mean the process by which we attempt to abstain from our presuppositions, those preconceived ideas we might have about the things we are investigating. This is referred to as bracketing. The core of epoche is doubt: doubt about the natural attitude or the natural biases of

everyday knowledge. Husserl (1859-1938) argued that human existence was characterised by the natural attitude which is our experience of the world with all our taken for granted assumptions in operation without much reflection on alternatives. This is how we live in the world and researchers live by the natural attitude also. As a consequence, much is hidden from view, therefore much can be revealed through phenomenological methods by setting aside the natural attitude or becoming critically aware of the natural attitude, thereby gaining a greater critical understanding of the assumptions at play in a person's lived experience.

An epoche enables researchers to describe the things themselves and attempt to set aside our natural attitude or all the assumptions we have about the world around us. The goal and challenge here is to let things we experience appear in our consciousness as if it were the first time. There is considerable debate regards whether or not epoche is achievable or not. Phenomenologists following Husserl argue that the epoche is achievable while existential phenomenologists who follow the work of Heidegger, Sartre and Merleau-Ponty believe that you should try to achieve epoche but accept that you can never fully bracket off your presuppositions and achieve a "God's eye view" (Langdridge, 2007).

Phenomenological reduction continues the process initiated with the epoche and involves three key elements to this process: description, horizontalisation and verification (Bradford, 2010). When we as researchers begin to see things as they appear with our assumptions bracketed off, researchers must then begin the process of describing not only in terms of our perception but also in terms of our consciousness and aim to capture and describe the total experience of consciousness in much detail.

This is achieved by repeated reflection on the phenomenon (experience of depression), examination and elucidation, all the time remembering the rule of horizontalisation. All information is treated with equal value and all detail is described regardless of how mundane it appears. The researcher examines minute details and then the whole in order to identify the essence of the phenomenon.

In the natural attitude we are likely to "verticalise" by thinking that one thing is more important than another. This is resisted in phenomenology when attempting to understand the meaning of an experience described by the participant. The key to reduction is repeating, looking to uncover the layers of meaning inherent in the phenomenon being perceived. Once this process has been achieved, the researcher begins to formulate tentative hypotheses about hierarchy of meaning and engage in the process of verification (Langdridge, 2007). This involves taking the analysis back to the text to check that it makes sense in this context. Finally, the final stage is to write a complete textural description of the experience.

Imaginative variation is another stage that may be employed following phenomenological reduction, to further elucidate meaning from an experience. This is simply the process of approaching the phenomenon being experienced from different perspectives by imaginatively varying features of the phenomenon such as gender, race or sexuality. The aim is to imaginatively vary elements of our experience so the essence may come into view and the contingent fade away. Essence(s) in phenomenology represents a move from describing an individual's experience to exploring the structures underlying the experience. Husserl (1859-1938) stated that it was possible to identify the universal structure or structures (essence(s)) underlying

the experience based on a single experience. Although Husserl (1859-1938) maintained that it was possible to do this from a single experience, researchers do this using a number of participants thereby discerning essences from multiple descriptions (Bradford, 2010).

Husserl acknowledged that this process takes much effort so as not to revert back into the natural attitude where our everyday way of seeing the world colours our experience. All experiences should not be seen as individual pieces of information but more an expression of the essence itself. Essence emerge from rigorous examination and reflection on experience itself as given to consciousness among participants in research and is not some form of inner intuition. Epoche, phenomenological reduction and imaginative variation provide the method for identifying essences (Langdridge, 2007).

Martin Heidegger (1927) in his book “Being and Time” provides a critique of Husserl’s work and presents his own existential project. Heidegger built on the phenomenological tradition. Heidegger (1927) sought to examine what is – that is, what exists. He argued that it was not possible to investigate things in their appearing and identify their essence (structure) in a neutral or detached way. He believed that all people are inseparable from the world they inhabit and, therefore, it is not possible to bracket off one’s way of seeing and identify the essence of a phenomenon, as Husserl proposed.

Heidegger (1927) maintained that our way of existing must be seen in its historical and cultural context and understood with due regard to the role of language – it must

be interpreted and not simply described. He developed a phenomenological method that is concerned less with universals – essences of the things in their appearing – and, instead, concerned more with interpreting the meaning of the things in their appearing from a position that is always grounded in the things themselves (Heidegger, 1927).

Firstly, Heidegger (1927) refers to man or person or subject as Dasein which means "being there". He uses Dasein instead of man or person or subject in order to look with fresh eyes at what it means to exist, a uniquely human problem, and also to emphasise a number of features of existence that may be obscured when using other terms such as man, person or subject. Kearney (1994) outlines the key features of Dasein which include the following: temporality, facticity, mood, being-towards-death, care, authenticity, being-with, and discourse.

Temporality relates to our experience of time and is at the heart of what it means to exist. This is so because our understanding in the present always involves our past and a projection of our future. Dasein is always projecting itself towards future possibilities since existence for humanity requires us to create it rather than simply live it. Facticity of our existence acknowledges that although we create ourselves, there are limits to these choices, since we are thrown into a world that predates us and that limits our possible ways of being. Physical, psychological and social factors, our historical circumstances will all serve to limit our possibilities, but even here these do not determine what Dasein might or might not do, since Dasein can make of this facticity what he chooses (Kearney, 1994). Mood, for Heidegger, refers to a pre-reflective way of experiencing the world as an ontological phenomenon that, results from an awareness of the fear of non-being. Anguish, for example, frequently

experienced as depression, is not simply something that colours our way of living as a result of negative life events but rather is the result of becoming aware of the nothingness of existence. What's important here is to identify that our experience of the world is first and foremost lived pre-reflectively through a mood and only later understood through reflection (Heidegger, 1927).

Being towards death identifies that the ultimate limit to existence is death and this marks an end to all human possibilities. As we do not determine the beginning or end of our lives our experience is always subject to an awareness of the inescapably finite nature of life and the end of our possibilities. Care relates to us being involved in the world, actively engaged in other things and people (Kearney, 1994). Authenticity is when Dasein no longer takes the world for granted but, instead, recognises the fundamental reality of being that is being towards death and the need to engage in the possibilities of existence. Most of time, Dasein exists inauthentically, hiding from the reality of being towards death through the security that comes with being part of the crowd where Dasein no longer lives its possibilities thereby reducing the anguish of existence (Langdridge, 2007). Being with relates to the social nature of Dasein. For Heidegger, we are inescapably social beings, always in relation to the other, always being with (Kearney, 1994). Finally discourse, for Heidegger, is the way in which the meaning of the world is manifested for Dasein. The world and our being in the world is, in effect, intelligible through discourse. Further development of phenomenology by Professor Smith resulted in Interpretative phenomenological analysis (IPA) discussed below.

4.32 Interpretative Phenomenological Analysis

Jonathan Smith, Professor of Psychology developed interpretative phenomenological analysis (IPA), a critical realist approach which is rooted in hermeneutic phenomenology (Smith, Flowers & Larkin, 2013). IPA has rapidly become one of the best known and most commonly used qualitative methodologies in psychological research. IPA is concerned with the detailed examination of personal lived experience, the meaning of experience to people and how people make sense of that experience (Smith, 2011). IPA has its roots in phenomenology, hermeneutics and idiography and recognises that there is not a direct route to experience and that research is really about trying to be "experience close" rather than "experience far" (Smith, 2011). IPA is concerned with the detailed examination of human lived experience. It conducts this examination in a manner which enables that experience to be expressed in its own terms, rather than according to a predefined category system (Smith, Flowers & Larkin, 2013). This is what makes IPA phenomenological and connects it to the core ideas unifying the phenomenological philosophers discussed above.

IPA concurs with Heidegger that phenomenological inquiry is from the outset an interpretative process in that individuals experience cannot be plucked straightforwardly from their heads and it requires a process of engagement and interpretation on the part of the researcher. This ties IPA to a hermeneutic perspective. Larkin et al (2006) state that the two main aims of IPA include an attempt by the researcher to understand the participant's world and to describe what it is like and secondly to develop a more interpretative analysis which positions the initial description in relation to a wider social and cultural context. As with so many

qualitative methods, IPA can be easy to do badly, and difficult to do well as it demands that a number of rather testing “balancing acts” are maintained by the researcher (Larkin, 2006 pg 103). Smith (2011) describes IPA as a double hermeneutic, whereby the researcher is trying to make sense of the participant trying to make sense of what is happening to them.

IPA also pursues an idiographic commitment, situating participants in their particular contexts, exploring their personal perspectives, and starting with a detailed examination of each case in great detail before moving to more general claims. This involves a detailed analysis of each case followed by the search for patterns across all cases. IPA requires an intensive qualitative analysis of detailed personal accounts derived from participants. The aim is to learn about the participant’s cognitive and affective reaction to what they are experiencing. Smith (1996) believes in a chain of connection between embodied experience, talk about that experience and a participants making sense of, and emotional reaction to, that experience. IPA is concerned with analysing what participants say in order to try and learn about how they are making sense of their experience (Smith, 2011). Thus IPA is connected to each of the intellectual currents outlined above.

With IPA there is less emphasis on description and greater engagement with mainstream (principally social – cognitive) psychological literature. The focus of IPA is on how people perceive an experience and the meaning of that experience for them. The researcher does not enter the research process with a predetermined research hypothesis, however they will have a more general question that they wish to explore. The focus on experience and the meaning it has for the participants marks out IPA as

a phenomenological method. The aim of IPA is the detailed exploration of a participant's view of the topic under investigation however the role of the researcher is recognised through the way in which the analyst interprets a participant's understanding (Langdridge, 2007). Smith and Osborn (2003) also refer to the use of a double hermeneutic, with the researcher trying to make sense of the sense making activities of the participant. Studies are inductive, grounded in the data rather than pre-existing theory, and invariably idiographic, focused, initially at least, on a single case before moving onto other cases and more general knowledge claims.

4.33 Critique of IPA

In order to present a critique of IPA I am going to present and discuss the debate offered by Giorgi (2010) and Smith's (2010) defence of IPA as a research methodology. Giorgi (2010) argues that as phenomenology is a relatively new philosophy with some distinguishable features and that when social scientists base their research methods on that perspective, variations in methods can take place that are attributed to phenomenology but the variations are not necessarily consistent with the phenomenological perspective nor with good scientific practices. He acknowledges that while the practice of science may have a philosophical basis, the practices themselves are not identical to those of philosophy and that if a philosophy is to be applied to science then some modification is required.

Giorgi (2010) claims that the theory and practice of IPA developed by Jonathan Smith in the UK, has little to do with continental philosophical phenomenology. He argues that the originators of IPA have given no indication as to how their method is related to the method of philosophical phenomenology. He believes that it would be more

accurate to refer to their approach as Interpretive Experiential Analysis. Smith (2010) responding to Giorgi's (2010) critique states that the "sweeping" critique is only based on two book chapters and that Giorgi (2010) did not research and read fully the papers and texts related to IPA therefore his critique was not fully informed. He argues that IPA has theoretical underpinnings in phenomenology and hermeneutics and that this is discussed in a number of papers along with being extensively discussed in the book on IPA by Smith et al (2009) which Giorgi (2010) did not review or at the very least did not reference in his critique.

Giorgi (2010) argues that the fact that Smith and Osborn (2008) state that IPA is not a prescriptive method is an oxymoron since within science, all methods are meant to be intersubjective. Also within science results are correlated with methods which are why the research method is always carefully articulated in all research reports. This is to ensure that another researcher can evaluate the adequacy of the method and replicate the study if so desired. However if the method is not prescriptive and if a second researcher can adapt the method to his or her own way of working, then how can an interested party check the findings and replicate the study. He argues that not following a prescriptive method is poor science and goes against what a phenomenological scientific perspective would advocate (Giorgi, 2010).

Smith (2010) agrees with Giorgi (2010) that qualitative research should endeavour to be scientific and believes that IPA is scientific. However Smith (2010) states that he defines science differently to Giorgi (2010) and that the process within qualitative research may not be as prescriptive as quantitative research methods. He argues that conducting good IPA research requires the development of some complex skills –

interviewing, analysis, interpretation, writing, and researchers at different stages will have different levels of fluency and adeptness at these skills. It is the degree of proficiency in these skills which will influence the quality of the research carried out more than the conscientious following of procedures. Therefore Smith (2010) argues that he cannot be prescriptive in how to conduct a good interview and then analyse it. He can only offer guidelines to good practice based on his professional judgement and experience. In summary much depends on the quality of the skills of the researcher and how they follow the guidelines outlined. Smith (2010) argues that there are steps to follow however there is flexibility within these steps and that there are quality control criteria which help guide the researcher to conduct good work as well as the reader to evaluate it.

With regard to replication Smith (2010) argues that the majority of qualitative researchers do not view replicability as a criterion they aspire to or consider their work should be judged against because the construct derives from paradigmatic assumptions which do not necessarily apply in, or sit easily with, human science research. He argues that evaluating qualitative research using quantitative criteria such as replicability is inappropriate to qualitative inquiry as it is a complex, interactive, dynamic process and it is not clear exactly what one would be expecting to replicate. For example two highly skilled researchers could interview the same participant using the same interview guide and guidelines however interviewer B would not be expected or able, to replicate interviewer A. This does not mean that the interviews were not successful or scientific. Smith (2010) states that it is more appropriate to have the scientific basis of IPA assessed according to criteria that are appropriate to it,

rather than those which are not. He further maintains that once a method has been accepted, it should then be strictly followed.

Finally Giorgi (2010) states that IPA researchers do not have to account for all the raw data and argues that this licence fosters an unaccountable selectivity and heightens the chances of biased reporting of the results and such a procedure goes against what scientific results try to achieve. With regard to this critique Smith (2010) states that Giorgi (2010) presents replication and checking as the same thing however they are two separate issues. With regard to checking, Smith (2010) states that the reader should be able to check the results and how they came about and has written extensively on how to do this (Smith, 2003; Smith et al, 2009). Checking can be done at a number of levels. It can be checked by the academic supervisor of postgraduate students to ensure the students' analytic process has been systematically carried out and recorded. Also when reading a paper one can check that each theme presented has been supported with sufficient extracts from participants to illustrate both convergence and divergence in how the theme is manifested. Smith (2010) argues that Giorgi (2010) did not examine a completed piece of IPA research and therefore his critique was not fully informed.

To conclude, Husserl's work established the importance and relevance of a focus on experience and its perception. The founding principle of phenomenological enquiry is that experience should be examined in the way that it occurs, and on its own terms. Husserl maintained that all experiences should not be seen as individual pieces of information but more an expression of the essence itself. Epoche, phenomenological reduction and imaginative variation provide the method for identifying essences

(Langdridge, 2007). In developing Husserl's work further, Heidegger (1927) contributed to a view of the person as embedded in a world of objects and relationships, language and culture, projects and concerns. He moves us away from the descriptive commitments of Husserl, towards a more interpretative position with a focus on understanding our involvement in the lived world, something which is personal to each of us but which is a property of our relationship to the world and others.

Heidegger (1927) sought to examine what is – that is, what exists. He argued that it was not possible to investigate things in their appearing and identify their essence (structure) in a neutral or detached way. He believed that all people are inseparable from the world they inhabit and, therefore, it is not possible to bracket off one's way of seeing and identify the essence of a phenomenon, as Husserl proposed. IPA is an interpretative phenomenological approach and therefore Heidegger's explicit ascription of phenomenology as a hermeneutic enterprise is significant. Following Heidegger, IPA is concerned with examining how a phenomenon appears, and the analyst is implicated in facilitating and making sense of this experience. The aim of IPA is the detailed exploration of a participant's view of the topic under investigation however the role of the researcher is recognised through the way in which the analyst interprets a participants understanding.

4.4 Sampling

Purposive sampling was used in this study. In purposive sampling individuals are selected to participate based on their first hand experience with a culture, social process or phenomena of interest (Streubert and Carpenter, 2003). IPA researchers

employ fairly homogeneous samples (Smith, 2009). The sampling is therefore purposive rather than random, the aim being to gather detailed information about the experience of a fairly specific group on a fairly specific topic. Therefore this study had a sample size of eight participants (six women and two men). Smith (2011) argues that a sample size of eight participants is optimal in Doctor of Philosophy (PhD) studies to ensure that a detailed account of individuals' experience is obtained. He further argues that reduced participant numbers allows for a richer depth of analysis that could be inhibited with a larger sample (Smith, 2009). To ensure a fairly homogeneous sample as outlined by Smith (2009), inclusion criteria for the study were discussed and agreed with my academic supervisors.

The **inclusion criteria** for participants included the following:

1. Individuals who had experienced depression during their life which was identified by their doctor but are now in a state of recovery (recovered) as decided by the individual themselves

2. Individuals had experience of being on medication for depression at some stage

3. Participants had to be 18 years or older to participate

4.5 Negotiating Access to Sites and to Participants

Ethical approval was sought and granted from The Cork Teaching Hospitals Ethics Committee (Appendix 1). Following ethical approval been granted (Appendix 2), I contacted by phone ten general practice (GP) surgeries in the Cork and Kerry region to inform them of the study and ask permission to display the research poster

(Appendix 3) in order to recruit participants. I selected the surgeries from the phone book in major towns in Cork and Kerry including Cork city. The surgeries differed in the number of GPs attached to them with some surgeries having eight GPs and others having three GPs. I wished to contact and display the posters in large GP practices as there would be a significant number of individuals' attending. I then either sent the research posters to the practice for display or alternatively displayed the poster myself. Furthermore as I had worked in a number of GP surgeries and attended the primary care team meetings, a relationship of trust had been established with the GPs. Therefore, I was able to identify and make contact with the GPs of general practice surgeries necessary to access participants and gave them information (Appendix 4) related to the study in case potential participants enquired about the study. A poster (Appendix 3) with information about the study and contact details was posted in each of the surgery waiting rooms.

Fourteen individuals contacted me directly after seeing the poster and I went through the inclusion criteria with these over the phone and if the participants met the criteria, an information leaflet (Appendix 4) was sent to them providing details of the study and following this if they wished to participate, an interview date was scheduled. Of the fourteen who contacted me, eight met the inclusion criteria. Two calls were from family members asking about the study and expressed that they believed their mothers could participate in the study as they had experienced depression. I informed them to give my mobile number to them to contact me if they were interested. They did not contact me. Two more individuals stated they were currently experiencing depression so they did not meet the inclusion criteria. I did ensure that they had support before the phone call ended. The final two were experiencing mental health difficulties but

were not and had not experienced depression. Five of the participants contacted me themselves after receiving the information leaflet and we scheduled an interview. I rang the remaining three who I sent the information leaflet to and asked if they had received and read the information leaflet and if they wished to participate in the study. They agreed.

The semi-structured interview took place either in my place of work (quiet office) or a venue chosen by the participant such as their home (four participants choose this option). Access to the office was sought and granted from the Area Director of Nursing (Appendix 5). The participants were informed that participation was voluntary and that they could withdraw from the process at anytime. They were advised that interviews would be digitally recorded and that they were asked to provide written informed consent to participate in the study before the interview began (Appendix 6). Before written consent was obtained I went through the information leaflet again with each participant to ensure they understood fully what they were consenting to. Those agreeing to participate were interviewed using in depth interviews using an interview guide (Appendix 7). The interview guide was developed in collaboration with my academic supervisor. A lot of discussion and reflection emerged during the development of the interview guide as it needed to be based on the philosophical underpinnings of phenomenology.

4.6 Data Collection Instrument – Semi-Structured Interview

Data collection in qualitative studies is typically directed toward discovering the who, what, and where of events or experiences (Sandelowski, 2000). IPA studies predominately employ in depth semi-structured interviews to collect data (Smith,

2011). Therefore, after gaining permission from the hospital ethics committee and other relevant bodies, the data was collected using in depth semi-structured interviews (Appendix 7). A list of predetermined questions helped to give structure to the interview.

There was a well thought through rationale for using interviews in this study. Smith (2011) argues that IPA requires an intensive qualitative analysis of detailed personal accounts derived from participants and that the most common method of data collection is in depth semi-structured interviews. Interviews also provided a face to face encounter with respondents so large amounts of "expansive and contextual data" could be quickly obtained (Hughes, 2002). Finally as I am an experienced mental health nurse (12 years), a cognitive behavioural therapist (7 years) and a dialectical behaviour therapist (4 years), I have acquired a lot of experience in interviewing and working with individuals experiencing emotional difficulties. I have developed an ability to engage and build rapport with individuals experiencing emotional difficulties. This placed me in a good position to be skilful in obtaining the data required from the participants from the interviews. Smith (2011) argues that good interviewing skills are vital in IPA to acquire the data and that the researcher must be mindful of their interviewing skills and develop them if lacking. However, interviewing does have its challenges. Interviews can be sometimes difficult to conduct and manage, require a lot of time (Bell, 1999) and is vulnerable to interviewer bias (Kvale & Brinkmann, 2009). Bearing these in mind, I ensured that there was adequate time allowed for the interviews along with adequate time for any set backs that may arise during the research process.

Wengraf (2001) suggested that the ideal research participant needs to be thoughtful and reflective. The success (or failure) of an interview may also hinge upon the presence (or absence) of interpersonal chemistry between researcher and respondent (Wengraf, 2001). The interviewee may give a misleading impression, which is not necessarily intentional (Hughes, 2002) and as the researcher I was alert to the possibility of influencing the participants responses (Hughes, 2002). I was mindful of any signs that this was occurring through the use of reflexivity of the "natural attitude". The adoption of a phenomenological attitude where our habitual, taken for granted understanding are bracketed off (Finlay, 2008) further enhanced my skill in conducting the interviews. I was aware of not allowing my understanding of models of depression and my experience working with individuals who experience emotional difficulties lead to certain questioning or avoidance of further enquiry due to the participant accounts aligning with my existing understanding of depression. Heidegger (1927) argued that it was not possible to investigate things in their appearing and identify their essence (structure) in a neutral or detached way. He believed that all people are inseparable from the world they inhabit and, therefore, it is not possible to bracket off one's way of seeing and identify the essence of a phenomenon.

I was very aware of this before, during and after I conducted the interviews. For this study, Heidegger's view point was considered more realistic as it is difficult not to be impacted by one's own assumptions and beliefs. However in this study through the use of reflexivity and adopting the phenomenological attitude, I did in so much was possible attempted to bracket off any presuppositions I had throughout the interview process about the knowledge I had acquired over the years as a practitioner in mental

health. This was necessary to ensure that the findings of the study reflected the experiences of the participants therefore during the interviews I was aware of the beliefs and knowledge I held as a result of practicing as a mental health practitioner. I achieved this through the use of reflexivity.

Reflexivity in qualitative research involves researchers turning a critical gaze towards themselves. It involves examining how the researcher and intersubjective elements impact on and transform research (Finlay & Gough, 2003). It involves researchers describing the decisions and dilemmas encountered in their fieldwork experience. Reflexivity can be utilised to continually monitor and audit the research process in qualitative research. It is a means of transferring personal experience into public (and so accountable) knowledge (Finlay & Gough, 2003). Within qualitative research, the researcher is a central figure who actively constructs the collection, selection, and interpretation of data. The research is co-constituted, being a joint product between the participants, researcher, and their relationship (Finlay & Gough, 2003).

I was mindful to leave my professional knowledge, models relating to mental health difficulties and diagnostic criteria to one side and explore the meaning of depression to the participants' in the study. This was achieved through reflexivity, discussion with academic supervisors and being mindful of my own thought processes and internal emotional experiences and taking a stance that I had never heard the word depression before and I was attempting to learn about an experience I had no prior knowledge of. I would say to participants' that they were to view me as a person who was not from this planet and had never heard the word depression and had no lived experience of it or anyone in my world. I informed them that I may ask questions

where the answer may appear obvious but the purpose of asking was to ensure that I did not make any assumptions.

I also practiced this approach prior to the interviews being conducted as part of my work as an Advanced Nurse Practitioner in Psychotherapy and also in my personal life thereby developing my skill and awareness (through reflexivity) to allow me to do this while conducting the interviews. I achieved this through practicing mindfulness for the past five years and part of this practice is to learn to notice any judgements I make about others, situations, experiences and myself and once I notice them to describe instead of judging. For example, when I heard a participant express that they felt hopeless about the future; I could make a judgement (mindfulness terminology) such as “That is part of depression”. In mindfulness practice this would be conceptualised as a judgement. Others would describe it as a thought. However, using non-judgemental stance as part of mindfulness I would just describe “Laura has expressed that she is feeling hopeless about the future because she is currently feeling very sad” which would be her own words. This then allowed me to explore what hopelessness meant to her and what the lived experience of hopelessness in the context of experiencing depression was like. I found this skill very effective in conducting the interviews because when I noticed a judgement I would describe and seek further clarification as I never presumed to know the meaning participants attributed to their experience.

4.7 Procedure

In qualitative research data collection from a sample is often in their natural environment in order to create a relaxing, non-threatening environment (Kvale &

Brinkmann, 2009). In keeping with the ethos of qualitative methodology, the area selected was a private room (my office) or a venue chosen by the participant such as their home (four participants requested to be interviewed in their home). Tea and coffee facilities (I made the tea and coffee) were made available to create a comfortable relaxed environment in my office. Prior to commencing each interview, I re-explained the purpose of the study, informed the participant that they could withdraw from the interview at any point, answered any questions the participant had and finally gained written consent from each participant (Appendix 6). To ensure an effective interview, I ensured that all equipment was present and functioning correctly prior to commencement. Audibility of respondent's data was obtained by testing the digital recorder. Before recording commenced, I explained why the interviews were been recorded to the participants as advised by Martin (2002).

Twelve interviews were conducted with eight participants. The interviews lasted between 40 and 72 minutes. Four participants were interviewed on two occasions with a week between interviews. These participants were interviewed twice as they brought much in-depth information to the interview and the researcher was unable to complete the interview guide in one interview. I had emailing Professor Smith with regard to conducting more than one interview with participants if necessary before I conducted the interviews for guidance. He stated that if conducting more than one interview added to the study then that was acceptable. Flowers (2008) argues that it is advantageous to interview participants more than once in IPA studies as the researcher can become aware of lost opportunities and a second interview enables the researcher to gain greater clarity and richness from the interviewee. Active listening was also employed and sustained throughout the interview (Kvale & Brinkmann,

2009). Non-verbal support (such as a friendly smile and an open posture) was delivered in an unobtrusive way, allowing participants to relax. I sought to use open body language to ensure that participants felt comfortable during pauses and silence that occurred at times during the interviews. One participant became tearful during the interview. I had reflected about this occurring before the interview taking place so I felt comfortable in supporting the participant during the interview. I was also familiar with individuals becoming emotionally upset when expressing difficult situations in their lives in my work. I allowed the participant to express herself and asked open questions to ascertain what she was experiencing at that time. She stated that she felt relief in telling her story/ experience of depression and that she had never communicated her experience in one communication before and that she found that very cathartic.

Following each interview, I thanked the participant and asked them if they had any questions or concerns with regard to the interview. No questions or concerns arose. I also informed them that if they became distressed at any time following the interview to contact me and we could meet to discuss their experience. No participants expressed any adverse consequences following the interviews. I did receive text messages from seven participants thanking me for the opportunity to express their experience and how they had found the experience very positive in that it brought their experience to a close and helped them to acknowledge where they had come. Digitally recording the interviews allowed me to obtain an accurate, verbatim account of the interview which has a key advantage over other methods of data collection (Polgar and Thomas, 1995).

4.8 Data Analysis

The purpose of data analysis is to impose some order on a large body of information so that some general conclusions can be reached and communicated in the research report (Polit and Hungler, 2008). According to Thorne (2000) data analysis is the most complex and mysterious of all phases of qualitative research. Priest, Roberts and Woods (2002) state that the aim of data analysis is to cast light on the experiences of participants. Rapport (2005) suggests that different disciplines approach qualitative research in different ways; for example he notes that nursing has been a sympathetic audience to interpretative phenomenology. However in saying that, Crotty (1996) argues that nurse researchers may not be doing phenomenological research justice as they may be taking a superficial view of this methodology and thereby not utilising these methodologies accurately. This in turn impacts on the quality of the phenomenological research been conducted by nurse researchers. Smith (2011) also argues that there is an apparent lack of understanding in both students and supervisors that IPA is primarily an interpretative approach. This misconception, accompanied by a lack of confidence in raising the level of interpretation in analyses, results in broadly descriptive IPA that lacks depth and therefore demonstrates little difference to a standard thematic analysis. He argues that this does not represent good IPA (Smith, 2011).

Being mindful of the critique presented above I took the following steps. First hand account work on Heidegger (1927) and Husserl (1859-1938) along with the work written by Jonathan Smith (2009) on Interpretative Phenomenological Analysis were read. Also I attended a workshop on phenomenological research by an experienced and well published phenomenological researcher, Dr Linda Finlay along with

attending a qualitative research summer school in Dublin City University which included utilising IPA as a research methodology. I attended a phenomenology conference titled “Phenomenology, Aesthetics and the Arts” which highlighted the impact of imagery and meaning through images and pictures art in a persons experience and how these images can represent meaning and help the person make sense of and communicate their experience. I also developed an IPA checklist (Appendix 8) from reviewing Smith’s (2009) work on IPA along with incorporating other phenomenological concepts in order to deepen the analysis further. Finally I utilised Smith’s (2011) IPA evaluation guide (Appendix 9) throughout the analysis to ensure that I was staying as close to IPA methods of analyses as possible. In doing the above, I reduced the risk of conducting poor phenomenological (IPA) research.

The interviews were transcribed verbatim with the omission of identifying names and places to ensure anonymity. As I was concerned with making sense of the participant’s world I spent a considerable amount of time working through the transcript and listening to the recording in order to identify the major themes. The analysis began with a single case and proceeded through the following stages.

4.81 Data Analysis Process - Interpretative Phenomenological Analysis

The aim of this method of analysis was to produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system (Smith, 2013)

Stage 1: The participants’ interview transcripts were read and re-read. This process enabled me to become immersed in the data.

Stage 2: Initial noting was the next stage of the analysis. This involved reading through each participant's interview transcripts and writing descriptive (normal text), linguistic (*italic text)* and conceptual comments (underlined text) at the right hand side of the transcript (Appendix 10). This was a very slow process. Descriptive comments involved analysing the transcript to identify key words, phrases or explanations which the participant used. This part of the analysis very much took things at face value and highlighted the objects which structured the participant's thoughts and experiences. The linguistic comments were concerned with language use and the transcript reflected the ways in which the content and meaning was presented. Here I paid attention to pauses, functional aspects of language, repetition, and degree of fluency. Metaphor was particularly important here as metaphor was the linguistic device that linked descriptive comments to conceptual comments. Finally conceptual comments addressed the transcript at a conceptual level and were more interpretative. This was a slow process and required a lot of personal reflection on my own understanding and the new emerging understanding. I was mindful here of Smith (2009) guidance in that "one is using oneself to help make sense of the participant, not the other way around. If you start becoming more fascinated by yourself than the participant, then stop, take a break – and try again" (Smith 2011, pg 90).

In order to deepen the analysis I developed an IPA data analysis checklist (Appendix 8) which listed the stages of the analysis process along with listing the phenomenological concepts such as embodiment, temporality, spatiality, sociality, selfhood, project, discourse and mood as discussed earlier. This ensured that I was mindful of incorporating phenomenological concepts into the analysis. I also wrote

out “reminders” (Appendix 11) of the process and taped them on the wall in front of me so as to be visually reminded of the process on a continuous basis. Finally along with having my checklist (Appendix 8) I also had Jonathan Smith’s (2011) IPA evaluation guide (Appendix 9) at hand throughout the analysis process to ensure accuracy.

Stage3: Development of emerging themes was then noted in the left hand margin of the same transcript so a layered document was being developed with the emergent themes being developed from both the transcript and the comments which were on the right side of the document (Appendix 12).

Stage 4: Emergent themes were then listed separately on paper in their original chronological order (Appendix 13). The emergent themes were then separated from each other by cutting up the list into separate themes. They were then spread around on the floor and themes which represented similarities were grouped together. This process of looking for patterns and connections across emergent themes (Appendix 14) was completed via abstraction (like with like), subsumption (emergent theme itself acquires a super-ordinate status as it helps bring together a series of related themes), polarisation (oppositional relationships), contextualisation (identifying the contextual or narrative elements), numeration (frequency of emergent theme), function (theme examined for their specific function within the transcript). During this process I continually returned to the text to check the emerging analysis.

Stage 5: Each of the above stages was completed for each participant one case at a time. I was mindful to treat each case in its own terms. This meant bracketing the

ideas emerging from the analysis from the first case while working on the second and so on until all eight cases were completed.

Stage 6: This stage involved looking for patterns across cases. The tables were spread out on the floor examining them for connections and identifying what themes were most evident. This led to the relabeling of some themes. The next step involved presenting a table of super-ordinate themes and sub ordinate themes in a coherent order. The themes were named and linked to the originating text through reference to specific quotes via page and line numbers (Appendix 15).

All sections were then filed together for direct reference when writing up the findings. A table was developed to identify whether or not the super-ordinate theme was present for each participant (Appendix 16). All super-ordinate themes were present for all participants. Copies of the complete interview transcripts were kept during the writing up stage as were the original digital recordings. This was done in order to refer back throughout when anything appeared unclear during the writing up stage of the project. Following this the writing up process took place and the transcripts were referred to throughout this stage. I started with the first section, selected various examples of data that were filed under that section and a commentary was offered to link the examples moving from a empathic phenomenological description to a more critical and interrogative analysis of the extracts in line with IPA. Each section followed the same process until the project was written up. Finally I discussed the findings in relation to the literature on the topic of individuals experiences of depression.

4.9 Rigour

The research base of any professional activity needs to be rigorously evaluated if it is to contribute to the advancement of knowledge and practice (Andrews et al, 1996). According to Koch (2006) the responsibility lies with the writer to show the way in which a study attempts to address the issue of rigour. It is for the reader to decide if the study is believable or not. Davies et al (2002) argue that the description, "strict enforcement of rules" is closest to capturing what we conventionally mean by the application of rigour in the research process. In other words, there is some kind of systemized, ordered, and visible approach to research methods.

Qualitative research is often criticised for lacking scientific rigour in that it is vulnerable to researcher bias, it lacks reproducibility and generalisability. Koch et al (1998) claim that the integrity of the research process can be protected by attending to the issues of objectivity and generalisability and their use as evaluation criteria and highlight that the most commonly heard criticism is that qualitative research is anecdotal, impressionistic, and strongly subject to researcher bias. Koch et al (2006) and Smith (2010) argue that qualitative research cannot be reproduced and that there is no guarantee that another researcher would not give an entirely different account.

In saying that I believe as does Smith (2009) that as human beings we understand and interpret events in our world in a unique and personal way and how we make sense of our experiences depends on many factors including childhood experiences, culture, society, and language. Therefore the way we attribute meaning to our experiences will also depend on my own input in extracting the information from the research participant therefore it is possible that depending on the researcher it is possible for

different data to emerge. However I do not view this as a limitation of qualitative research but more of a strength as it demonstrates the complexity of human experience and highlights mankind's attempt to understand human experience while acknowledging that there are potentially endless interpretations depending on what factors impact on the individual's experience. This is not to say that the qualitative researcher throws caution to the wind and does not adhere to the research process. On the contrary they seek to utilise various methods such as reflexivity, and audit trails to ensure rigour is maintained (Koch, 2006, Smith, 2009, Smith, 2010).

According to Clayten et al (2000) throughout a qualitative study, a researcher must demonstrate its rigour, by establishing trustworthiness. Issues concerning validity and reliability take on different meanings in the qualitative paradigm. Ely et al (1991), Wheeler (1992), and Smith (2009) suggest that these terms are inappropriate in qualitative inquiry. To establish trustworthiness Guba and Lincoln (1989) appeal to the criteria of credibility, transferability, confirmability and dependability. They maintain that a study is credible when it represents faithful descriptions and when co-researchers or readers confronted with the experience can recognize it. The researcher should be able to show how each theme was derived from the descriptions, which can be achieved by returning to the original text to make sure all conclusions are firmly grounded in the data or explained by the researcher's interpretative scheme (Koch, 2006). The rigor of this study was discussed in terms of credibility, transferability, confirmability and dependability.

4.91Credibility

As with so many qualitative methods, IPA can be easy to do badly, and difficult to do well therefore it demands that a number of "balancing acts" are maintained by the researcher (Larkin et al, 2006 pg 103). Some of the techniques that can be used to ensure a study is trustworthy or credible include; peer debriefing/review, audit or decision trail, triangulation, thick description, clarifying researcher bias, reflexivity, prolonged engagement and field journal (Smith, 2009, Creswell, 1998, Lincoln and Guba, 1985, Cutcliffe et al, 1999, Clayton et al, 2000, Koch, 2006 and Davies, 2002). Creswell (1998) believes that at least two of the techniques mentioned above should be used to ensure a study is trustworthy and credible. The techniques used to ensure this study was credible which looked at exploring individuals' experience of depression included the following; clarifying researcher bias which was achieved through regular discussion and supervision with my academic supervisors, peer review, keeping a decision or audit trail and reflexivity. I also utilised Smith's (2011) IPA quality evaluation guide (Appendix 9) to ensure that the research utilising IPA was robust and of good quality as outlined directly by the Jonathan Smith who developed IPA.

4.92 Dependability

I was aware that conducting research in an area in which I had a lot of pre-existing knowledge and experience, I may bring my own values and beliefs pertaining to depression, thereby giving rise to bias which could challenge the trustworthiness of the study. This was overcome by engaging in peer debriefing and clarifying researcher bias with academic supervisors and through reflexivity. Smith (2009) maintains that when researchers are generating themes from qualitative data, they can enhance

against researcher bias by enlisting the assistance of research colleagues or in the case of a doctoral student, discussion with their academic supervisors. In light of this and the fact that the researcher was conducting interviews with individuals who experienced depression, interpretations of the information/ themes was shared with my academic supervisors as this gave me the opportunity to challenge the robustness of emerging categories/themes. By engaging in this activity, issues or patterns that were missed were highlighted by my supervisors. Furthermore, by explaining the logic behind the choices that were made and the reasons for one line of enquiry and not another, the researcher was assisted towards a more reasoned and complete interpretation. This process led me in becoming much more tentative in the analysis and presentation of findings. Kvale & Brinkmann (2009) refer to this technique as peer debriefing. They suggest that from the point of view of credibility, the process helps to keep the inquirer "honest" exposing him or her to searching questions by an experienced protagonist doing his/her best to play the devils advocate. The inquirers biases are probed, meanings explored and the biases for interpretations clarified. All questions are in order during a debriefing, whether they pertain to substantive, methodological, legal, ethical, or any other relevant matters. Therefore by engaging in the debriefing process with my academic supervisors, the research became more trustworthy.

4.93 Confirmability

Confirmability requires one to show the way in which interpretations have been arrived at via the inquiry (Koch 2006). Self-awareness of the researcher is essential to the credibility of the study. One way of increasing self-awareness is to keep a journal in which the content and process of interactions are noted, including reactions to

various events (Koch, 2006). Leaving a decision or audit trail entails discussing explicitly decisions taken about the theoretical, methodological and analytic choices throughout the study. Koch (2006) recommends that researchers leave an audit or decision trail so that the pathway for decisions made in the data analysis can be checked by another researcher. Beck (1993) argues that trustworthiness (rigour) of a study may be established if the reader is able to audit the events of the study. Koch (2006) conducted a study expressing the concerns of older patients in two care of the elderly wards in the United Kingdom. She maintained an audit/decision trail by keeping a field journal. The researcher maintained an audit trail in the same manner by keeping a field journal also. The journal was divided into six sections: access (process of entry into the GP surgeries), setting (office used/ participant's home), experiences (my direct experiences), issues (any issues that affected my research such as participants cancelling scheduled interviews or difficulty contacting GP's) participant as co-researcher (to explore the notion of participants as co-researchers in the sense that this study would rely on their co-operation) and prejudice (how previous experiences, cultural, personal and professional might affect how the data was interpreted). I made journal entries when anything arose in the course of the study, whether it was difficulties gaining access to the participants or sites, how the interviews were conducted, data analysis or any experiences with the participants. Any difficulties that arose were also discussed with my academic supervisors. All interactions in the research process were seen as equal and important and were included in the journal to ensure an accurate audit/decision trail was maintained. This process resulted in the development of an IPA analysis checklist (Appendix 8) used in the analysis phase.

4.94 Transferability

According to Holloway and Wheeler (2002) transferability is evident when the research findings can be applied to other settings and populations. Transferability of the study's findings was reinforced through the use of purposive sampling and by using the participant's narratives to illustrate the themes thus transferability of the findings was increased. Smith (2011) states that repeating the study with participants with different characteristics could offer further understanding of a phenomenon. For example repeating this study with a sample from a different socio economic group may result in different findings adding more to our understanding of the experience of depression.

4.10 Ethical Considerations

Ethical approval was sought (Appendix 1) and granted (Appendix 2) from The Cork Teaching Hospitals Ethics Committee. Throughout the entire process of this research study the researcher was always aware that the research study was of a sensitive nature, therefore the consideration of ethical issues was required at every stage. In order to maintain ethical integrity, each of the ethical principles (autonomy, beneficence, non-maleficience, and justice incorporating respect, confidentiality and informed consent) were addressed at each and every stage of the research process.

4.10.1 Autonomy.

Autonomy is related to people's freedom to determine their own actions, respect and the protection of confidentiality and anonymity (Beauchamp & Childress, 2013). Participant's autonomy was respected throughout this study. All participants were

given sufficient information in order for them to make an informed decision to participate in the study. Participants were not coerced into taking part and all were given sufficient time to consider whether they wanted to participate or not. Informed consent was obtained before any of the interviews were conducted. Participants were informed that they could withdraw from the process at any time. Kvale & Brinkmann (2009) state that a generally accepted ethical position is that subjects should be free to participate or withdraw from participation without recrimination or prejudice. Also they were informed that they could withdraw any of the information they had provided. Respect for each participant's anonymity and privacy was paramount. Confidentiality was ensured for all participants by withholding names and coding all data. The data collected and the arrangement of the findings did not identify participants. To ensure confidentiality each subject was given a code linked to a pseudonym, e.g. Individual 1 (I1) (Derek). The master list with the names and code were kept separately from the data in a locked cabinet. I was the only person with access to this filing cabinet. The true identity of participants was only known to me. All information is held on a computer and has a password to access information in the researcher's home. All data kept on hard copy was stored in a locked drawer. Transcripts and recordings of the interviews are kept in a locked drawer and on a password protected laptop. Prior to each participant's involvement in the study they were made aware that all interview data would remain confidential except if the researcher believed that the participant or another person known to the participant was in any danger. Then I was obliged to inform the appropriate bodies. This was also stated in the consent form which each participant signed.

4.11.2 Beneficence.

The principle of beneficence refers to only “doing good” when dealing with participants (Rumbold, 1999). With beneficence, according to Beauchamp and Childress (2013) the benefits of a research study need to outweigh the potential for harm in every case. Participants were informed that there were no immediate risks or benefits for participating in this study. It was hoped that this study would contribute to the body of knowledge on individuals’ experiences of depression in order to inform how mental health clinicians work with those experiencing depression. Furthermore it was hoped that this study would lead to an in-service training programme for staff working with clients experiencing depression thereby leading to more evidence based practice. Finally through dissemination of this study’s findings, mental health clinicians could become more aware and informed when caring for clients experiencing depression.

4.10.3 Non-maleficience.

This principle relates to the researcher not causing harm to the participants in any way. In qualitative research, as the participants relate their experiences this may expose them to emotional distress especially when discussing their experience of depression. In order to minimize this risk, participants were informed that they could withdraw from the interviews at any time. Furthermore they were informed that they could receive counselling from me following the interview if required. As I am a registered mental health nurse and accredited Cognitive Behavioural Psychotherapist I felt that I was equipped to address any emotional distress experienced by the participants. I was very aware that this would be a different role than that of a researcher. I believed that as the participants agreed to talk to me regarding the

research, if they became emotionally distressed and I then advised them to talk to another person (psychotherapist) it could adversely affect the participant/ researcher relationship. I also believed that as the research was a co constructed piece of work, so should the process involved in unearthing the data which may have resulted in emotional distress by either party.

In saying that, the participants understood that if they became emotionally distressed we would stop the interview at that time and all participants agreed to that. However on further reflection, having another psychotherapist available to provide support if participants became distressed could have been helpful. This would have ensured that the emotional support role and researcher role were kept separate. With regards to emotional support for me as researcher, I received emotional support from my academic supervisors throughout the process. Finally to reduce the risk of causing harm to the participants, ethical approval was sought and granted from The Cork Teaching Hospitals Ethics Committee (Appendix 2).

4.10.4 Justice.

Beauchamp & Childress (2013) state that the principle of justice requires that people be treated in a fair way. I upheld this principle by treating all participants in the same manner, ensuring they all had the adequate information needed to part-take in the study and that all were given enough time to decide whether or not they wanted to participate. Furthermore all were treated equally during the interview stage and all participants right to confidentiality and anonymity were respected.

4.11 Conclusion

A qualitative, phenomenological (IPA) methodology was used in this study as I aimed to explore individual's experience of depression. Participants were selected by placing research posters in GP surgery waiting rooms and individuals who had experienced depression contacted me if they were interested in participating in the study. Negotiation to the study sites was accessed through the GP's. Ethical approval was sought and granted. Following ethical approval general practitioners (GP) of the surgeries were contacted by me in order to access participants by placing a research poster in the surgery waiting rooms. Following ethical approval written permission was sought and granted from the Director of Nursing where the researcher was employed in order to access my office if required to conduct the interviews with the participants.

Data was collected using in-depth semi-structured interviews and analysed using an IPA framework of thematic analysis. Finally the rigor of this study was discussed in terms of credibility, transferability, confirmability and dependability. Various techniques were undertaken to ensure trustworthiness of the study. These included the following; clarifying researcher bias, peer review, keeping a decision or audit trail, keeping a journal and reflexivity.

Chapter 5

Presentation of Findings

5.1 Introduction

This chapter presents the findings that emerged from the interviews conducted and subsequently analysed using Interpretative Phenomenological Analysis (IPA). Following a rigorous analysis process of twelve interview transcripts, informed by Smith et al (2009), data was broken down into four recurrent super-ordinate themes which related directly to how individuals made sense of their experience of depression. The super-ordinate themes that emerged from the analysis included: The Descent; The World's Conversations and Me - Engagement with Social Discourses; Broken Self - Transforming the Self; and Embracing myself and my Mind - Transformation of the Self. The super-ordinate themes are expanded further in table format (Table 2.0) below:

Table 2.0: Master Table of Themes	
Super-ordinate Themes	**Subordinate Themes**
The Descent *"It felt like I was in a world where there was a constant dark black cloud everyday over me … it was just awful…so dark with no way out"*(pg 4, line 77).	**Drowning in my Experience** *"I felt like I was under water most of the time not able to breathe and then every time before I could die I was allowed up for air just enough before I would go under the water again"* (pg 4, line 71). **Imprisoned by Fear** *" … being in bed at night, being in the dark and totally scared to death literally thinking totally hopeless and having this pain in my chest and crying and not being able to sleep …"* (pg 9, line 232).
The World's Conversations and Me - Engagement with Social Discourses *"… the doctor described it was serotonin in my brain and that because I was just draining myself physically of the chemical that I was so low I wasn't able to reproduce this happy mood, good hormone, chemical or whatever it is. I needed something to take, to boost that again and he said once that was boosted you begin to think clearer"* (pg 4, line 107).	**Society's Conversations** *"I never understood what was happening to me really. Em, I just thought I was going through a rough time. I didn't realise there was em, there was an actual word or a diagnosis for it so the wrong thing to do was I looked up on the internet"* (pg 2, line 35).
	Disconnection from Self *"Well I kind of knew what brought it on but I couldn't understand how I wasn't able to get rid of it. I couldn't understand why it just wouldn't go away. …I actually thought it was something going on physically in my brain, a mental disease that I was going to be stuck with forever"* (pg 8, line 261).

Broken Self - Transforming the Self *The fear of failure and when that happens, you've failed to keep it together in your body, in your mind everything and (its) just out there … "I'm a failure"* (pg 7, line 176).	**Unknown self - Loss of self and one's identity** *"(others) might not have any contact with me or they wouldn't kind of view me the same as they would have done before or they would look at you kind of strange thinking you know "your one's not fully there, we cant have anything to do with her" you know"* (pg 9, line 289).
	Desperate for a Way Out *"I suppose for me it (depression) was em, ah, a loss of control"* (pg 1, line 22).
	Conflict with self and what's known *"Well I kind of knew what helped bring it on but I couldn't understand why it wouldn't go away … I actually thought it was something going on in my head that I was going to be stuck with forever"* (pg 8, line 259).
Embracing myself and my Mind - Transformation of the Self *"I live my life now everyday because I was living months in advance, what if, what if and I was getting hysterical and totally putting my body into total overdrive … it's just all about helping yourself" (pg3, line78).*	**"I began to smell the coffee again" - Recovery** *"My sleeping pattern improved, I would sleep very well at night …I felt brighter in the morning, people would say to me "you look happy today" …putting on weight"* (pg 19, line618). **Letting Go** *"…you have to learn to trust yourself and learn to accept yourself. I struggled with that for years and years … cos I would not trust myself … and where I am now compared to where I was then and that's pretty cool" (pg 13, line 432).*
	Connectedness *"I think a spiritual connection is vital in people's psyche for emotional wellbeing … being connected to something bigger than yourself"* (pg 40, line 1355).
	Re-evaluation of Life and Self *"And then when I started learning that this (depression) is only a piece of me, it is not all of me. And then I start learning well what else do I do in my life" (pg12, line 302).*

It is acknowledged that the themes presented are one possible account of individuals' experience of depression. It is further acknowledged that the findings presented are based on my interpretations and that other researchers may have focused on different aspects of the participants' account of their experience of depression. Quotations from the interviews are used to describe and illustrate the themes. The reiterative process respected convergences and divergences across all eight participant accounts of their experience of depression.

To improve readability missing material is indicated by dots (…), and where material has being added to explain what a participant is referring to is presented within brackets ( ). Dots at the beginning or end of an extract indicate that the person was talking prior to or after the extract. All identifying information has been removed or changed and pseudonyms used to ensure participant anonymity.

5.2 Study Participants

Firstly the demographics and biographies of the participants are presented to put the findings in context and to allow the reader to gain a sense of the eight participants who volunteered to participate. A purposive homogeneous sample was utilised in this study in line with IPA research as outlined in the methods chapter. Six women and two men took part in the study. Four of the participants were between the age 30 and 39; two participants were between the age 40 and 49, and two between the age 50 and 55. All participants were from a middle socioeconomic background as defined by Gilbert (2008). Two participants own their own business, while the rest of the participants are employees. All participants are home owners. Five participants are

married with four participants having children. A short biography for each of the participants is presented in Table 2 below:

Table 3.0 Participant Biography

Participant Biography
Derek Derek is a 35 year old married man with two children. He works as an accountant and described enjoying his work overall. He has a good relationship with his wife and children and described his family as been very important to him. He described experiencing depression twice in his life; the first experience was following a girlfriend ending a relationship. He found this very difficult to accept and attended his general practitioner who diagnosed him with depression and prescribed him antidepressants which he took but felt that they did not help him as he noticed he felt physically worse taking them so he ceased taking them. He experienced depression more recently when his wife became redundant from her job. They were under financial difficulties which subsequently resulted in Derek experiencing increased emotional distress however at the time of the interview Derek was not experiencing emotional distress.
Sophia Sophia is a 40 year old married lady working as an executive assistant in an education setting. She described a loving supportive relationship with her husband whom she met three years ago. They did not have children at that time although stated she would love to start a family. She enjoyed doing charity work and was studying to work with the elderly. She experienced depression in the past due to interpersonal difficulties in

her workplace and attended her GP who stated that she was experiencing depression and prescribed antidepressants for her and recommended that she attend counselling which she did. She subsequently left her workplace as she acknowledged that it was not a good environment for her emotionally and recovered.

Laura

Laura was a 36 year old married lady who works in a bank. She has three small children whom she finds challenging at times. She used to work fulltime in the past but worked part-time at the time of the interview as she believed it was very important that a mother spend as much time as possible with her children. Laura described experiencing depression twice in her life, the first time when she was assaulted ten years ago and again three years ago due to increased demands on her time and financial difficulties. Although she experienced depression in the past she did not understand what she was experiencing as depression until her GP diagnosed her as been depressed and recommended she attend counselling. She enjoys running, socialising and spending time with her children and husband as a family.

Alicia

Alicia is a 50 year only single lady who worked as a general nurse at the time of the interview. She owns her own home and enjoys travelling and socialising with friends. She enjoys swimming, learning about nutrition and complementary therapies such as Reiki. She has experienced depression as diagnosed by her GP and psychiatrist on several occasions throughout her life and felt she understood and managed her emotional health much better over the past four to five years. She described being more accepting of herself and felt she had let go of painful past experiences which had resulted in her recovery. She had been on antidepressant medication in the past

but was not on antidepressants at the time of the interview.

Luke

Luke is a 55 year old married man with three adult children. He owned his own business which went into liquidation in 2009. He stated that this triggered him experiencing depression. He stated that he also experienced depression about 20 years ago when another business of his had to be sold to pay debts accrued. He stated that he had now come to terms with the loss of his business and had begun work on developing another business. He described a good relationship with his wife. His children had left the family home and all worked. He had become increasingly interested in mental health awareness and psychotherapy since his experience of depression and reads extensively on the topic in his spare time.

Jackie

Jackie is a 38 year old single lady who works as a legal executive. She owns her own home and enjoys decorating it. She was also studying to be a counsellor at the time of the interview on a part-time basis and was very much enjoying it. Jackie first described experiencing depression following the end of a relationship which was diagnosed by her GP. Jackie then stated that she again experienced depression in the last few years as a result of been bullied at work by her boss. She after a long period of time resigned from this job and secured employment in another firm. Jackie took antidepressant medication following the first episode of depression however opted for counselling on the second occasion as she believed she needed to address what was happening to her at the time.

Isabella

Isabella is a 37 year old single lady who works as a graphic designer with a newspaper. She enjoys her job very much although does not like working nights which she has to do as part of her work. She enjoys reading and tries to spend time with family and friends when she can. She began experiencing depression following the end of a long-term relationship and described the relationship as unhealthy but could not see that at the time. She acknowledged that now and stated that it took her a long time to view the relationship in that manner but felt fortunate that she was no longer in that relationship. She experienced depression on several occasions following this relationship and was commenced on antidepressants by her GP. She also received counselling which she described as helpful in her recovery. She very much enjoys decorating her home which she last did following bad flooding.

Rebecca

Rebecca is a 42 year old married lady with three teenage daughters. She described her relationship with her husband whom she has been with since her early 20's as good. They run a small business. Since the recession, finances have being more difficult and Rebecca returned to the workplace. She began experiencing stress at work due to the increased demands that were placed on her. As a result she began experiencing depression as diagnosed by her GP. She subsequently resigned from the job to focus on her recovery which was supported by her family and felt it was the best decision she made as she enjoys life again and spending time with her children and husband.

With a greater understanding of the participants' in this study presented above I will now present the findings of the study below.

5.3 The Descent - *"It felt like I was in a world where there was a constant dark black cloud everyday over me … it was just awful…so dark with no way out".*

This theme emerged through the use of metaphor in expressing participants' experience of depression and their attempt to describe, understand and communicate their account of depression to both the interviewer and themselves. As hermeneutics involves interpretation of text the super-ordinate theme that emerged; The Descent – "It felt like I was in a world where there was a constant dark black cloud everyday over me … it was just awful … so dark with no way out" developed from the subordinate themes; 'drowning in my experience' and 'imprisoned by fear'. The extracts from participant accounts are presented to demonstrate a layered interpretation by moving from a phenomenological, empathic account which described individuals' experience to a critical and interrogative analysis of their experiences of depression. A phenomenological reading of participants' experience identified that all participants were overwhelmed by their experience and all participants expressed this experience through the use of metaphor and imagery.

Derek and Alicia when describing the emotions associated with their experience used the following water metaphor:

Derek: *"I felt like I was under water most of the time not able to breathe* (referring to the emotions he experienced) *and then every time before I*

could die I was allowed up for air just enough before I would go under the water again" (pg 4, line 71).

Alicia: *"… I was just too drowned in the feelings of the pain (sadness)…"* (pg 7, line162)

Derek and Alicia struggled with the overwhelming emotions they were experiencing. There is a sense that there was an unfair element to this experience for Derek in his description *"every time before I could die I was allowed up for air just enough before I would go under the water again"*. He appeared to be burdened with having to endure these overwhelming emotions indefinitely and the relief death would bring was not offered.

The imagery described by Alicia and Derek capture a number of central features of their experience. These features are revealed through further interrogative analysis of their accounts which identified how images of being under water and unable to breathe is a metaphor for Alicia and Derek's life in that they were drowning in overwhelming emotions due to how they perceived their life circumstances. At another level Derek is completely helpless in exercising any control over his life. Derek's description of not been able to *"breathe"* when under the water and then been *"allowed up for air, just enough"* suggests a slow agonising death as he osculates between being under and above water. Breath is one of the root meanings of the Greek word "psyche". The psyche was breath but also that which contained the very essence of being alive, in fact, is life. There is no easy sudden escape for Alicia and Derek.

Sophia and Isabella also described their experience through powerful vivid imagery;

Sophia: *" … being in bed at night, being in the dark and totally scared to death literally thinking totally hopeless and having this pain in my chest and crying and not being able to sleep …"* (pg 9, line 232)

Sophia described being in a dark place with no way out which may demonstrate a sense that things cannot improve "*thinking totally hopeless*" thereby emphasising the enormity of her experience. Her use of imagery describes the emotionally overwhelming situation Sophia found herself in and there is clear evidence of the impact this experience has had on her relationship with her body (embodiment) "… *having this pain in my chest and crying and not being able to sleep …".*

Isabella also used imagery in her description of her experience and gave a clear picture of the impact her experience had on her relationship with her body (embodiment) "*the tears falling down my face"*, and the impact on her relationship with her work colleagues (sociality) "*then trying to hide at work"*

Isabella: *"It would be me sitting at my computer at work and just the tears falling down my face and then trying to hide at work "yeah ok I'll be over there in a minute""* (response when colleagues asked her a question) (pg 1, line 24).

Laura, Luke, Isabella and Derek also make reference to the darkness of their experience. Luke and Isabella described been in a dark hole and how overwhelming this was at the time;

Luke: *"The last time, I was in a very dark hole that I couldn't ah, get out of … it was just a dark, dark place ... it was more a feeling of being overwhelmed…"* pg 5, line 150).

Isabella: *"… its just darkness, even on a bright day…"* (pg 1, line 18). *"…Jesus that was a big hole, … and the whole was very deep, I think it was probably 2 years ago, 3 years ago, I think my hole was at its deepest, now it was pretty deep a couple of years before that too…"* (pg 10, line 325).

Laura described in more detail with stronger imagery the darkness of her experience comparing swimming in a "dark swimming pool" with gray cold walls treading water just about keeping her head above water but not getting anywhere. This may be a metaphor for her experience in that she felt that she was just about surviving however was not moving forward, just endlessly existing.

Laura: *"… being in a dark swimming pool really. And just swimming or like being in the sea but I associate the sea with being a nice place so, it wouldn't be the sea, it would be a swimming pool, so gray, cold walls and there was no light in there and you're just treading water or just, you know, you're swimming along but you're just getting nowhere and you're just keeping your head above water but you know, that's all that's happening, you're just in the same place and you're just struggling."* (pg 2, line 48).

Derek further used metaphor when he described *"a constant dark black cloud everyday over me"* which may suggest that the light and warmth of living was no longer present and this followed him around on a daily basis, identifying the mood, spatiality and temporal elements of his experience.

Derek: *"…I didn't know what was going on with me. It felt like I was in a world where there was a constant dark black cloud everyday over me … it was just awful…so dark with no way out …kind of looking for a light switch but it doesn't exist …life had taken if out of the room that I was locked into …so unfair" (pg4, line 77)*

Jackie also described blackness and been in a "black bubble" where she was able to see positive things and people outside but was not able to access it and described been shut out;

Jackie: "*… you're living in a black bubble, do you know, as if you're inside in some kind of thing, you know, some kind of a glass ball and your actually trying to get away from it but you can see positive things and people outside who are all happy and cheery and you're locked in this thing then and you're just shut away"* (pg 1, line30).

Jackie described been trapped both spatially and temporally thereby perceiving herself as having no control over the situation she found herself in. She used metaphor when she described been trapped *"in a black bubble …locked in this thing then and you're just shut away"* which may suggest that the light and warmth of living was no longer present and this followed Jackie around on a daily basis, again identifying the mood, spatiality and temporal elements of her experience.

Rebecca also used a metaphor when she described her experience. She described the experience like changing the channel on television. You may go to bed on the channel you choose indicating feeling good in oneself and waking in the morning and someone changed the channel without your consent and you are powerless to change it back as one no longer has the remote control. This description highlights how

sudden one can experience distressing emotions and the loss of control over one's life as a result.

Rebecca: *"You can go to bed and you're watching RTE and everything is fine and you wake up in the morning and it's like somebody is after putting on BBC beyond your control"* (pg 1, line 15). *"And you don't know how it happened* (channel changing) *but that's it"* (pg 1, line 23).

Finally, Derek used another metaphor to describe his overwhelming experience. He described feeling as though he was in the middle of a "massive street" with eight lanes, with buildings with advertising boards all around him, with cars flying past and the advertising boards "were turned up full volume telling me loads of different information".

Derek: "*I felt like I was in the middle…of a massive street …8 lanes of traffic with buildings all around me with those advertising boards …I don't know the correct name but it felt like there were cars flying past and all these advertising boards were turned up full volume telling me loads of different information …it was very confusing and frightening and I had no control over what the boards were saying and they wouldn't stop just like my mind …it just wouldn't stop …"* (pg 10, line 214).

Further interrogative analysis identified how images of vast space and a sense of busy closing in buildings was a metaphor for Derek's life closing in around him. There was too much going on outside, too much noise to be able to concentrate. This resonated with his intra-psychic process within his own mind. His mind was full, busy, not slowing down making it difficult to concentrate and focus. His intra-psychic process

which involved thinking about thinking, gave Derek a major sense of his own mind. His experience made Derek think about his own thought processes. This may be represented or communicated through the metaphor of “advertising boards” displaying this intra-psychic process along with negative thoughts he was having about himself, the world and his future. Derek may have been experiencing a sense of loss of control over his life and his relationship with the world.

The first theme ‘The Decent’ emerged through the use of metaphor in expressing participants’ experiences and their attempt to describe, understand and communicate their experience to both the interviewer and themselves. A phenomenological reading of participants’ experience identified that all participants were overwhelmed by their experience and all participants expressed this experience through the use of metaphor and imagery such as water and darkness metaphors. Another commonality for all participants was that they described their experience in isolation. There was a strong sense from their descriptions that they were alone during this experience. This demonstrates the intensely isolating experience they endured. In reality they were physically surrounded by family, friends and work colleagues however they described their experience from a place of isolation.

5.4 The World’s Conversation and Me – Engagement with Social Discourses

This theme derived from the process of contextualisation (Smith, 2013) when the transcripts were examined for connections between emergent themes in order to identify the contextual or narrative elements within the analysis. Todorova (2011) argues that “context” be clearly expanded to include socio-cultural situatedness.

Furthermore sensitivity to socio-cultural context in IPA analysis is consistent with the coherent epistemological and theoretical framework, since we can identify the social meanings which are entwined with the personal meanings which enables individuals to ascribe meaning to their experience of depression. The super-ordinate theme that emerged; "The Worlds Conversation and Me - Engagement with Social Discourses", developed from the subordinate themes; 'society's conversations', and 'disconnection from self'.

5.41 Society's Conversations

A phenomenological reading of participants' experience of depression identified how participants first became aware of what had been experienced in terms of a medical diagnosis. This medical understanding was reiterated through the medium of broadcasting radio, newspapers, internet, books and health professionals namely their general practitioner. Once they became aware of this participants began to conceptualise their experience in terms of medical symptomatology. This resulted in participants labelling themselves as depressed thereby experiencing an additional layer of distress. They were initially experiencing distress as a result of their emotional experience and when a label of depression was attached to that experience they became further distressed. The label of depression arguably activated the internalised social discourses they held regarding the term depression which resulted in additional distress been experienced. This was due to the term depression having a negative meaning for participants.

Sophia understood what she was experiencing as a difficult experience without attaching a label initially.

Sophia: *"I never understood what was happening to me really. Em, I just thought I was going through a rough time. I didn't realise there was em, there was an actual word or a diagnosis for it so the wrong thing to do was I looked up on the internet"* (pg 2, line 35).

Sophia's use of the word diagnosis highlights how the biomedical discourse informed her understanding of what she experienced. Looking up the internet led to Sophia understanding her experience of depression in terms of symptoms. This led to her making an appointment with her GP. Sophia may have developed a new appraisal of her experience based on noticing symptoms which she read on the internet and thereby understood her experience as depression. This demonstrates a shift in how Sophia understood her experience and subsequent behaviour. The biomedical discourse was reinforced when she met with her GP as described below;

Sophia: *"… the doctor described it was serotonin in my brain and that because I was just draining myself physically of the chemical that I was so low I wasn't able to reproduce this happy mood, good hormone, chemical or whatever it is. I needed something to take, to boost that again"* (pg 4, line 107).

Alicia and Luke also described their experience of depression biologically;

Alicia: *I suppose when you're born, genetically, there might be a genetic predisposition"* (pg 11, line316).

Luke: *"…having read a bit about it (depression) … I think some people are just more prone to, in the same way a gene might make you more prone to cancer. And if you are aware to your predisposition … then it's a valuable thing"* (pg 3, line 66). *"there is a possibility that's it's a brain deficiency but everybody who has depression has something, some substance missing if you like"* (pg 16, line 548).

It is evident above that Sophia, Alicia and Luke readily bought into the chemical imbalance explanation provided by either their GP or from the material they read. This would suggest that Sophia, Alicia, and Luke having being exposed to the biomedical discourse regarding depression and illness in general became internalised into their belief systems regarding depression and illness. When for example Sophia's GP then offered the chemical imbalance explanation, it aligned to some extent with Sophia's belief system around illness and its biological roots. This new understanding arguably impacted on her meaning making of her experience of depression.

Derek, Jackie and Isabella described the impact they experienced when they first realised they were experiencing depression;

Derek: *"I remember one day I was in my car and I heard an ad or something on the radio about depression … it said something about not sleeping and feeling down then "you were depressed" … that's what they were saying … if I remember correctly … I remember getting a massive fright when I heard that because I thought shit "I am in more trouble now than I thought". "I have depression"…..…again. "I have a mental illness" … that scared the life out of me … you have no idea …"* (pg 5, line 86).

Jackie: *"the GP said here's the number of a counsellor… I actually said to myself, "she thinks I'm off my game", "she thinks I'm bonkers like". These people (counsellors) are only for people with psychiatric difficulties"* (pg 5, line 161).

Isabella: *"I did remember going to the doctor and he said you might have depression and I thought I was going to die …I genuinely thought I had a serious medical issue" (*pg 2, line 60).

Isabella also identified the temporal, selfhood and project elements when she described the meaning to her of being informed by her doctor that she was experiencing depression. The language she used "*… that's me doomed forever and ever and ever"* to understand her experience highlights the finality of been informed she was experiencing depression and that her life and how she viewed herself was now different forever.

Isabella: *"… that particular day when the doctor said to me you have depression, I just thought that's it, that's me doomed forever and ever and ever"* (pg 4, line 116*).*

The above extract demonstrates how Isabella understanding changed and how she then became more distressed as a result of labelling her experience as depression. Derek and Jackie described similar experiences *"I am in more trouble now than I thought". "I have depression", "she thinks I'm off my game", "she thinks I'm bonkers like"*. They also began to reframe their experience and label themselves as depressed which resulted in another layer of distress emerging, a layer of distress they

did not previously experience. The participants described distress as a result of their experience but once a label was attached to their experience, it then took on a different meaning. Participants then became distressed about been labelled as being depressed. This new meaning was informed by their internalised social discourses which led to their additional layer of distress. Therefore the re-labelling of their experience as depression had significant consequences in terms of levels of distress experienced. It highlighted how participants took the label of depression on board as a legitimate explanation for their experience. Further analysis demonstrates the impact this had on their perceived relationship with not only the self and others but also with the world. Their new understanding robbed how they related to their experience and to others.

Rebecca explained the recurrent pattern of depression and offered an explanation from what she had read to its recurrence;

Rebecca: *"… your brain learns and it kind of maybe gets into a habit. Like I know from what I've read that if you get it (depression) … if you had it once and you don't get anymore relapses, but if you get more than one relapse then kind of it seems to fall into a similar pattern, you know"* (pg 14, line 466).

At a more critical and interrogative analysis of the above extracts it could be argued that the reductionist approach is used to conceptualise emotional experiences such as depression. All participants clearly identified with the breakdown of their experience into symptoms (disturbed sleep, appetite, no energy, feeling down). The participants

described the biological and psychological symptoms *"not sleeping and feeling down"* they experienced and took on the developed world framing of these symptoms as depression, a *"mental illness"*. This demonstrated how social discourses of depression had been internalised by participants thereby shaping how they experienced and understood their emotions.

Participants described experiencing a *"massive fright", "scared the life out of me"*; *"I genuinely thought I had a serious medical issue", "she thinks I'm off my game";* which demonstrates the development of a new understanding for their experience informed by various discourses. They established a new appraisal of their experience based on noticing symptoms from listening to the radio, reading on the internet or speaking with their GP and linked this to being depressed. They then arguably experienced another level of distress about being emotionally distressed. This could be conceptualised as meta-distress which in essence is distress about distress. This additional layer of distress is informed by social discourses with the trigger for participants been an identification of the physical consequences (symptoms) of their emotional experience. This in turn resulted in some participants focusing on identifying a treatment or a cure as identified in Derek's extract below;

Derek: *"Well … I looked up drugs because a lot of information said to go on antidepressants … then I would read the side effects … then the benefits….it was all so confusing and frightening at the time … different doctors were saying different things … it was all very frustrating you know"* (pg 6, line 119).

The apparent framing of depression as an illness requiring medical treatment is clearly evident in the above extract. At a more critical and interrogative analysis of the above

extract it is evident that the dominant cultural understanding of depression is that of an illness requiring medical treatment. This is further evidence of the biomedical discourse influence in how participants conceptualised their experience of depression thereby impacting on them in their search for meaning within their experience.

The above participant extracts highlight how the biomedical discourse is responsible for the way depression is defined, diagnosed, and treated. The biomedical discourse of depression is arguably circumscribed (limited) due to its foundations resting on Western rationalism in that as a society we need to understand by deductive and intellectual means and not rely on sensory interpretation. This is evident when both Luke and Derek refers to *"different doctors were saying different things…..it was all very frustrating you know"* and also earlier in the text when he stated *"numbers are my thing……not the head"*. One could argue that Luke and Derek had internalised biomedical discourses based on western rationalism and therefore conceptualised their emotional experience in the same manner they approached their work, accountancy for Derek and business in Luke's case, which is about logical deduction requiring intellectual reasoning. Furthermore their frustration regards differing opinions offered by doctors further emphasises how Luke and Derek had internalised social and biomedical discourses based on western rationalism where they believed that all medical doctors would share a common understanding of depression;

Luke: *"one person (Out of hours GP) is telling me this and this (about depression) and the other person (own GP) is telling me totally the opposite …it's confusing because I suppose I've always gone in on the basis of trust and therefore there's a trust there …to deal with me properly* (pg 12, line 396). *"…the psychiatrists and my own GP*

seemed to be … telling me two totally different things you know (pg 12, line 421).

Alicia was the only participant to describe a positive experience where she believed that celebrities discussing openly their personal struggles with depression created a positive perception regarding the experience of depression and communicated the *"human side of everyone"* which she viewed as helpful;

Alicia: *"I think actually celebs coming out and admitting it (depression) is a huge thing. Part because like they're looked up on as being God Almighties and the best thing since sliced pan and I think people are fearful to show their human side you know* (pg 16, line 444).

I think it's changing definitely with celebs admitting to it and bringing out the human side of everyone and then it's coming out more and more" (pg 16, line 468).

The impact of popular culture in individuals' conceptualisation of depression and providing a normalisation effect is considered helpful. So popular cultural discourses can be used in a positive way in the same way unhelpful or inaccurate discourses have impacted negatively on individuals understanding of depression.

Derek also referred to this openness as the means of communicating the universality of the experience of depression however he described the need for more open accepting dialogue being communicated in wider society via the media, internet and television;

Derek: *"I think it's good that mental health is spoken about so much but I do think that there is too much focus by Drs and on TV and radio and in the papers about the symptoms and seeing those as the problem … I think …well … there should be more focus on … ok … acknowledge the symptoms but to give hope to people that they can sort out their life problems … It seems the focus is on stopping the symptoms and I had that experience when I went to my GP who prescribed antidepressants for me after he diagnosed me with depression. He did not ask me so much about what was going on in my life. The focus was on stopping the symptoms … OK … I know its necessary to help with the not sleeping and not eating and no energy … and not going out but … but it's also important to tell people its normal what they are going through and to focus on that and sorting that out along with helping with the not sleeping and not eating. I think the focus is on the wrong thing …"* (pg 22, line 409).

At a more interrogative analysis level, Alicia and Derek's view in the above extracts identified how socio-cultural discourses contribute to the socialisation of individuals and society about what constitutes depression and highlights the impact social discourses have on individuals' interpretation of their experience of depression.

5.42 Disconnection from Self

This subordinate theme described how some participants identified causal factors that led to their experience of depression while others were impacted by the social discourses in attributing meaning to their experience of depression. Alicia questioned what her psychiatrist said to her as she attempted to understand more fully what she was experiencing and also to find a way of recovering. This was not received well by the psychiatrist as outlined in the extract below;

Alicia: *"Dr X said to me, "thank god all my patients weren't like you" or something to that effect because I'd always come up with an answer if they, you know, well that's not going to work, that's not going to work, you know. Even though I was there for help I was resisting help so I was a difficult patient"* (pg 9, line 212).

Alicia in the above extract described her questioning and arguably hopelessness in her search for meaning as her been "difficult" and "resisting help". Perhaps there is a compliant *"patient"* who does not ask as many questions and does not express their opinion. Perhaps this was Alicia's way of attempting to attribute meaning to her experience of depression.

Luke expands further on the impact the biomedical discourse had on how individuals' experience depression and how attributing meaning to the experience of depression was not encouraged from his experience;

Luke: *"I think in a lot of ways we don't have a holistic approach, both to depression and the way we treat people medically … its very factory orientated, get 'em in get 'em out. They are not trying to get to the root cause of the problem, they're trying to stem the problem … but that doesn't allow people to move on in other ways … write a script (prescription) … you're going to feel better in a couple of days time and blah blah blah, but its not a holistic approach* (pg 10, line 348).

Alternatively Laura wanted to be prescribed medication and not to discuss what had happened in her life that had led to her experiencing depression even though her GP wanted her to talk to someone. Laura had understood her experience in a very biological manner which subsequently impeded her from attributing meaning to her experience. Here her GP understood the importance of attributing meaning to Laura's experience of depression and actively encouraged her to discuss her experience. This highlights another discourse that was presented to Laura by her GP as outlined in the extract below;

Laura: *"I remember saying to my doctor (GP) "look just give me the tablets" cos I wanted a quick fix … she (GP) said "you know you will have to go on medication but you do need to talk to someone as well" …I remember not understanding why she wanted me to talk to someone … I just felt the tablets would fix it … it must be a hormonal thing … the tablets would fix it"* (pg 6, line 197).

Jackie and Isabella described how they could identify what contributed to their experience of depression however described believing that they would experience depression "*for the rest of my life"*. This may indicate the impact social discourses had on their understanding of their experience and how this impacted on them attributing meaning to their experience as outlined in the extracts below;

Jackie: *"Well I kind of knew what brought it on but I couldn't understand how I wasn't able to get rid of it. I couldn't understand why it just wouldn't go away. …I actually thought it was something going on physically in*

my brain, a mental disease that I was going to be stuck with forever" (pg 8, line 261).

Isabella not only described a similar experience she described that she *"got depressed because I got depression"* identifying the meta-distress she experienced. She now identified and labelled herself as a depressed person.

Isabella: *"I came home and got depressed because I got depression … I thought it (depression) was a lot more serious …I thought this is going to be me for the rest of my life, that this is the state I am going to be in, and that wasn't good. The thought that I would have to go on medication … I refused … just thinking that this is really bad to be on medication"* (pg 3, line 69).

Further analysis of Isabella's account demonstrates that the experience of depression robbed her in how she related to herself thereby changing her identity. Depression in essence became something of a destiny, preventing Isabella from being open and free to access a range of alternative self-interpretations, identities, and possible ways of being-in-the-world as evident in the account above.

Sophia clearly identified causal factors for her experience and was able to link what she experienced to life circumstances. She expressed this clearly and without question;

Sophia: *"I knew why I was feeling low because I was very close to my sister and there was a big family fall out and I can't describe it, it was like bereaving a person that was still living. And it, it was awful, I mean I was, she was like another mother to me, the closeness, actually to the extent it was possibly unhealthy, our relationship. We spoke too much on the phone and we saw each other too much. I probably depended on her too much and I was able to cope with work because I had somebody to confide in but then..... So, she was like my lifeline, so to speak, but then when that was gone I didn't have anything, I was totally alone"* (pg 9, line 248).

Derek also described trying to identify causal factors that led to his experience of depression however he was overwhelmed with the information related to depression in the public domain. The information he referred to related to the social discourses available to him at that time. Derek engaged in a process of inquiry regards what his options were and this resulted in a change in his behaviour *"…my whole life had become consumed with finding out about depression and scanning myself for depression"* as outlined below;

Derek: *"tried antidepressants the first time I got depressed after my girlfriend at the time ended our relationship … they didn't agree with me I think … I felt strange on them so I stopped taking them … I didn't think they were going to help this time … I saw a reason for why I was feeling the way I was you see … I didn't want to numb that out … that happened the 1st time I was depressed. I had read something in a paper also saying that this could happen … that the medication would numb out the feelings and I would have to deal with them when I stopped taking*

> *them anyway so I didn't want that … that would just delay things … I didn't want to do that …"*
> *"I even looked at antidepressants on youtube and there was so much information … some said they were great with no side effects and others said they were terrible and stay away … my whole life had become consumed with finding out about depression and scanning myself for depression"* (pg 6, line 127).

There is a clear sense in the above extract of Derek trying to articulate some very strong emotions, physical sensations and thoughts which emphasises his struggle to explain his experience. It is evident that he was attempting to reappraise his experience by linking causal factors to his experience *"first time I got depressed after my girlfriend at the time ended our relationship"*. This is a difficult process due to the dominance of the biomedical discourse in society evident in the language participants used when describing their experience. Derek believed that medication would not work based on his past experience thereby identifying the importance of past experiences in perception of current experiences which shaped Derek's behaviour in deciding not to take medication.

Along with past experience his perception regards the impact of medication on recovery is clearly evident *"I didn't want to numb that out …that happened the 1st time I was depressed. I had read something in a paper also saying that this could happen…that the medication would numb out the feelings and I would have to deal with them when I stopped taking them anyway so I didn't want that…that would just delay things…I didn't want to do that"*. This perception is also grounded in biomedical and social discourses where Derek believed that the concept of recovery

was influenced by various factors demonstrating the influence of discourses on knowledge acquisition.

5.5 Broken Self – Transforming the Self

This super-ordinate theme represented the process of participants transforming into a different self, a self they believed they were powerless to stop and a self they did not wish to be. The super-ordinate theme developed from the subordinate themes of; 'unknown self; loss of self and one's identity', 'desperate for a way out' and 'conflict with self and what's known'.

5.51 Unknown self - Loss of self and one's identity

A phenomenological reading of participants' experience of depression demonstrates that depression was viewed as a complex, multifaceted phenomenon which could return at any time thereby impacting on the relationship participants' had with themselves. Participants described a change in how they understood themselves, how they viewed themselves and how they related to themselves and others. Some participants' described viewing themselves through the eyes of others and the distress they felt as a result. These experiences resulted in participants describing their sense of loss of self and identity and having to experience a new self that they did not want to experience.

Alicia, Rebecca, and Laura all described a change in how they perceived themselves (selfhood). The experience of depression for them resulted in each of them making negative generalisations about themselves as evidenced below:

Alicia: *The fear of failure and when that happens, you've failed to keep it together in your body, in your mind everything and (its) just out there … "I'm a failure"* (pg 7, line 176).

Rebecca: *"… feel you're not good enough (perception of herself when experiencing depression). That's the part that once, once I start slipping that kicks in as well" (pg 5, line 149).*

Laura: *"I felt it was a reflection of myself, that I was weak and that I couldn't cope with being a mother… I just wasn't juggling all the balls the way I should be and that, that was pointing to me directly as not being able to do my job"* (pg 4, line 124).

Isabella, Luke, Laura and Sophia described the impact it had on their everyday life; how they functioned and the internal processes that occurred as a result of experiencing depression along with how it impacted on their relationship with their body (embodiment), their relationship with others (sociality) and self (selfhood) and how their everyday life was affected (project).

Laura described the physical impact depression had on her and the change in the relationship with her body (embodiment) as a result and identified that time *"just wasn't me"* identifying the loss of self and identity once known:

Laura: *"I suppose it (depression) was part of my spirit as well that was dragging me down but I always just felt the physical weight in my heart just there, I suppose it just wasn't me, it was this thing that was slowing me and staggering me"* (pg 1, line 14).

Luke outlined the many areas of himself that had changed and described feeling that he was lost and had lost himself (selfhood):

Luke: *"there are a number of elements impacting on you … they're social, they're personal, they're spiritual and they're probably self worth, self esteem … your self esteem reduces down"* (pg 1, line31) … *lack of confidence in myself … huge sense of em, injustice in the world … I felt lost spiritually …just that loss and then feeling lost* (pg 10, line 331) …*"For me anyway, it was the whole experience was kind of a lack of belonging, an unfairness in the world nearly …not feeling part of something which I think is kind of important too* (pg 18, line 619).

Isabella described the internal processes that occurred as a result of experiencing depression:

Isabella: *" it would always happen (thoughts/ memories) when I wake up in the morning and having a shower I would continuously recall embarrassing moments that would happen, that had happened to me in the past … every morning I'd have something to be shameful about"* (pg 7, line 202).

Sophia described how the everyday tasks she was once committed to and which were central to her life were affected (project).

Sophia: *"I didn't have any clarity in the morning. Like for me I'm a very organised person but you're totally all over the place. You don't have any structure, you can't think clearly, you just feel very low and... I describe depression as a light switch, that it can go on and off, you could have periods of 6 months and then a little trigger, something, could be something really small that could set off some sort of an attack, as I call it"* (pg 1, line 13).

Rebecca and Jackie described the impact it had on their relationship with other's and those around them (sociality) which in turn further impacted on their own sense of self and their identity and they described this as shameful.

Rebecca: *"… the thought of being somebody with depression … I had it in my head that was like, the worst thing you could ever have"* (pg 9, line 276) *"… I still have issues around shame and depression. I try and work through it but I think it's very, I don't know, it's just something I have"* (pg 9, line 282).

Jackie: *"(others) might not have any contact with me or they wouldn't kind of view me the same as they would have done before or they would look at you kind of strange thinking you know "your one's not fully there, we cant have anything to do with her" you know"* (pg 9, line 289).

Derek described a sense of loss of his future and his life without it ever been retrieved. Derek questioned the name ascribed to his experience which may suggest the enormity Derek faced when trying to conceptualise his experience of depression. He identified feeling so sad and low which he had not experienced before and identified differences in the intensity of feelings and emotions perhaps as a means of attributing meaning and understanding. He described the experience of depression as a never ending journey with recovery not possible thereby expressing feelings of hopelessness and helplessness.

Derek: *"When I had depression if that's what you want to call it, I felt so sad and low. I had never felt that bad before and I thought there was no way out … I truly believed that things would not improve and that my life would not get better … things would stay the way they were and*

> *actually only get worse … you know what I mean … that … this made me feel totally hopeless and despairing"* (pg 2, line 10).

There is an acknowledgment from the participants that they were experiencing depression which appeared to add to their level of distress. They attributed their experience of depression as a result of personal failings and stated that others would view them in a more negative way which may highlight the impact social discourses had on participants' interpretation of their experience and ultimately themselves. It demonstrates how the label of depression and the discourses that are attached to the label resulted in participants experiencing additional distress (meta-distress).

Further analysis highlights the profound change in how participants experienced their world and the impact on not only the self but the world around them. The experience of depression appeared to envelop them and take a tight grip leaving them helpless and hopeless about their life and future. Depression became something of a destiny, preventing participants from being open and free to access a range of alternative self-interpretations resulting in a sense of helplessness and hopelessness. They attached negative meanings to themselves and their future and believed others would view them negatively also highlighting the relational element to their experience. The experience of depression involved a major diminishing of the life world with relational, corporeal, and temporal depletion.

Furthermore, although Derek questioned identifying his experience as an illness or disorder, he used those terms to describe his experience demonstrating that he may be socialised to describe his experience using these terms via his exposure to social discourses. His experience of depression and self-questioning was marked by a sense

of time being experienced slowly and indefinitely. Again there is a temporal quality evident here with his experiences clearly embedded in time;

> *Derek:* **"***…things would stay the way they were and actually only get worse, you know what I mean?"* (pg 2, line 15).

Derek's human need for understanding is clearly evident when he asks a confirmatory question *("you know what I mean?").* This question may have been his attempt to continue to develop new understanding or "check" if he had the "correct" understanding based on the discourses available to him. Therefore Derek may have believed that the interviewer was socialised and influenced by the same discourses as he was. Derek arguably was searching for validation of his personal emotional experience and although he was no longer experiencing depression continued to try and understand his experience more fully. This need for understanding is embedded in the human experience, thus through human consciousness, human beings create one's own values and determines meaning in one's life, in effect our true essence.

For most participants the descriptions they gave may have been influenced by the internalised social discourses, thereby shaping their understanding and expression of their experience. This may have been part of participants processes in understanding their experience and may have contributed to the transforming of self while experiencing depression. It may also demonstrate the impact internalised stigma of mental illness had on how participants conceptualised their experience of depression and the relationship participants had with themselves at that time.

5.52 Desperate for a Way Out

All participants described feeling they had lost control of their lives or described thoughts of suicide which may have been an indication that they were trying to regain control or that because they felt that they had lost control their only option was suicide. Luke, Jackie and Isabelle described directly the loss of control they experienced:

Luke: *"I suppose for me it (depression) was em, ah, a loss of control"* (pg 1, line 22).

Jackie: *"Things kinda get on top of you easier(as a result of experiencing depression) and you just can't control, you're actually not in control of your life … you've totally lost control and you cant find a way back.* (pg 2, line 41). *"It (depression) just took control of me like this kind of monster"* (pg 9, line 273).

Isabella: *"I genuinely thought that this is going to be me for the rest of my life, that this is the state I'm going to be in for the rest of my life"* (pg 3, line 87).

Alicia, Sophia and Derek on the other hand did not directly describe a loss of control however they described experiencing suicidal thoughts which may have been their attempt to regain control or a solution to their problems as they believed that they were no longer in "control" of their emotions and lives:

Sophia: *"I had … suicidal thoughts … I would get up and basically be so lethargic because I would have absolutely had no … I had to go into a stressful environment with a very irrational boss, may I say, and to deal with that. I'd be sitting at my desk and I'd be feeling anxious and*

> *panicked and all in my thoughts be all day be "please make this go away, what's going on, what is happening to me". Em, I couldn't wait to get out of there. It was a constant feeling of "I want to run away". I can't describe it, I wanted to get into my car and I wanted to run away. I wanted to get out of what ever was happening to me. It was like an out of body experience. I wanted to just step out of myself"* (pg 11, line 303*).*

Further interrogative analysis identified that depression was like a creature invading the self and taking control over it. The experience of depression involved a major diminishing of participants life world with relational, corporeal, and temporal depletion. This depletion was accompanied in each case by occasional extreme emotions, frenzied thoughts, and attempts to escape. Sophie described "*wanting to step outside myself*" demonstrating the embodied experience of depression and her attempt to escape.

Derek and Alicia describe another purpose to their suicidal thoughts in that they found it soothing in some way. Alicia fantasised about her own death and funeral which had a soothing effect which may imply it was a means of escape and gave her a sense of control over her in one sense as she felt that she had no control over her emotions and experience at that time.

Alicia: *"I wasn't aware of that, my mind was using that tool (fantasising about own death and funeral) but I was aware of the after affect of it*" (pg 5, line 103).

Derek also described an "easing" effect when he thought about suicide and also saw it as a means to solving not only his problems but also his family's difficulties thereby perhaps ensuring Derek had some control over what he was experiencing;

Derek: *"… this is hard … and embarrassing to say … but I thought of killing myself … it would all be over then … I remember thinking … sure the house will be paid off…the car … and Kate will have way less stress in her life … she will get over me and meet another man and be happy but at last she will be more financially secure … I would have thought about dying a lot … it eased things for me …"* (pg 14, line 300).

Finally Rebecca described the absolute uncertainty when it came to experiencing depression in that it can happen anytime without warning and one is never certain to its duration thus demonstrating the unpredictability of the experience of depression and the lack of "control" over it:

Rebecca: *"I suppose feelings that don't really make any sense because they come from nowhere. You can be fine and then, well what you would perceive as fine. You think you're doing everything the same as every other time and then all of a sudden they're just there (emotions). You can wake up and have that feeling (depression)"* (pg 1, line 7). … *"So you've dread around them, you're feelings are that this time you might be unlucky and they wont go away (feelings of depression) (pg 2, line 42).*

Derek also acknowledged how many times "*two times in my life now"* he experienced depression, perhaps also indicating the uncertainty of the experience;

Derek: *"I think of lots of things when I think about depression…I think about myself and when I went through it …two times in my life now…I think of how sad it is for people to go through it. I think about my family and*

friends who have had it….I think of it as an illness or disease…well that's what is said about it anyway" (pg 1, line 5).

Derek used of the word "now" perhaps implying that he believed that it could happen again, that it is an experience that one can never be sure they will not experience in the future thus identifying the temporal dimension to Derek's experience. Further interrogative analysis identified that the experience of depression disrupts everyday experiences of spatial orientation and mobility making it difficult for the person to move and perform basic functional tasks, resulting in a collapse or contraction of the life-world as is evident in the accounts above.

5.53 Conflict with self and what's known

The subordinate theme, **"**Conflict with self and what's known" identified the conflicts that arose for participants either because their own interpretation did not correlate with professionals which was found to be disconcerting, confusing and frustrating or their interpretation was not thought to be a shared experience by others and when they learned that others had similar experiences they found that to be a source of relief.

Luke and Derek described how their interpretation of their experience did not correlate with that of professionals and how the different professional opinions confused them and led to feelings of frustration. They also described the need to understand the meaning of their experience and how that was not the focus of the help they received which they continue to be unable to make sense of;

Luke: *"Its very important for me to make sense of what I am experiencing and I think it is for most people, its to separate the actual experience*

and make sense of that experience so that you can move on …" (pg 8, line 255).

Luke described in detail the circumstances that led to his experience of depression and the process of help he received;

Luke: *"I felt for a long time I was not doing something that I really want to do and em I knew I had a problem here and I went to the doctor …to South Doc and explained the whole thing. They said look I'll give you a prescription for the moment just to kind of get you right and get you on the right track…and then I went to my own GP and (GP said) "ah I wouldn't be bothered with any of that" …so I was told to stop everything (by own GP)* (pg 11, line 386). *Its confusing because I suppose I've always gone in (to GP) on the basis that you do not know what other people (GP's) do but, I go in on the basis of trust (trust in their professional knowledge and expertise)* (pg 12, line 399). *"… things (depression) got worse and worse … and then it got to the stage that a psychiatrist got involved … and tried to stabilise me with the medication* (pg 12, line 410). *"… another thing that was disconcerting is that, the psychiatrist and my own GP seemed to be telling me two totally different things … I haven't been able to make sense of that* (pg 12, line 421).

Derek: *"I remember after that my mind kept focusing on the symptoms the man was talking about on the radio…frightening stuff…you know….I started feeling very anxious and afraid. I kept scanning myself for symptoms. The focus then shifted to what I was feeling and if I didn't sleep or if I wasn't hungry…well I started noticing what was written in newspapers and realised there is so much information out there … .so much different information…it was confusing….for me anyway….I am not in that line of business …numbers are my thing not the head…*

…..…different doctors were saying different things…it was all very frustrating you know…I had tried antidepressants the first time I got depressed after my girlfriend at the time ended our relationship….they didn't agree with me I think…I felt strange on them so I stopped taking them…my whole life had become consumed with finding out about depression and scanning myself for depression".

Both Luke and Derek identified in the extracts above how different discourses such as depression as a medical disorder and how the media disseminated the information related to how they experienced depression and how this impacted on their understanding and more importantly their subsequent behaviour. Derek noticed that he became more mindful of the symptoms of depression, of which he then focused on *"scanning myself for symptoms*". Luke ceased taking the prescribed medication South Doc (an out of hours GP service) prescribed after he spoke with his own GP. They both identified that *"different doctors were saying different things"* and how frustrated and confused this was for them in trying to make sense and understand, as this was not their area of expertise *"I am not in that line of business……...numbers are my thing not the head"*.

Rebecca, Sophia and Jackie all described not fully understanding what was going on and that they should be able to resolve things themselves and that the experience of depression would go of its own accord and they described feeling confused when it did not resolve itself:

Rebecca: *"…with your head I think you feel that (you should be able to fix your head independently) because it's something that's there and you're thinking all the time anyway and you're doing stuff with your head that*

you should be strong enough to fix that disease yourself whereas with your body you know that like you've got the flu you didn't do anything (to cause the flu), you cant feel the flu as in shame around the flu. Whereas whatever it is about depression, because it's your head, its all about thoughts more than physical" (pg 13, line 411).

Sophia: *"I never understood what was happening to me really. Em, I just thought I was going through a rough time. I didn't realise there was em, there was an actual word or a diagnosis for it so the wrong thing to do was I looked up on the internet … that panicked me totally (what she read about depression) when I was feeling all of these symptoms, that this is what it could be. So I decided to go to my doctor and he said I did have depression and at that stage I was probably gone lower than I knew myself"* (pg 2, line 35).

Jackie: *"Well I kind of knew what helped bring it on but I couldn't understand why it wouldn't go away … I actually thought it was something going on in my head that I was going to be stuck with forever"* (pg 8, line 259).

Laura on the other hand described the internal conflict she had with herself and described not having time for depression and that she had a family to raise and a life to live and that experiencing depression was not an option for her. She described asking her GP for medication as she believed that it was due to "hormones" and did not wish to see a therapist or avail of any help by mental health professionals;

Laura: *"I just felt, I actually don't have time in my life for this at the moment. I have three children, I'm very busy, I can't fall down now because I have to take care of my children. And because I don't want, I don't*

> *want to be depressed because that's just a big thing now I have to sort out and I don't want to sort it out. I just literally wanted to close the box on it and just let it there and hopefully it will go away…and I genuinely thought that it would go away if I just had a bit of a break or I just kind of gave myself a bit more time, try to get a bit more organised in my day"* (pg 3, line 74) … *"I remember saying to my doctor "look just give me tablets" cos I wanted a quick fix. She said "no, I think you need to talk to somebody" and I said "I don't need to talk to anyone, its just hormones … the tablets will fix it"* (pg 6, line 197).

It is evident that from the extracts above that participants experienced emotions such as frustration, confusion, anxiety and fear as a result of conflicting information been presented by people who they believed should know. They identified secondary emotions (frustration, confusion, anxiety and fear) being experienced with an awareness of the symptoms of depression being reported in the media. This new perspective resulted in participants becoming hyper-vigilant and in Derek's case scanning himself for "*symptoms of depression*".

At a more critical and interrogative analysis level, there is a clear shift in focus from attributing meaning to their experiences to focusing on symptomlogy. Therefore there is a loss of importance in attributing meaning to their experiences. There is a loss of self once known and loss of identity by participants internalising the biomedical discourse of their experience. This identified the impact social discourse had on participants' experience. At a more hermeneutic level the above extract might suggest

that participants such as Luke and Derek were engaged in an existential struggle to determine what meanings they foreground. On the one hand they attempted to understand the meaning of their experience and on the other hand focused on the symptoms of depression as a means of understanding their experience in a more simplified manner although this was not the reason they conceptualised their experience in that way. Perhaps they engaged in this method of understanding due to the internalised social discourses they had acquired throughout their lives.

Luke and Derek's belief that knowledge is related to the work one does and individuals in the same "line of work" understand their field of work in a similar way may offer an explanation for their confusion as they identified that *"different doctors were saying different things"*. This may identify a schema Luke and Derek have in relation to professional knowledge and the sharing of a common language and understanding. As a result of this schema they have developed an underlying assumption that if individuals are from the same/ similar professional background then overall they would be communicating similar professional opinions. However this was not their experience in relation to healthcare professionals which was new learning for Luke and Derek and this was a huge source of confusion for them both as this contradicted their schema. They were in a state of cognitive dissonance, a state where both were experienced excessive mental distress and discomfort as they held two contradictory beliefs at the same time. Again this may represent discourse regards professionalism and occupations sharing the same or similar philosophies, opinions and work practices and how this impacted on their experience of depression. As early life experiences shape our development of schemas and in turn underlying assumptions it is understandable that they would experience secondary emotions of

anxiety and fear along with their primary emotion of sadness. Arguably the addition of secondary emotions complicated things further and added to their sense of feeling out of control and a loss of self once known adding to their existential struggle.

In summary, this super-ordinate theme represented the process of participants transforming into a different self, a self they believed they were powerless to stop and a self they did not wish to be. This self was unknown, there was a loss of self, a loss of one's identity, a sense that the locus of control was beyond their realm and a conflict with self and what's known which may suggest that participants experienced an existential struggle and a sense of the self transformed into something unfamiliar, unknown, and which was experienced as emotionally overwhelming.

5.6 Embracing myself and my Mind - Transformation of the Self

This theme derived from the process of polarization therefore the transcripts were examined for oppositional relationships between emergent themes where the focus was on difference instead of similarity. The super-ordinate theme that emerged; "Embracing myself and my Mind - Transformation of the self", addresses the process of participants' transformation whereby they re-emerge from their experience with a greater sense of self, a return to their values, a sense of finding self, regaining perspective, a sense of connectedness, self empowerment, hope, a process of acceptance and finally establishing a meaning with regard to their experience of depression. The super-ordinate theme developed from the subordinate themes; *"I began to smell the coffee again"* – Recovery'**;** **'**Letting go', 're-evaluation of life and

self' and 'connectedness'. The extracts from participant accounts are presented to demonstrate a layered interpretation moving from a phenomenological, empathic account to a more critical and interrogative analysis. A phenomenological reading of participants experience of depression identified a positive return to their lives and a re-engagement in their lives with a greater sense of self and perspective. They acknowledged the difficulty of their experience along with the learning as human beings they acquired.

5.61 *"I began to smell the coffee again"* – Recovery

Participants described what contributed to their recovery and the factors related to this process such as supportive partners or professionals in their life. Also some participants described noticing improvement in their physical functioning such as appetite and sleep as outlined in the extracts below;

Sophia: *" I was recovering … my whole physical aspect, it started that night that I slept and then when I slept and the next day I was beginning to plan my days and have nice days and be able to say have nice breakfast, I began to smell the coffee again. I began to taste my food. Everything was tasteless; I had no interest in eating or interest in anything. I began to get interested in stuff again, the news, people, my brain started to take in information and that was all just little progression. So I knew after about two weeks which is thankfully quite quick"* (pg 16, line 362).

Jackie: *"My sleeping pattern improved, I would sleep very well at night …I felt brighter in the morning, people would say to me "you look happy today" …putting on weight"* (pg 19, line618).

Derek: *"… I remember also reading the signs and symptoms of depression and the signs of recovery and these were signs of recovery so this helped me to feel more positive which then made me feel better in myself…"* (pg 20, line 372).

During participants process of recovery they identified how noticing the signs and symptoms of depression (biological symptoms) reducing was helpful in their recovery. Noticing the signs and symptoms of depression when participants experienced depression was a source of fear and hopelessness and led them to continually scan themselves whereas now noticing the disappearance of the symptoms of depression is a sign of recovery and is welcomed. This could indicate that its not necessarily identifying the signs and symptoms of depression that is problematic but the manner in which they are presented to society (social discourse) is creating distress (meta-distress).

Alicia described that as a society we acknowledge the experience of depression more now and she believed that made society more open to those who experienced depression which in turn made the experience less negative and hidden which was more positive and contributed to recovery;

Alicia: *"we're more human about it (depression) now as opposed to "oh god it doesn't exist (depression)" or its not there"* (pg 17, line 490) … "*people are kind of in the media and kind of you know coming out and acknowledging it and saying it and that's shaping how everybody else, a lot of people then view it in more human terms … because it takes a lot of courage I think, to admit to it and a lot. I think if someone like I, I think if someone admits and has that inner strength to say look I have depression and it means you've gone on a long journey"* (pg 17, line 495).

Alicia believed that acceptance and acknowledgement of the experience of depression was more positive and healing, which allowed individuals and society to become unstuck and addressed the experience of depression in a more human way.

Derek also offered his reflection and gave an insightful account of the importance of mental health awareness in society. From the extract below, Derek acknowledged that it is important to identify the consequences of depression such as disturbed sleep, poor appetite, reduced energy and so forth however he argued that by focusing on these symptoms impeded an individual's recovery. He identified instilling hope as paramount in recovery and advocated that the manner in which medicine and society communicates the experience of depression needs to change. He believed the medical discourse communicated through the media focused mainly on symptomatology which he believed was ultimately unhelpful to individuals experiencing depression;

Derek: *"Ok talk about the signs and symptoms of depression but don't have those as the focus of the treatment. Educate people that these occur as a result of what's going on in ones life…Then focus on helping with*

that and getting people…to…believe in themselves and accept change if possible what they can in their life and support them in that. Don't jump to medication…I didn't take medication even though it was prescribed as I knew that it was something I needed to work through…don't get me wrong…I know people who have taken antidepressants and found them helpful but not for me. I took them the first time I was depressed and didn't find them helpful … I think reading on the internet about depression and the signs and symptoms of depression and focusing on these was not very helpful for me looking back. It was only after I stopped doing this that…well I was then able to focus and accept our situation…and my current situation. Then I was able to move on and feel more hopeful and that's when I started to get better" (pg 24, line 471).

5.62 Letting Go - Acceptance and Normalising

Most participants believed that they were able to move forward in their recovery when they acknowledged and accepted their current experience of depression. Some participants stated that by normalising their experience to themselves, they were able to accept their circumstances and begin to address it as they felt empowered to do so and it gave them hope that things could improve. Sophia found inspiration from another person's story of depression. This story normalised the experience of depression for her and allowed her to live her life as outlined in the extract below;

Sophia: *"But another thing about depression I have found, I have read the most inspiring slogan or caption I think I've ever read in my life, and it was actually by em, I cant remember his name … He suffered all his life … he said "Don't think of the past" he said "because the past makes you depressed, don't think of the future because it makes you anxious which links to anxiety and panic, live in the here and now". So what I try to establish at night is that today is over, I'll think of tomorrow when tomorrow comes. I try, I live my life now everyday*

because I was living months in advance, what if, what if and I was getting hysterical and totally putting my body into total overdrive … it's just all about helping yourself" (pg3, line78).

Alicia also described the benefits of normalising the experience of depression and the relief she felt as a result of reading literature on depression;

Alicia: *"I was given a lot of information about depression and handouts and all that kind … I suppose it was such a relief because what I was reading on paper was what I was experiencing and what I was thinking and what I was feeling and I went "Oh my god I'm not the only one that thinks this way or feels this way, this is real for a lot of other people". So it was a big relief" (pg 6, line 130).*

Luke, Isabella, Rebecca, Alicia, Derek and Laura all described how acceptance of their experience enabled them to move forward with their recovery and described how it was the first step in their recovery process;

Laura: *"I suppose then when I did acknowledge … the fear was there … I was just … this is something now and its not nice and how am I going to get out of this and deal with this … (pg 4, line 114).*

Luke: *"it was a relief to be told that I had depression cos suddenly you have something that you can say well, not that I know what's wrong with me but its been identified. Em, while its upsetting, you go about saying what do I need to do to get out of this … this is something that needs to be dealt with and I know what I have to do now … it was an empowering experience in the sense that, this is where we are at, this is what I have to deal with" (pg 16, line 564).*

Laura described that when she acknowledged/ accepted that she was experiencing depression, she could then address it. Until that point she denied to herself that she

was finding her life difficult which impeded her from moving forward. Isabella was more descriptive in her account of acceptance. She described the process of getting to a place of acceptance in more depth. It involved her having to acknowledge what she was experiencing at the time and allowing herself to experience it without fighting. It was a painful process however it was necessary to move forward;

Isabella: *"I just walked with the black dog, "hey black dog, how's it going, come on I've to go here, I've to do this, I've to do that" so I just lived with it and when I wanted to cry I cried and when I didn't want to cry I didn't want to cry. When I wanted to speak to someone I spoke to someone, when I didn't I didn't" (pg 5, line 143). …"…you have to learn to trust yourself and learn to accept yourself. I struggled with that for years and years. You know that where the self hatred came from, cos I would not trust myself … and where I am now compared to where I was then and that's pretty cool" (pg 13, line 432).*

Alicia described the battle that goes on in the journey to acceptance and identified that only when she accepted was she able to move forward;

Alicia: *"I was kind of looking for answers but I wasn't listening so there was this battle going on. I was looking for a way out but I wasn't listening because I was, I just wouldn't, I wasn't ready to listen because to listen I had to let go of the idea of suicide when it wasn't ready to go. So then in the end I accepted the elephant in the room, it's 90% so, lets work with the 10" (pg 10, line 250).*

Rebecca described how acceptance was a process that continued after she no longer experienced depression and that she continued to accept what she described as her limitations and this was important in her continued recovery;

Rebecca: *"… I have to accept my limitation … I cant go out and work five days a week, go to the gym, come home, mind the children, ahh look perfect, em, be perfect. I cant do it. I can only be me" (pg 16, line 521).*

Derek also stated that acceptance of his life circumstances and emotions at that time facilitated his recovery although it had been delayed due to the social discourses he was exposed to as outlined in the extract below;

Derek: *"It was only when I realised I was doing that that I refocused on my circumstances and began to view it in a different way….I suppose you could say I started to accept my new circumstances …This process for me was delayed I think by me focusing on what the internet or the Drs on the radio said about depression. I know it's supposed to be helpful but I think it just needs to be done differently"* .

An acceptance of how he was feeling and linking it to life factors appear to have been helpful in Derek's recovery. There is a sense that acceptance of current circumstances and emotions helped alleviate the emotional distress Derek experienced. Furthermore when Derek ceased focusing on what the social discourses were communicating, he was able to re-evaluate his experiences and engage more meaningfully in his recovery.

At a more critical and interrogative analysis level, it is evident that acceptance alleviates suffering and thereby helps an individual to move forward in their recovery as evidenced in the participant accounts above. Normalising experiences also appears to lead to moving forward for participants. Non acceptance of emotions and circumstances leads to suffering and remaining stuck. Being trapped in a self dialogue of what is fair or unfair, right or wrong, should be or should not be ensures an

individual remains stuck and prevents them from attributing new understanding of their experiences. Therefore moving from depression to recovery involved making sense of the internal messages and coming to conclusions or actions that felt right for participants. Furthermore, participants acknowledged that they had moved far in relation to recovery and began seeing themselves as vulnerable to depression and seeing it as part of who they are but not feeling controlled or defined by it.

This may lead to greater emotional suffering thereby ensuring the self-dialogue becomes more and more negative, more and more hopeless thus strengthening the belief that nothing will change and that they are unable to do anything to bring about change leading the person to feel more helpless and disempowered. This then may intensify the emotional experience which then in turns strengthens the belief that nothing can be done leading to more suffering. As a result this can lead to self isolating behaviour (and other maladaptive behaviours) and disengagement from ones life exacerbating the situation further. Therefore acceptance and letting go appeared to be vital in the process of recovery as with acceptance of circumstances and emotions, past and present individuals could move forward and become unstuck. It was evident that this was a significant turning point for participants' in this study and by engaging in acceptance, they were then able to attribute meaning and move forward in their recovery.

5.63 Connectedness

All participants' identified the importance of connecting to others whether loved one, professionals, or spiritually as significant in the transformation of the self. They identified that this allowed them to move through their journey and emerge with a greater understanding of themselves and what they had experienced and questioned if

it would have being possible without the sense of connection they experienced. In contrast when examining the first theme which described individuals' experience through metaphor, all participants described the sense of isolation and been alone in their experience. This theme on the other hand highlighted the importance of connecting to others in aiding their recovery.

Derek identified in the extract below a number of factors he found helpful in his recovery such as not feeling alone, establishing a sense of a team, meeting with friends, reengaging in his life and communicating with his wife Kate. All of these factors Derek outlined involved connecting with others in some way;

Derek: *"I then started talking with Kate and I didn't feel so alone then … I felt we were a team and that we would get through it together … we had each other whatever else we had or didn't have … that really helped in me getting back to myself … difficult yes but not a disaster … this really helped me … I started enjoying things more like meeting friends and doing things with my wife"*.

At a more critical and interrogative analysis level, the word team implied a sense of togetherness. It is apparent that feeling connected to Kate aided in Derek's recovery. Therefore it is evident that as human beings, feeling and being connected to others is vital in recovery from difficult life events and that isolation from others puts a person at greater risk of becoming more depressed. Derek's expression "*back to myself*" implied he was far removed from himself, was not feeling himself, feeling like someone else, someone different. "*Back to self*" resonates with recovery and where he wished to be. Derek's use of language "*difficult but not a disaster"* demonstrated a reappraisal of his circumstances in a more constructive realistic manner than

previously understood. This implies that Derek went through a process where he was able to cognitively reappraise the situation resulting in emotional regulation.

Rebecca, Jackie and Sophia also described the importance of others and connecting with others in their recovery and their transformation. Sophia identified that connecting with those who are supportive towards her is what's important and the impact that made in her recovery;

Rebecca: *"if you get help and you're lucky that, I suppose, you've support around you (husband and daughters), and there's something inside you that will just keep pushing" (pg 11, line 333)*

Sophia: *"I do everything humanly possible I can as a person to help myself. I try and eat right, I walk everyday, I try and avoid people that don't, you know that are very negative or don't..... I engage with people that I know like me and I'm fortunate that I have that choice now in my life" (pg3, line51). … "I didn't think I'd be sitting here now saying this three years later but in a positive way depression has made me a stronger person and it has changed my whole life around for the complete better … And it took the fear away, my fear of a relationship with somebody. I'd always find fault (with relationships) and I don't know was it the fear, "oh god what if it didn't work out", all this negativity" (pg, line166).*

Jackie further described the importance of connecting with others in her recovery and that she did not have many friends, however did have one good friend she confided in which helped in her recovery;

Jackie: *"… was hard actually because I didn't have a lot of good friends, do you know and I, I kind had nowhere to go really with it. I had one very*

good friend now that stuck around the whole time and she knew what was going on as well you know" (pg 9, line 296).

Isabella and Laura described connecting with professionals and how that was helpful to them in their recovery;

Isabella: *"I didn't express it not really well to people except for my therapist … I did find that slowly but surely and gradually it just, the anger level, the hatred level, the despair level, it trickled down and it just, it wasn't as powerful as what it was … because I was able to express it to my therapist in comparison to not saying anything to anybody else" (pg 7, line 233).*

Laura: *"I only realised the value of talking, I would have been able to talk to my husband and mother but I suppose it was hard for them because they were worried about me … I think the community (mental health) nurse coming everyday and speaking to me and teasing things out … and her saying "Look it will take time but you will, I promise you'll feel better" … I clung onto that (pg 12, line 416).*

Alicia described a more societal connection, a larger connection as been helpful in the recovery journey in the extract below;

Alicia: *"I think actually celebs coming out and admitting it is a huge thing. Part because like they're looked upon as being God Almighties and the best thing since sliced pan and I think people are fearful to show their human side you know … I think its changing defiantly with celebs admitting to it and bringing out the human side of everyone and then it's coming out more and more … we're more human about it now as opposed to "oh god it doesn't exist" or its not there or whatever (pg 16m, line 444).*

Finally Luke described been connected spiritually as helpful in his recovery;

Luke: *"I think that spirituality, not necessarily religion, but I think a spiritual connection is vital in people's psyche for emotional wellbeing … being connected to something bigger than yourself"* (pg 40, line 1355).

Luke was the only participant to describe being connected in another way other than with other human beings. The other participant all described been connected with others such as loved ones or professionals as significant in their recovery.

5.64 Re-evaluation of Life and Self

All participants described re-evaluating their lives and self as part of the experience of depression. Most participants identified that this was welcomed however some participants stated that they would rather not have experienced depression while others believed that it changed their lives for the better.

Participants' such as Luke, Sophia, and Derek identified how the experience of depression was a means of communicating to them that they had strayed from their values in life and they were no longer living their lives consistent with their values;

Luke: *"I felt for a long time that I'm not doing something that I really want to do … and I knew I've a problem here …* (pg 11, line 386).

Sophia: *"(depression) was a prompt to me to say that your life isn't the way it should be and things will have to change if you're going to be well, you know. And I used always be a very stressed person and I felt if I'm going to continue with the stress I'm going to get ill, I'm going to bring*

something on myself. Cos its the worst thing ever, so I think it happened for a reason that em, there was, the purpose of it really was of my wake up call, that all of this started happening to me and I wasn't coping and it was like a crash really and em, the purpose of that depression was to make me to start to get clarity that this cant continue and I need to get myself sorted out and I need to move away from this, a life style change basically, you know. So that's what I've tried to do and em, every day is a self healing process …" (pg10, line276).

The above extracts identify that Luke and Sophia were not living their lives in the manner they wished and that the experience of depression helped them to regain their perspective. This process became even clearer in the following extract where from a phenomenological reading, Derek identified that he began searching for a *"more positive meaning"* from his difficult experience of depression. He identified that he had become *"very materialistic"*, something he was not happy about and by identifying that his family been present in his life helped in his process of recovery. Derek therefore reappraised the situation he found himself in which resulted in him attributing new meaning to his experiences thereby allowing him to develop a new perspective.

Derek: *"I started to look more for the positive meaning from what I was going through…I know that sounds a bit mad but that's what I did…I felt that I had become very materialistic and been down and going through this was a way for me to be where I was suppose to be…and not somewhere else…this really helped me…I started to see what I did have and who was in my life and felt lucky to have that…..this also helped a lot….I had been feeling bad for about 4-5 months before all this happened…it felt so much longer but I know it was this length of time because …I know it was that long"* (pg 18, line 379).

At a more critical and interrogative analysis level, Derek's use of language *"sounds mad"* implies that perhaps he identified his understanding as unique or different by engaging in this kind of re-evaluation of his circumstances and experience. He identified becoming very materialistic which he clearly was not happy with. Therefore one could argue that Derek's experience of feeling down, sad, and depressed helped him to re-examine his life as it did for Sophia and Luke.

These emotions acted as a means of communication to participants in that they were communicating that they were not living their lives consistent with their values. They had somehow distanced themselves from their values by virtue of living their everyday lives and when their circumstances changed they were forced to take note of what their emotions were attempting to communicate to them as individuals. They may not have initially listened and took notice of what their emotions were attempting to communicate to them as they were focused on the symptoms of depression thereby blocking the necessary healing process. It was only when they began to hear what their emotions were trying to communicate to them were they able to reappraise their circumstances and develop a new perspective which led to their recovery. Participants viewed this re-evaluation of their lives as helpful as it ultimately provided clarity and direction.

Jackie, Laura and Alicia described how they learned to view themselves differently and that they viewed themselves as stronger after their experience. Laura and Jackie both described viewing themselves as stronger human beings following their experience of depression;

Laura: *"I think I have a more positive perception about depression, if that kind of makes sense … I suppose now I can see that I'm strong. Before when I was depressed I didn't feel strong at all. I felt so weak. I felt that I was a weak person because I suffered from depression but now I feel strong because I've come out the other side of it" (pg 14, line 477)*

Jackie: *"It (depression) has been helpful and it has made me a stronger person, I believe anyway. And it has made me look at things differently. So it has had its benefits but I still wouldn't want to go back there … (pg 22, line 735).*

Alicia was able to detach herself from depression in that while she was experiencing depression first, she saw herself as a *"depressed person"* whereas after she viewed herself as *"a person who experienced depression"*;

Alicia: *"And then when I started learning that this (depression) is only a piece of me, it is not all of me. And then I start learning well what else do I do in my life. I work, I do this, you know, God, you know it really showed the light, you know, big time" (pg12, line 302).*

At a more critical and interrogative analysis level the above extract demonstrates how internalised social discourses impact on individuals' understanding of their experience of depression, their self and their emotions. Internalised social discourses can prevent individuals from attaching personal meaning to their experience of depression.

Finally Isabella described the experience of depression as a means of getting to know oneself *"… as awful as depression is, you really get to know yourself"*;

Isabella: *"… I am more open now to talk about what upsets me in a clear concise way … and I believe you don't have to suffer and acceptance*

of myself … I now say to myself; you'll deal with this in your own time, in your own way, and it will take longer to, for some issues, … some issues are a lot more touchier than other subjects. And little by little and gradually the rage, the wild beast of anger will calm down and the self hatred will get tired and will go to sleep. It's the difference now, compared to what I was, is just night and day … as awful as depression is, you really get to know yourself" (pg 13, line 414).

To conclude the super-ordinate theme that emerged; "Embracing myself and my Mind - Transformation of the self", addressed the process of participants' transformation whereby they re-emerged from their experience with a greater sense of self, a return to their values, a sense of finding self, regaining perspective, a sense of connectedness, self empowerment, hope, a process of acceptance and finally establishing a meaning with regard to their experience of depression. The above super-ordinate theme developed from the subordinate themes; "I began to smell the coffee again"; Letting go, re-evaluation of life and self and connectedness

5.7 Conclusion

This chapter presented the findings that emerged from in-depth semi-structured interviews conducted and subsequently analysed using Interpretative Phenomenological Analysis (IPA). Four super-ordinate themes explicated from the study related directly to how social discourses contributed to how participants' made sense of their experience of depression and were supported by quotes and extracts from participant's accounts. It demonstrated how social discourses contributed to individuals experience of depression leading to an additional layer of distress. This additional layer of distress was informed by social discourses with the trigger for participants being an identification of the physical consequences (symptoms) of their

emotional experience. This could be conceptualised as meta-distress which in essence is distress about distress.

The super-ordinate themes presented included; ‘The Descent’, ‘The Worlds Conversations and Me - Engagement with Social Discourses’, ‘Broken Self - Transforming the Self’, and ‘Embracing myself and my Mind -Transformation of the Self’. The first theme ‘The Decent’ emerged through the use of metaphor in expressing participants’ experiences and their attempt to describe, understand and communicate their experience to both the interviewer and themselves. A phenomenological reading of participants’ experience identified that all participants were overwhelmed by their experience and all participants expressed this experience through the use of metaphor and imagery such as water and darkness metaphors.

The next theme ‘The World’s Conversation and Me – Engagement with Social Discourses’ derived from the process of contextualisation (Smith, 2013). The transcripts were examined for connections between emergent themes in order to identify the contextual or narrative elements within the analysis. The super-ordinate theme that emerged; “The World’s Conversation and Me - Engagement with Social Discourses”, developed from the subordinate themes; ‘societies conversations’, and ‘disconnection from self’.

The third theme that emerged ‘Broken Self – Transforming the Self’ represented the process of participants transforming into a different self, a self they believed they were powerless to stop and a self they did not wish to be. The super-ordinate theme developed from the subordinate themes of; ‘unknown self; loss of self and one’s

identity', 'desperate for a way out' and 'conflict with self and what's known'. The participants' experience of depression demonstrated that depression was viewed as a complex, multifaceted phenomenon which could return at any time thereby impacting on the relationship participants had with themselves. Participants described a change in how they understood themselves, how they viewed themselves and how they related to themselves and others. Some participants described viewing themselves through the eyes of others (internalised social discourses) and the distress they felt as a result. These experiences resulted in participants describing their sense of loss of self and identity and having to experience a new self that they did not want to experience.

The final theme 'Embracing myself and my Mind - Transformation of the Self' derived from the process of polarization. This addressed the process of participants' transformation whereby they re-emerged from their experience with a greater sense of self, a return to their values, a sense of finding self, regaining perspective, a sense of connectedness, self empowerment, hope, a process of acceptance and finally establishing a meaning with regard to their experience of depression. The super-ordinate theme developed from the subordinate themes; *"I began to smell the coffee again"* – Recovery'**;** **'**Letting go', 're-evaluation of life and self' and 'connectiveness'.

In conclusion the first theme; 'The Descent' demonstrated how individuals described their emotional experience through metaphor without labelling their experience. The following theme; 'The Worlds Conversations and Me' highlighted how social discourses informed their understanding of their emotional experience when they

received the label of depression either by self or a healthcare professional. Once the label of depression was received, individuals then viewed their emotional experience through this lens resulting in an additional layer of distress (meta-distress) been experienced. This then impacted on their overall experience of depression (third theme; ‘Broken Self’) as they had two layers of emotional distress to deal with which made their experience more difficult. These included the distress related to their experience and the meta-distress related to the social discourses that informed their understanding of their experience when labelled depressed. The final theme; ‘Embracing myself and my Mind’ demonstrated how individuals through connecting to others, accepting their experience and attributing meaning to their idiographic experience resulted in their recovery and elimination of meta-distress.

Chapter 6

Discussion

6.1 Introduction

In this chapter, a discussion on the pertinent research results is presented. In writing this chapter I aim to merge the research and conceptual literature presented in the literature review chapters with the experiences of the participants: Alicia, Derek, Luke, Jackie, Sophia, Isabella, Laura and Rebecca. I used reflexivity to aid my approach thereby ensuring that the participants' narratives and experiences do not become lost in discussing the findings in the context of research and conceptual literature. As this was a co-constructed piece of work between each participant and me, it is important that their experiences remain the central focus of this chapter while also arriving at reasoned arguments based on the findings. I spoke with others who conducted IPA studies from various disciplines including nursing (one individual), systemic psychotherapy (two individual), clinical psychology (three individuals) and counselling psychology (two individuals) to see how this was best done. Some did either not fully grasp what exactly I was aiming to achieve, or I was not able to clearly articulate my intentions to them. This demonstrated that I was not getting the essence of what I hoped to do across clearly which was helpful as it allowed me to acknowledge that if I was not communicating this clearly to those who had completed IPA studies then I was unlikely to achieve my aim which was to keep the participants' experiences central to the chapter.

I then reflected on the participants' accounts of their experience of depression and remembered the validating effect expressing their idiographic experience had for them in the interviews. Many participants expressed that reflecting on their experience had been helpful and that they had not engaged in that process before. This reinforced the importance of ensuring that their account remained central and I felt a strong sense of responsibility to do this to the best of my ability. I also considered what I had discussed in supervision (throughout the writing of this research study) with both my supervisors in relation to staying close to the participant accounts and not viewing their experience through the lens of a cognitive therapist. Therefore I realised that just as I had approached the interviews from a neutral stance, as a researcher and not as a therapist, where I took each participant's experience as a unique idiographic account of their experience (Smith, Flowers, and Larkin, 2013), I would do the same with the discussion chapter.

As emotional experience is very personal and individual I approached the integration of the research and conceptual literature in the discussion chapter tentatively. I was mindful not to over generalise participants' accounts into the literature, however arrive at plausible observations and arguments informed by both. I then went back to those (nursing, psychotherapy, clinical and counselling psychology) I had spoken to and communicated this to them and they understood what I hoped to achieve. I now felt confident that I could proceed with writing up the discussion chapter where the participants' accounts remained central to the chapter, interwoven tentatively with the research and conceptual literature.

Following a brief overview of the findings, three main findings are discussed: selfhood; connectedness; and meta-distress. These findings are discussed as they featured strongly in the participants' accounts with the finding meta-distress emerging as one not previously identified in the research literature. The four super-ordinate themes related to how individuals made sense of their experience of depression:

1. The Descent

"It felt like I was in a world where there was a constant dark black cloud everyday over me … it was just awful…so dark with no way out"

2. The Worlds Conversations and Me - Engagement with Social Discourses

"… the doctor described it was serotonin in my brain and that because I was just draining myself physically of the chemical that I was so low I wasn't able to reproduce this happy mood, good hormone, chemical or whatever it is. I needed something to take, to boost that again and he said once that was boosted you begin to think clearer"

3. Broken Self - Transforming the Self

"The fear of failure and when that happens, you've failed to keep it together in your body, in your mind everything and (its) just out there … "I'm a failure"

4. Embracing myself and my Mind - Transformation of the Self

"I live my life now everyday because I was living months in advance, what if, what if and I was getting hysterical and totally putting my body into total overdrive … it's just all about helping yourself".

The findings suggest a profound change in how participants experienced themselves, others and the world they inhabited, similar to that captured by Radcliffe et al (2013:10): "a kind of all-enveloping affective change that permeates every aspect of experience" and is often described as akin to inhabiting a "different world, a suffocating, alien realm that is isolated from the rest of social reality"

The findings of this study demonstrate how profound the experience of depression was and its impact on an individual's sense of self and identity (selfhood). Not only was an individual's relationship with themselves impacted but also their relationship and ability to connect (connectedness) with those around them. Finally this study's findings, though supportive of the many understandings of the lived experience of depression revealed an aspect of the experience of depression not found in the research literature related to the lived experience of depression, namely the finding of meta-distress, which in essence is distress about distress. This chapter will critically discuss these three significant findings: selfhood; connectedness and meta-distress. Selfhood relates to the super-ordinate themes: 'Broken Self – Transforming the Self' and 'Embracing myself and my Mind'. Connectedness relates to the super-ordinate themes: 'The Descent' and 'Embracing myself and my Mind'. The finding meta-distress relates to the super-ordinate theme 'The World's Conversations and Me' which will be discussed first.

6.2 Meta-distress

An important finding from this study related to the concept of meta-distress. Distress was identified in the studies reviewed but attributed to the experience of depression

itself and it was not conceptualised as two layers of distress which emerged in this study. Due to the internalised social discourses individuals acquire during their lives; they become activated when they experience depression which adds another layer of distress (meta-distress) to the distress they are experiencing as a result of experiencing depression. This became evident with the participants in this study. I will now discuss how this process occurred, taking into consideration the role the media had in relation to the information it disseminated and how this resulted in participants experiencing meta-distress in this study.

The super-ordinate theme 'The World's Conversations and Me' highlighted how social discourses informed participants' understanding of their emotional experience when they received the label of depression which contributed to participants experiencing meta-distress. Various social discourses impacted on how participants in this study understood their experience of depression. Discourses of depression make the connection between the individual and the social as it acknowledges that the experience of depression is both a language and a lived experience and therefore cannot be treated as an entity outside the discourses in which it is constructed. In essence social discourses contribute to individuals' phenomenological experience of depression. According to McClusky (1997) beliefs about health and illness which are contingent on their social, cultural and historical context relate to the theoretical position of social constructionism outlined in chapter two and three. Therefore individuals' lived experience of depression is grounded in social context which also contributes to their understanding and experience of depression.

In this study participants identified how they first became aware of what they had experienced in terms of a medical diagnosis. This awareness came about through the medium of radio, newspapers, internet, books and health professionals, mainly their general practitioner**.** Once they became aware of this participants began to conceptualise their experience in terms of medical symptomatology. They established a new appraisal of their experience based on noticing symptoms and linked this to being depressed. The media have an influence on the everyday lives of individuals and communities. Radio, television, print media along with other systems of representation such as academia, school, art, literature, film and music are all elements out of which we form identities both as individuals and as communities. These vehicles of cultural production help shape our sense of self. However, the media does not always objectively record and describe reality, nor do they neutrally report the facts and stories (Henry and Tator, 2002).

Sophia understood what she was experiencing as a difficult experience without attaching a label initially. Looking up the internet led to Sophia understanding her experience of depression in terms of symptoms which led to her making an appointment with her GP. Sophia may have developed a new appraisal of her experience based on noticing symptoms which she read on the internet and thereby understood her experience as depression. Isabella and Jackie described the impact they experienced when they first realised they were experiencing depression which was an end to the life they once knew. This fits in well with McPherson and Armstrong (2009) observation that individuals' may self-diagnose as depressed before they meet with their primary care physicians. This is an indication of the dominance of the biomedical discourse in society and the ease of access to information via print

and electronic media. This point is well illustrated by Nettelton and Burrows (2003) who argue that the diffusion of health and medical information on the internet means that information that once was only available via consultation with medical professionals is now readily available along with being able to take self-directed diagnostic tests via the internet.

Alicia, Luke, Isabella, Jackie, Derek and Sophia all understood their experience from a biomedical perspective. Sophia understood it as a serotonin imbalance in her brain following a discussion with her doctor while Alicia believed it to be genetic which demonstrates the impact of the biomedical discourse in contributing to participants' understanding and meaning making process of depression. One of the most notable biological explanations regarding the aetiology of depression relates to the theory that depression is a result of a serotonin imbalance in the brain. However there is little empirical evidence underlying these ideas (Nelson et al, 2005). A number of studies have also been conducted examining the impact of genes in depression (Sullivan et al, 2000, Kendler et al, 2006, Hettema et al, 2006, Claes et al, 2009). Claes et al (2009) hypothesis that there are potentially four genes that contributes to individuals developing depression. However they acknowledge that the research pertaining to these genes is limited with few studies conducted. They believe that the evidence is greatest for the FKBP5 gene where four large studies have been conducted. They also acknowledge that further studies are needed to determine the significance of genetics in the development of depression.

The contemporary developed world framing of depression as an illness requiring medical treatment is clearly evident in the participant accounts in this study. It is

evident that the dominant cultural understanding of depression is that of an illness requiring medical treatment to facilitate a cure. This is further evidence of the biomedical discourses influence in how participants conceptualised their experience of depression thereby impacting on them in their search for the meaning within their experience.

This understanding relates to Kendell's (1975) and Boorse's (1998) argument for the existence of mental illness based on the reality of illnesses of the body and brain. An illness of the body leads to an illness of the brain. According to Kendler (2005) and Moncrieff (2007), assuming that depression is a brain disease limits scientific progress as it implies that genetic and brain variations that predispose to depression are abnormalities, when in fact they may be neutral, or ever advantageous, in certain environments. Furthermore, it neglects the role of life events and other causal factors that may lead to an individual experiencing depression. It also implies that depressive symptoms are pathological, distracting attention from the task of identifying the function of the emotion of feeling low or depressed. Szasz (2010) argued further that for those who regard mental symptoms as signs of brain disease the concept of mental illnesses such as depression is unnecessary and misleading. He argues that if people suffer from disease of the brain, in essence a neurological disorder, then that is how it should be phrased. The idea that mental illness is sui generic (a form of illness like physical illness but essentially and distinctly mental) implies that one views mental illness as a "deformity of the personality". This explains human disharmony or more generally life problems.

It is evident from the literature to date that research cannot conclusively state that depression is as a result of genetic or biological factors however medical professionals, the media, and newspapers continue to communicate this discourse as fact which then is internalised by individuals' in society and contributes to their understanding when they experience depression. This also relates to the movement to concretize and promote a unified body of knowledge on mental health and mental illness, now generally known as mental health literacy (MHL). The aim of MHL training is to ensure individuals know how to recognise, prevent, and seek help/ treatment (usually meaning professional help) for mental disorders with depression referred to as a mental disorder (LeFrancois, Menzies, & Reaume, 2013). MHL is a form of knowledge that is not necessarily tethered to culture and experience. MHL training for depression might be seen as a manifestation of a collection of ongoing practices through which the "mentally ill" are socially and institutionally identified and managed (LeFrancois, Menzies, & Reaume, 2013). Therefore if only one way of conceptualising mental health and mental ill health is disseminated then that becomes the discourse in society and many individuals are more likely to label their emotional experience through the language and understanding of that particular discourse.

All participants in this study clearly identified with the breakdown of their experience into symptoms. The participants described the biological and psychological symptoms *"not sleeping and feeling down"* they experienced and took on the developed world framing of these symptoms as depression, a "*mental illness"*. This demonstrated how social discourses of depression had been internalised by participants, shaping how they experienced and understood their emotions which ultimately contributed to how participants made sense of their experience of depression. Participants described

experiencing a *"massive fright"*, (Derek) *"scared the life out of me"* (Derek); *"I genuinely thought I had a serious medical issue"* (Isabella), *"she thinks I'm off my game"* (Jackie)*;* which may demonstrate the development of a new understanding for participants of their experience in their search for understanding. They established a new appraisal of their experience based on noticing symptoms from listening to the radio, reading on the internet or speaking with their GP and linked this to being depressed.

They then experienced another level of distress about being emotionally distressed. This could be conceptualised as meta-distress which in essence is distress about distress. This additional layer of distress is informed by various discourses with the trigger for participants being an identification of the physical consequences (symptoms) of their emotional experience such as poor sleep, poor appetite and low energy. Isabella described that she *"got depressed because I got depression"* identifying the meta-distress she experienced.

The concept of meta-distress was not evident in the literature I reviewed or at the very least was not conceptualised in that manner. Distress is identified in the studies reviewed but attributed to the experience of depression itself and not conceptualised as two layers of distress which emerged in this study. This is significant for a number of reasons; firstly due to the internalised discourses individuals have acquired during their lives, they become activated when they experience depression which adds another layer of distress (meta-distress) to the distress they are experiencing as a result of experiencing depression. To use a metaphor to describe this concept; the distress of experiencing depression is akin to carrying a four stone bag of potatoes (weight of

distress) on one's back, heavy and difficult but not impossible; the internalised discourses which results in meta-distress is akin to adding another four stone bag of potatoes on one's back; now the individual has to carry eight stone in weight which is significantly more difficult. Therefore arguably if there is a plurality of perspective communicated by healthcare professionals, media and academia then individuals would internalise these discourses and result in the elimination of meta-distress. However in this study participants attempted to make sense of their experience but were confronted with a discourse disseminated by the media around medical diagnosis, genetics, and pharmacological intervention. This led to a specific way of understanding their experiences resulting in an additional layer of distress.

Numerous studies have examined the contribution the media has on understanding the experience of mental illness and depression (Rowe et al 2003, Rapley & O'Ferrall 2003, Sieff 2003, Ward 1997, Rose 1998, Parslow 2002, Francis et al 2004). According to Rowe, Tilbury, Rapley and ' Ferrall (2003) much has been written in the media about mental health and depression that can only be described as a false and misleading construction of mental health and mental ill health. So stigmatising, it is said, is the effect of negative media coverage that there is growing pressure for more accurate and less stereotypical reporting of mental illness (Clarke 2009, British Psychological Society 2000).

Although the British Psychological Society paper (2000) is 16 years old, more recent studies such as the one conducted by Clarke (2009) exploring the portrayal of depression in men's magazines between 2000 and 2007 found that depression in men's magazines is encapsulated in stereotypical male discourses of success at work,

ignorance of feelings and reluctance to seek help. Depression was also largely described as having a biochemical and/ or genetic cause. Only a few articles mentioned the possible effects of socio-economic and gendered experiences of maleness or masculinity. The magazine portrayal emphasised that men are not to have feelings and in particular negative feelings and if they do they should not seek help through psychotherapy. It was communicated that men must be highly successful at work or sport, even celebrated, and if hit with depression which is portrayed as a biological disease then they need to be treated actively and aggressively with antidepressant medication prescribed by a doctor. Clarke (2009) also noted that men's experience of depression contrasted greatly with women's experience. Women were described, usually by inference, as both weak and "using" men through their demands that they be highly successful at work and financially. This study also highlighted clearly the gender discourse pertaining to men's experience of depression.

Alicia and Derek identified how socio-cultural discourses contribute to the socialisation of individuals and society about what constitutes depression and highlighted the impact medical, and social discourses have on individuals' interpretation of their experience of depression. It is evident that the dominant socio-cultural understanding of depression is that of an illness requiring medical treatment to facilitate a cure. Davies (2013) argues that psychiatry is big business in that 47 million antidepressant prescriptions were given in the UK alone in 2012 without solid scientific justification. Human distress and difficult life events are now medicalised into illnesses that require treatment with the number of mental disorders increasing with each new edition of the DSM published. Treatment usually involves the prescribing of highly profitable drugs. He concludes that negative drug trials are

routinely buried; there is evidence that antidepressants work no better than placebos and research is regularly manipulated to produce positive results. He also argues that physicians are seduced by huge pharmaceutical rewards, creating more disorders and prescribing more medications; and ethical, scientific and treatment flaws are unscrupulously concealed by mass marketing.

However, depression can be also understood as part of the suffering that constitutes what it is to be human. While contemporary approaches to depression are valuable, they are also restrictive. Therefore it is important to be more inclusive in terms of how society conceptualise this experience so as to contribute to a broader discourse on this very common human experience. There are many ways individuals experience and understand these experiences to what is commonly referred to as depression and if society, professionals and the media limit what informs this experience, a limited understanding of that experience is communicated resulting in individuals internalising a limited understanding. It seems clear from the above that many individuals can only make sense of their emotional experience through this restrictive lens, thereby leading them to understand their experience in terms of symptomology only, contributing to the experience of an additional layer of distress, namely meta-distress.

In conclusion the experience of depression is complex and multifaceted and understanding this common human experience is influenced by various discourses. I have presented an argument regards how the social discourses and in particular the biomedical discourse disseminated by the media contributes to the development of internalised discourses which become activated when individuals experience

depression. The internalised discourses impacted on the meaning making and how participants made sense of their experience in this study. They then arguably experienced another level of distress about being emotionally distressed. I have conceptualised this experience as meta-distress which in essence is distress about distress. These included the distress related to their experience and the meta-distress related to the social discourses that informed their understanding of their experience when labelled depressed.

6.3 Selfhood

The phenomenological changes that an individual experiencing depression undergoes are profound although its impact on an individual's sense of self and identity is arguably obvious. With depression there is a change in the feeling of how the world as a whole appears and is experienced. Arguably the sense of self is diminished in depression rather than disrupted. With depression there is a radical change in all experience and thought, one that also implicates the ability to act. Radcliffe (2015) argues that the experience of depression differs radically from many people's mundane, everyday experience. The biomedical understanding of depression does not capture the way in which depression invades the self taking control over it, an account described by all the participants in this study. As all participants described the impact depression had on their sense of self I will discuss this finding further.

Selfhood related to the super-ordinate themes: 'Broken Self – Transforming the Self' and 'Embracing myself and my Mind' in this study. The super-ordinate theme 'Broken Self – Transforming the Self' represented the process of participants transforming into a different self, a self they believed they were powerless to stop and

a self they did not wish to be. Depression, therefore, appears to be an illness of the self, robbing participants of the manner in which they related to themselves and consequently changed their identity. Participants in this study described a change in how they understood themselves, how they viewed themselves and how they related to themselves and others. Some participants described viewing themselves through the eyes of others and the distress they felt as a result. Alicia, Rebecca, and Laura all described a change in how they perceived themselves. The experience of depression for them resulted in each of them making negative generalisations about themselves such as believing that they were a failure, not good enough or weak. These generalisations demonstrate how the experience of depression invaded the self and took over leaving the participants with a sense of lost identity.

Robertson et al (2005) study arrived at similar findings describing how participants attached negative meaning to life experiences; to future experiences; and used negative limiting language drawn upon to express life narratives. With regard to the attachment of negative meanings to life experiences, they found that participants not only attached negative meaning to their depression but also to many areas of life experiences. For example hurtful experiences were interpreted negatively, without possible positive aspects being considered and their experiences were interpreted as devastating and debilitating. They found that rejection was experienced in an overwhelmingly negative manner, and personal criticisms were accepted as true, instead of been rejected in favour of less negative meanings which was also reiterated by Alicia, Rebecca and Laura. Aho (2013) found that depression became something of a destiny, preventing the person from being open and free to access a range of alternative self-interpretations, identities, and possible ways of being-in-the-world.

This was also echoed in Rhodes and Smith (2010) study which explored the experience of depression from the view point of one individual. They found a profound and near total change in the participant's experience of self.

Participants in my study also described a total change in their experience of self. Derek described a sense of loss of his future and his life without it ever being retrieved. He identified feeling so sad and low which he had not experienced before and identified differences in the intensity of feelings and emotions perhaps as a means of attributing meaning and understanding. He described the experience of depression as a never ending journey with recovery not possible thereby expressing feelings of hopelessness and helplessness; *"I truly believed that things would not improve and that my life would not get better"*. Derek's description confirms that a sense of self is diminished in depression rather than disrupted in his description regarding the finality of it and the fact that things would not change or improve.

Interestingly the two male participants in the study were able to express and articulate their experience and describe their feelings clearly. This was not found in many of the studies reviewed. According to Honkalampi et al (2000) men are less able to identify and express their feelings and are hypoemotional. Brownhill et al (2005), examining similarities and contrasts between men's and women's experience of depression, found that men experiencing depression and the emotional distress that accompanies this manifested it in avoidant, numbing, and escape behaviours, which could lead to violence, aggression, and suicide. In Rhodes and Smith (2010) study Paul (participant) commented numerous times on death and dying suggesting a fundamental transformation of the self.

Participants in my study also expressed thoughts of suicide suggesting a transformation of the self as was found in Rhodes and Smith (2010) study with one participant. Arguably if the participants believed that their life would not improve due to a total change in their sense of self and identity, suicide provided a way to resolve this unbearable reality (perceived). All participants described feeling they had lost control of their lives either directly or described thoughts of suicide which may be an indication that they were trying to regain control or that because they felt that they had lost their sense of self and identity their only option was suicide. Luke, Jackie and Isabelle described directly the loss of control they experienced with Jackie stating that *"you just can't control, you're actually not in control of your life … you've totally lost control and you can't find a way back. "It (depression) just took control of me like this kind of monster"* Isabella believed she would always experience depression which would never leave her *"I genuinely thought that this is going to be me for the rest of my life"*.

Participants in this study also described the need to understand the meaning of their experience and how that was not the focus of the help they received which resulted in them being unable to make sense of their experience. From participant's accounts there was a clear shift in focus from attributing meaning to their experiences to focusing on symptomology. Therefore there was a loss of importance in attributing meaning to their experiences. There was a loss of self once known and loss of identity by participants due to internalising the biomedical discourse of their experience. Luke and Derek were engaged in an existential struggle to determine what meanings they foreground. On the one hand they attempted to understand the meaning of their

experience and on the other hand focused on the symptoms of depression as a means of understanding their experience in a more simplified manner although this was not the reason they conceptualised their experience in that way. Perhaps they engaged in this method of understanding due to the internalised social discourses they had acquired throughout their lives. It is evident from participant accounts above that as Ratcliffe (2013) described, depression had an all-enveloping affective change that permeated every aspect of their experience. In essence the self they had known no longer resided with them and they were presented with a self unknown combined with a belief that this new self was to remain indefinitely. Depression, therefore, robbed participants of the manner in which they related to themselves and consequently changed their identity. This further demonstrates the diminishing effect depression had on the self in this study.

In contrast to the loss of self and identity, participants also described an emergence from a lost self back to the self they once knew. The super-ordinate theme that emerged; “Embracing Myself and my Mind - Transformation of the self”, addresses the process of participants’ transformation whereby they re-emerge from their experience with a greater sense of self, a return to their values, a sense of finding self, regaining perspective, a sense of connectedness, self empowerment, hope, a process of acceptance and finally establishing a meaning with regard to their experience of depression. This process involved acknowledging their current circumstances and also a re-valuation of their life in terms of where they found themselves and how that for some participants did not fit with their sense of identity and values.

Studies exploring the recovery aspect and return to a positive sense of self from a phenomenological perspective were limited. Phenomenological studies explored how the experience of depression impacted on participants (Aho, 2013; Rhodes and Smith, 2010; Smith & Rhodes, 2015) however did not explore a return to a more positive sense of self. Therefore this study provides some perspective and insight into this part of participants' experience of depression.

Participants in this study framed their re-emergence of their sense of self and identity as recovery and how that unfolded. Most participants (Luke, Isabella, Rebecca, Alicia, Derek and Laura) believed that they were able to move forward in their recovery when they acknowledged and accepted their current experience of depression. Some participants stated that by normalising their experience to themselves, they were able to accept their circumstances and begin to address it as they felt empowered to do so and it gave them hope that things could improve. This is in contrast to the above descriptions of negative self limiting language and a belief that things could not and would not improve. Sophia achieved this by finding inspiration from another person's story of depression presented in the findings chapter. This story normalised the experience of depression for her and allowed her and continues to allow her to live her life.

This fits in well with Gramling and McCain (1997), study which found that sadness was linked to failed expectations and disillusionment about life. They discovered that these expectations were linked to their childhood experiences or fantasies about life as a woman. If childhood was unhappy (sexual abuse, poor relationships), the desire was to improve life in adult years and if childhood was a pleasant experience (no divorce,

close with family, growing up in the same town), the desire was to mirror their childhood experience. When women failed to meet their goals (marriage or having fulfilling relationships, difficulty managing personal and professional roles, adult life not been what was envisaged when an adolescent) they felt sad. Resolution of the sad feeling involved moving through the sadness and through self-reflection and growth; the women were more able to accurately see the world and their relationship to it (Gramling and McCain, 1997). In short there was a transition in which the individual moved towards acceptance of their circumstances and formed a new and accepting understanding of their life situation. Only when they acknowledged their circumstances and the emotions they were experiencing, were they able to move forward. This experience of acceptance was also reiterated by all participants in this study.

Isabella was more descriptive in her account of acceptance. She described the process of getting to a place of acceptance in more depth. It involved her having to acknowledge what she was experiencing at the time and allowing herself to experience it without fighting. It was a painful process however it was necessary to move forward; *"I just walked with the black dog"*. It is evident that acceptance alleviates suffering and thereby helps an individual to move forward in their recovery as evidenced in the participant's accounts above. Therefore acceptance appears to be vital in the process of recovery and a return to a more positive sense of self as with acceptance of circumstances and emotions, past and present, individuals move forward and become unstuck. It is evident that this was a significant turning point for participants in this study and by engaging in acceptance, they were then able to

attribute meaning and move forward in their recovery and therefore have a greater sense of self once again.

In conclusion, for most participants in my study the descriptions they gave in relation to a loss of self and identity may have been partly influenced by the internalised social discourses they had acquired in their life path. This may have been part of participants' process in understanding their experience and may have contributed to the transforming of self while experiencing depression. It also demonstrates the impact internalised stigma of mental health difficulties had on how participants conceptualised their experience of depression and the relationship participants had with themselves at that time as evidenced in participants describing feeling ashamed of their experience of depression. However a review of their internalised discourse regards depression, an acceptance of their current circumstances and a re-evaluation of their values, resulted in participants regaining their sense of self and identity. In addition to this, a sense of connectedness with others also contributed to regaining a sense of self, which will now be discussed.

6.4 Connectedness

Ratcliffe (2014) argued that depression impacted on an individual's capacity for interpersonal relatedness. The individual experiencing depression feels cut off from other people, and may remark on their indifference, hostility or inability to understand (connectedness). Connectedness was a finding that all participants described ranging from how the experience of depression impacted on their ability to feel connected to others as described above by Ratcliffe (2014) to identifying that connecting with

others contributed to their recovery. It therefore was both the consequence of experiencing depression but also a factor that helped them break free from depression.

Participants' experience of depression and being disconnected from those around them was evident in this study. Participants often described this disconnection from the world and those in it through the use of powerful imagery and metaphor. Participants' lived experience of depression found that all were overwhelmed by their experience. The metaphors used varied amongst participants however all shared a sense of aloneness and loss of connection with the world and those in it including family, friends, professionals and human beings in general. Metaphors express, constitute, and amplify the subjective lived experience of depression and are an important means of emotional expression (Charteris-Black & Seale, 2010). Metaphors are not merely stylistic, but they are cognitively important also (Lakoff, 1980). They are pervasive in everyday life and not just in language, but also in thought and action. Therefore metaphor can be described as a comparison that shows how two things that are not alike in most ways are similar in another important way (Lakoff, 1980). Metaphor often uses imagery to illustrate or reinforce abstract concepts. Imagery is "the descriptive language used" (Smart, 1999, pg 364) to create a mood or reflect a concrete experience. When used to express an abstract concept, it becomes a metaphor however imagery is often used within metaphor.

Laura, Luke, Isabella and Derek make reference to the darkness of their experience of depression. Luke and Isabella described being in a dark hole and how overwhelming this was at the time also evident in Rhodes & Smith's (2010) study. Laura described in more detail with stronger imagery the darkness of her experience comparing

swimming in a “dark swimming pool” with gray cold walls treading water just about keeping her head above water but not getting anywhere and remaining disconnected from the world and those in it. The dark hole and dark swimming pool represents the aloneness participants experienced and represents their disconnection from others. Emslie et al (2006) state that the hole is one of the most common metaphors in depression although each individual’s dark hole will be unique to him or her, drawing on memories, fears, details, implications and unique symbolism generated from specific biographic experiences.

Interestingly the loss of connection participants experienced in my study was expressed through metaphor and imagery that situated them in places that ensured that they were disconnected from others as described above. Not only did participants feel disconnected from those around them but their descriptions and experience physically disconnected them from others. This may demonstrate how the experience impacted on participants’ openness to those around them and ensured they were disconnected both emotionally and physically in a metaphorical sense. Luke, Isabella, Derek and Jackie described the experience of depression in terms of something physical, a place, in that they were experiencing their world in a place that was different from before even though they continued to engage in the world, just in a different way. The place participants described was a solitary place, a place where the world and the people in it were shut out.

It is evident from above that participants in this study were physically disconnected from others with their relationship with others affected. Ratcliffe (2014) argues that individuals’ experience of other people consists of a felt openness to the possibility of

being affected by them in certain ways. It is this openness that is lacking in depression. The experience of depression therefore impacts on this openness which can also be understood as a loss of connecting with those around them which was evident in my study and also evident in many studies reviewed (Rhodes and Smith, 2010; Smith and Rhodes, 2015; Burr and Chapman, 2004; Clarke, 2006; Schreiber, 2001; Fancher et al, 2010; Hussain and Cochrane, 2002). This experience was also described in Clark's (2006) study of women who experienced depression where they described the experience of depression as a "place" and conceptualised it as somewhere in between life and death and shut off from others. Rhodes and Smith (2010) identified how Paul (participant) described his experience through the use of imagery where he found himself in a pit or hole, his hands tied with no escape which was a reoccurring image for him. This image suggests being abandoned which again highlights how his relationship with others was affected. Paul also described discovered that he was becoming less human and more mechanical, like a robot thereby impacting on his relationship with others (Rhodes and Smith, 2010). It is reasonable to conclude that individuals who experience depression feel disconnected from those around them not only emotionally and relationally but it is also experienced physically. The physical disconnection is experienced and expressed as a form of aloneness in places that are physically isolating such a dark holes or dark swimming pools thereby ensuring the individual experiencing depression remain disconnected from those around them which was evident in my study also.

Although feeling disconnected from others was an experience shared by all participants, so was the acknowledgement that connecting with others was viewed pivotal in recovery. All participants identified the importance of connecting to others

whether loved one, professionals, or spiritually as significant in their recovery. They identified that this allowed them to move through their journey and emerge with a greater understanding of themselves and what they had experienced and questioned if it would have being possible without the sense of connection they experienced.

Derek identified a number of factors he found helpful in his recovery such as not feeling alone, establishing a sense of a team with his wife, meeting with friends, reengaging in his life and communicating with his wife Kate. All of these factors outlined by Derek involved connecting with others in some way; *"I then started talking with Kate and I didn't feel so alone then … I felt we were a team and that we would get through it together … we had each other whatever else we had or didn't have … that really helped in me getting back to myself"*. The word team implied a sense of togetherness. It is apparent that feeling connected to Kate aided in Derek's recovery. Pies (2008) argue that although the boundaries between sadness and depression are sometimes vague, there are phenomenological features that help us distinguish these two concepts. With sadness we are capable of feeling intimately connected with others whereas with depression we feel outcast and alone. A number of studies (Clarke, 2006; Robertson et al, 2005) found that a sense of connecting to others is vital in helping individuals recovery from their experience of depression. Those experiencing depression feel isolated and disconnected from others as discussed above and it is the connecting to others that aids in their recovery. Clarke (2006) found that this sense of human connectedness was consistently reported by the participants as something that they valued most. The participants described a sense of confiding, belonging, being supported and encouraged.

Therefore it is evident that as human beings, feeling and being connected to others is vital in recovery from difficult life events and that isolation from others puts a person at greater risk of becoming more depressed. Derek's expression *"back to myself"* implied he was far removed from himself, was not feeling himself, feeling like someone else, someone different. *"Back to self"* resonates with recovery and where he wished to be which involved connecting with those around him including his wife.

Furthermore, Rebecca, Jackie and Sophia also described the importance of others including healthcare professionals and connecting with others in their recovery and their transformation. Sophia identified that connecting with those who were supportive towards her was what's important and the impact that made in her recovery. Rebecca identified feeling fortunate in receiving support from others and its benefit. Isabella and Laura described connecting with professionals and how that was helpful to them in their recovery.

Emslie et al (2007) identified that the relationship both men and women held with professionals differed. Some valued a close personal relationship with professionals while others felt that this personal relationship was a barrier to communication and preferred talking to a "stranger". Both men and women discussed the need to have some rapport, connection, or to click or gel with their GP and those providing talking therapies. This relates to Clarke's (2006) findings of connectedness and its value in recovery from depression. Another important factor identified was the importance of continuity of care in building personal relationships and the difficulty in having to repeat their stories to different health care professionals. The participants in this study all identified the importance in having professionals to trust in and help guide them in their journey. However this differed for participants. Some had very trusting

experiences (Isabella, Rebecca, Jackie, Laura) while others experienced less trust in their healthcare professional (Luke and Derek).

Finally Luke described being connected spiritually as helpful in his recovery; *"I think that spirituality, not necessarily religion, but I think a spiritual connection is vital in people's psyche for emotional wellbeing … being connected to something bigger than yourself"*. Luke was the only participant to describe being connected in another way other than with other human beings. The other participants all described being connected with others such as loved ones or professionals as significant in their recovery.

It is evident from my study and the studies reviewed that overcoming the experience of depression involves the ability to connect with others.

6.5 Conclusion

In this chapter, a discussion on the pertinent research results was presented. The themes that emerged from the analysed data and presented in the previous chapter was discussed with reference to the conceptual and research literature. The four super-ordinate themes related directly to how individuals made sense of their experience of depression and were discussed in relation to existing literature pertaining to individuals' lived experience of depression. The four super-ordinate themes related directly to how individuals made sense of their experience of depression and included: 'The Descent'; 'The Worlds Conversations and Me - Engagement with Social Discourses'; 'Broken Self - Transforming the Self'; 'Embracing myself and my Mind - Transformation of the Self'.

Three main findings were critically discussed: selfhood; connectedness; and meta-distress. These findings were discussed as they featured strongly in the participants' accounts with the finding meta-distress not being found in other studies. Selfhood related to the super-ordinate themes: 'Broken Self – Transforming the Self' and 'Embracing myself and my Mind'. Connectedness related to the super-ordinate themes: 'The Descent' and 'Embracing myself and my Mind'. The finding meta-distress related to the super-ordinate theme 'The World's Conversations and Me' which was discussed first. Conclusions were informed by both the literature and the findings together.

The results from this study suggest a profound change in how participants experienced themselves, others and the world they inhabited. This study's findings, though supportive of the many understandings of the lived experience of depression revealed aspects of the experience of depression not found in the research literature related to the lived experience of depression, namely meta-distress which in essence is distress about distress. It was evident from this study the significant impact social discourses had in how participants internalised these discourses and the influence this had on how individuals understood their experience of depression. Participants' experience of depression in this study identified how they first became aware of what they had experienced in terms of a medical diagnosis. This medical understanding was delivered through the medium of broadcasting radio, newspapers, internet, books and health professionals namely their general practitioner. Once they became aware of this participants began to conceptualise their experience in terms of medical symptomatology. This was an indication of the dominance of the biomedical

discourse in society and the ease of access to information. The internalised discourses impacted on the meaning making and how participants made sense of their experience in this study. They then arguably experienced another level of distress about being emotionally distressed. I have conceptualised this experience as meta-distress which in essence is distress about distress. These included the distress related to their experience and the distress related to the social discourses that informed their understanding of their experience when labelled depressed, resulting in what I conceptualised as meta-distress.

I would argue that while contemporary understandings to depression are valuable, they are also restrictive. Therefore it is important to be more inclusive in terms of how society conceptualise this experience so as to contribute to a broader discourse on this very common human experience. There are many ways individuals experience and understand depression and if society, professionals and the media limit what informs this experience, a limited understanding of depression is communicated resulting in individuals internalising a limited understanding.

Another important finding from this study related to the impact of depression with regard to participants' sense of self and identity. The experience of depression resulted in participants experiencing themselves in profoundly different ways and I would argue that part of this change is due to the internalised discourses participants had. I acknowledge that the experience of depression did impact significantly on participants in how they experienced themselves however internalised discourses contributed to this experience further. This finding represented the process of participants transforming into a different self, a self they believed they were powerless

to stop and a self they did not wish to be. Participants in this study described a change in how they understood themselves, how they viewed themselves and how they related to themselves and others.

This finding also identified the equally profound change in participants' sense of self and identity through their recovery which is poorly researched from a phenomenological perspective. In contrast to the loss of self and identity, participants also described an emergence from a lost self back to the self they once knew. Participants' transformation occurred whereby they re-emerged from their experience with a greater sense of self, a return to their values, a sense of finding self, regaining perspective, a sense of connectedness, self empowerment, hope, a process of acceptance and finally establishing a meaning with regard to their experience of depression. This process involved acknowledging their current circumstances and also a re-valuation of their life in terms of where they found themselves and how that for some participants did not fit with their sense of identity and values.

Finally, a significant finding which also contributed to selfhood related to participants connectedness with others. Connectedness was a finding that all participants described ranging from how the experience of depression impacted on their ability to feel connected to others to identifying that connecting with others contributed to their recovery. It was therefore both the consequence of experiencing depression but also a factor that helped participants break free from depression. Participants' experience of depression and being disconnected from those around them was evident in this study. Participants often described this disconnection from the world and those in it through the use of powerful imagery and metaphor. Although feeling disconnected from

others was an experience shared by all participants, so also was the acknowledgement that connecting with others was viewed pivotal in recovery. All participants identified the importance of connecting to others whether loved one, professionals, or spiritually as significant in their recovery. They identified that this allowed them to move through their journey and emerge with a greater understanding of themselves and what they had experienced and questioned if it would have being possible without the sense of connection they experienced.

Chapter 7

Thesis Conclusion, Reflections and Implications

7.1 Introduction

The aim of this study was to gain a phenomenological understanding of how individuals' who experienced depression understood and made sense of their experience of depression. It also aimed to explore how social discourses contributed and influenced individuals' lived experience of depression through a methodology of interpretative phenomenological analysis. Exploring the social discourses which contribute to individuals' understanding and meaning making of depression constitutes my contribution to extending efforts in, and answering calls to re-conceptualise the experience of depression in the context of normalising human distress in society.

This research was a co-constructed piece of work between the participants and me which sheds light on how individuals who experienced depression understood and made sense of their experience of depression. It is hoped that this study will add to the current body of knowledge pertaining to depression research representing another voice. I believe this to be necessary and view the communication of alternative discourses as a social responsibility so as to ensure that individuals who experience depression are able to draw from informed discourses. Thereby ensuring they do not experience meta-distress as a result of internalised unhelpful social discourses they have acquired over time. Although this thesis has revealed new insights related to the

lived experience of depression, it also builds on and draws from the valuable, insightful, and dedicated research conducted by many sociologists, psychologists, mental health nurses, medical practitioners, theorists, scholars, and writers. The final chapter draws conclusions based on the findings and discussion of the study followed by critical reflections. Finally, implications for future research and practice are presented.

7.2 Key Research Conclusions

The purpose of this study was to explore phenomenologically how individuals who experienced depression made sense of their experience and how social discourses contributed and influenced individuals' lived experience of depression. Phenomenologically, I aimed to explore and present an account of individuals' lived experience through a meaning focused approach rather than a cause and effect empiricist approach. This was important for a number of reasons including; the dominance of the biomedical discourses in society has shaped how individuals conceptualise their lived experience of depression thereby leading to individuals becoming distressed about their emotional distress (meta-distress); human emotion and emotional distress such as depression is a unique idiographic experience where individuals' attempt to derive meaning from their experience; thirdly, there has been a focus in the past and which continues today to definitively identify the cause and effect relationship which has contributed to the social discourses available to individuals' thereby impacting on their idiographic lived experience of depression.

This study identified four super-ordinate themes. The first theme; 'The Descent' demonstrated how individuals described their emotional experience through metaphor

without labelling their experience. The following theme; 'The Worlds Conversations and Me' highlighted how social discourses informed their understanding of their emotional experience when they received the label of depression either by self or a healthcare professional. Once the label of depression was received, individuals then viewed their emotional experience through this lens resulting in an additional layer of distress been experienced due to the meaning they attributed to the label received. This additional layer of distress was informed by social discourses with the trigger for participants been an identification of the physical consequences (embodiment) of their emotional experience. This then impacted on their overall experience of depression (third theme; 'Broken Self') as they had two layers of emotional distress to deal with which made their experience more difficult. These included the distress related to their experience and the meta-distress related to the social discourses that informed their understanding of their experience when labelled depressed. The final theme; 'Embracing myself and my Mind' demonstrated how individuals through connecting to others, accepting their experience and attributing meaning to their idiographic experience resulted in their recovery and elimination of meta-distress.

This study's findings, though supportive of the many understandings of the lived experience of depression revealed aspects of the experience of depression not found in the research literature related to the lived experience of depression, namely meta-distress. I will focus on the finding regarding meta-distress as this was a finding that emerged in this study that was not found in other studies reviewed. It was evident from this study the significant impact social discourses had in how participants internalised these discourses and the influence this had on how individuals understood their experience of depression. Discourses of depression makes the connection

between the individual and the social as it acknowledges that the experience of depression is both a language and a lived experience and therefore cannot be treated as an entity outside the discourses in which it is constructed (Masse, 2000). Participants' experience of depression in this study identified how they first became aware of what they had experienced in terms of a medical diagnosis. This medical understanding was delivered through the medium of broadcasting radio, newspapers, internet, books and health professionals namely their general practitioner. Once they became aware of this participants began to conceptualise their experience in terms of medical symptomatology. This was an indication of the dominance of the biomedical discourse in society and the ease of access to information via social media.

All participants clearly identified with the breakdown of their experience into symptoms. The participants described the biological and psychological symptoms *"not sleeping and feeling down"* they experienced and took on the developed world framing of these symptoms as depression, a "*mental illness"*. This demonstrated how social discourses of depression had been internalised by participants thereby shaping how they experienced and understood their emotions. Participants described experiencing a *"massive fright",* (Derek) *"scared the life out of me"* (Derek); *"I genuinely thought I had a serious medical issue"* (Isabella), *"she thinks I'm off my game"* (Jackie)*;* which may demonstrate the development of a new understanding for participants of their experience. They established a new appraisal of their experience based on noticing symptoms from listening to the radio, reading on the internet or speaking with their GP and linked this to being depressed.

They then experienced another level of distress about being emotionally distressed. I have conceptualised this experience as meta-distress which in essence is distress about distress. This additional layer of distress is informed by various social discourses with the trigger for participants being an identification of the physical consequences (symptoms) of their emotional experience. Isabella described that she *"got depressed because I got depression"* identifying the meta-distress she experienced.

The concept of meta-distress was not evident in the literature I reviewed or at the very least was not conceptualised in that manner. Distress is identified in the studies reviewed but attributed to the experience of depression itself and not conceptualised as two layers of distress which emerged in this study. This is significant as due to the internalised social discourses individuals have acquired during their lives; they become activated when they experience depression which adds another layer of distress (meta-distress) to the distress they are experiencing as a result of experiencing depression. This happened to the participants in this study. Therefore arguably if a plurality of discourses is communicated by healthcare professionals, media and academia then individuals would internalise a plurality of understandings which would result in the elimination of meta-distress.

7.3 Critical Reflections

7.31 Overview of Critique

The reflective critique addresses my own personal experiences of using a phenomenological method in mental health research as a result of undertaking this study. It also includes an evaluation of this study using Smith's (2011) IPA evaluation guide (Appendix 9) to ensure that this research was robust and of good quality.

7.32 Critical Reflection - Personal Reflections

This study has added new insights to the field of depression research, namely the concept of meta-distress. It has also ignited in me a sense of social responsibilty to write, debate, discuss and present the findings of this study through the very mediums the social discourses discussed throughout this study were dissemminated such as media, radio, newspapers and societal discussion. Disseminating the findings and cultivating alternative discourses can only be achieved through the mediums mentioned above. However, firstly, I must acknowledge and accept that the current social discourses exist. Only then can I become unstuck on the unhelpful social discourses and focus on dissemminating the plurality of discourses related to human distress such as depression. The process of reflexivity which has now become a way of being in the world for me will ensure that I engage in the process of acceptance of current unhelpful social discourses and actively dissemminate more accepting social discourses.

Throughout this study which involved examining the conceptual and research literature, identifying participants, interviewing participants, becoming emersed in their lived experience of depression, stepping back from my own biases and assumptions, debating and discussing with my academic supervisors my own process in relation to the research I was undertaking, the practice of self reflection was imperitive. Self reflection has been my map in reaching a co-constructed piece of work that I hope represents the participants' lived experience of depression accurately and respectfully. Although the process has been the most challenging academic piece of work I have completed to date, it has also shaped significanly my current and

future life path. So just as my sexual orientation shaped much of the direction of my early professional life and how I understand and approach human distress, so has the experience of conducting this study. I have become involved in a new initiative called State of Mind Ireland which reconceptualises human distress such as depression as a difficult life experience and cultivates a belief that as human beings we can overcome adversity and human distress. We are still at the early stages (18 months into the project) but I feel that it offers individuals in distress hope in overcoming difficult emotional experiences such as depression and it directly challenges some of the unhelpful social discourses that currently exist. This is a very exciting project that I believe will contribute significantly to a more accepting social discourse and the normalisation of human emotional distress. This project will be evaluated and researched on a continuous basis and is being undertaken in conjunction with the Health Services Executive and University College Cork. I am involved in the evaluation and research of this project.

Also I have taken up a role in management in the mental health services, a decision I do not believe I would have reached without conducting this study. I am now in a direct position where I can significantly implement change in the delivery of mental health services and foster and cultivate more helpful social discourses in the service I work in. This is challenging particularly in discussions where some individuals believe strongly in the biomedical model for example. However I am now sitting at the necessary table with not only the knowledge but the confidence and conviction of my vision as a direct result of undertaking doctoral study. It is again the sense of social responsibility I have acquired throughout this project that now drives me in

being part of delivering a mental health services that dissemminates a plurality of perspectives regarding the experience of depression.

Alternatively, I recognise that not all will appreciate the findings of this research study and that some individuals find various discourses helpful and therein lies the great value of plurality of perspective. Different viewpoints add different elements to the discourse of depression, which is all the richer for such diversity. I hope that my research will provide an alternative discourse that may be helpful to some individuals who experience depression and also that such an endeavour facilitates respectful coexistence of differing ideas about the lived experience of depression. I hope that future orientations to depression research and practice are characterised by inclusivity and dialogue: an interstitiality of the coexistence of difference and respect for difference.

7.33 Evaluation of the Research Study using Smith's (2011) IPA Evaluation Guide

The following section outlines an evaluation of this study using Smith's (2011) IPA evaluation guide (Appendix 9). For an IPA study/ paper to be considered acceptable it must meet the following four criteria: it must subscribe to the theoretical principles of IPA in that it is phenomenological, hermeneutic and idiographic; secondly, it must be sufficiently transparent so the reader can see what was done; thirdly, the analysis needs to be coherent, plausible and interesting to the reader; fourthly, sufficient sampling from corpus to show density of evidence for each theme (Smith, 2011).

This study clearly subscribed to the theoretical principles of IPA. An outline of what constitutes IPA and a detailed explanation of the process of IPA is presented in chapter four which guided the research. Furthermore, the extracts from participant accounts presented in the findings chapter demonstrate a layered interpretation by moving from a phenomenological, empathic account which described individuals' idiographic experience to a critical and interrogative analysis of their experiences of depression. This is evident throughout the themes in chapter five thereby demonstrating that this study subscribed to the theoretical principles of IPA.

The process of IPA and IPA analysis is evident throughout the thesis. A detailed explanation of how the study was carried out and how the sample was selected, and how the data was analysed is presented in chapter four. Furthermore detailed appendices (10, 12, 13, 14, 15, & 16) support the process taken and ensure the data analysis process was transparent for the reader. The presentation of the analysed data again moves from the descriptive to a more interrogative analysis of participants' experiences of depression presented in chapter five and discussed in chapter six. This demonstrates that the study was coherent, plausible and interesting to the reader meeting the criteria set out by Smith (2011).

Finally the criteria related to sufficient sampling from corpus to show density of evidence for each theme is evident as extracts from participants are presented demonstrating evidence for each theme. Smith (2011) states that with a sample size of eight or more participants each theme needs to be supported with extracts from at least three participants. In this study there was extracts from at least five participants demonstrating evidence for each theme.

Therefore, by evaluating this study using Smith's (2011) IPA evaluation guide it is evident that the above criteria are met ensuring that this study is of an acceptable standard to be considered IPA research.

7.4 Implications for Future Research and Mental Health Practice

In relation to mental health practice much work needs to be undertaken with regard to education of mental health clinicians regarding the concept of meta-distress. This is important so that clinicians can conceptualise individuals' experience of depression in terms of their lived experience and also the meta-distress the individual is experiencing due to the some social discourses they have internalised. It is probable that many clinicians are conceptualising individuals' lived experience of depression as one layer of distress instead of two layers of distress. Sharing this with individuals' experiencing depression may validate their lived experience while also facilitating exploration and discussion regards what internalised discourses they have acquired in their life journey and their impact on meaning making.

In considering future research and practice from the findings of this thesis, meta-distress needs to be further researched to determine the extent of its contribution to emotional distress for those experiencing depression. The literature review in this study highlighted the lack of reference and exploration of meta-distress related to individuals' experience of depression. Further research could shed light on the relationship between social discourses and depression in terms of gender, cultue and media and how exposure to different discourses impacts on individuals'

understanding of depression. A longitudinal study examining the changing discourses related to depression could present further understanding of this phenomenon.

In addition, researching the concept of meta-distress related to depression and how social discourses inform individuals' experience from different methological perspective may give rise to further understanding. For example conducting a comparative study of individuals between 18 and 25 and 55 and 75 who have experienced depression may highlight the impact of changing discourses over time. Furthermore in line with IPA methodology, researching individuals from different socio-economic backgrounds may result in different findings emerging. This may yield a broader representation of various demographic groups.

The use of reflective practice is common amongst all healthcare professionals in practice now and the addition of the impact of internalised discourses within reflective models may help clinicians to work more effectively with individuals' who experience depression. Clinical supervision is also provided to many mental health practitioners and the explicit addition of the impact of social discourses into supervision models could help clinicians to address how unhelpful social discourses contribute to meta-distress.

Finally as outlined in my reflections, a sense of social responsibility needs to be cultivated within healthcare education in terms of disseminating a plurality of perspectives in relation to the experience of depression. This can be achieved by more individuals becoming involved in projects such as State of Mind, or delivering

conferences that facilitate alternative discourses such as Critical Perspectives of Psychiatry delivered in University College Cork each year.

7.5 Limitations of Study

As with all qualitative research there is a risk of researcher bias due to the subjective nature of the research process and analysis. This issue was addressed both individually through continuous reflexivity and with my supervisors who reflected on the research process used and offered feedback and questions regarding the entire process. Furthermore I kept a reflective diary throughout the research process. Finally the process of re-reading and immersion in the data was utilised to reduce bias when analysing the data.

All data from this study is open to reinterpretation from another researcher which is acknowledged in qualitative research. Smith (2010) argues that the majority of qualitative researchers do not view replicability as a criterion they aspire to or consider their work should be judged against because the concept derives from paradigmatic assumptions which do not necessarily apply in, or sit easily with, human science research. He argues that evaluating qualitative research using quantitative criteria such as replicability is inappropriate to qualitative inquiry as it is a complex, interactive, dynamic process and it is not clear exactly what one would be expecting to replicate. For example two highly skilled researchers could interview the same participant using the same interview guide and guidelines however interviewer B would not be expected or able, to replicate interviewer A. This does not mean that the interviews were not successful or scientific. This just represents one interpretation of the participants' experience of depression.

As the participants volunteered to part-take in the study, it could be argued that those who participated only represented a particular cohort of individuals. However the lived experience of depression is an idiographic experience and therefore the participants may represent other individuals' lived experience of depression while also acknowledging that their experience is not representative of all individuals' experience. It was not the purpose of this study to arrive at a definitive conclusion as this would reflect the cause and effect positivist approach to research.

7.6 Conclusion

This chapter draws conclusions related to the study including critical reflections and finally discussed implications for research and mental health practice. The reflective critique examined my own personal experiences of using a phenomenological method in mental health research as a result of undertaking this study. It is hoped that this study will contribute to changing the discourse around depression and the body of knowledge regarding the lived experience of depression and mental health more generally and act as a catalyst for discussion and debate about the issues identified thereby bringing about change in the social discourses dissemminated regarding the lived experience of depression.

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Appendix 1

Letters to Cork Hospital Ethics Committee

(Omitted for reasons of confidentiality and anonymity)

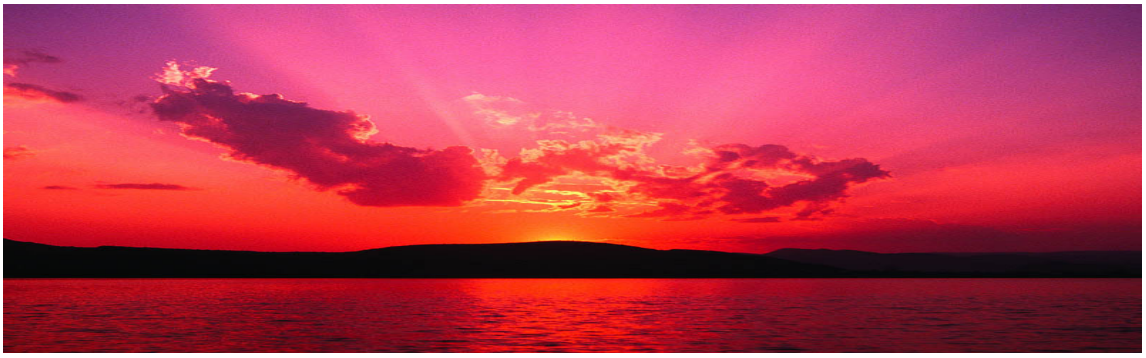
Appendix 2

Letters granting ethical approval from Cork hospital ethics committee

(Omitted for reasons of confidentiality and anonymity)

Appendix 3

Research Poster



Your Say Needed! !

A Study to Explore Individuals' Experience of Depression

- Have you or somebody you know ever experienced depression and have recovered?
- Would you like to contribute to how health care professionals and society understand an individual's experience of depression?
- Would you like to contribute to the future development of services for individuals experiencing depression?

If you answer YES to these questions then I would like to hear your personal story.

My name is James O Mahony and I am a registered Advanced Nurse Practitioner, Psychotherapist and PhD student with the School of Nursing and Midwifery in University College Cork. Talking to you will help me better understand experience and help to shape services required for individuals experiencing depression.

For more information you can contact me on 0872657582 or james.omahoney1@hse.ie or my research supervisor Dr Harry Gijbels on h.gijbels@ucc.ie .

This study has been granted ethical approval from The Clinical Research Ethics Committee of the Cork Teaching Hospitals, Lancaster Hall, 6 Little Hanover Street, Cork

Appendix 4

Information Leaflet

Information Leaflet.

1. Title of study:

A Phenomenological Study: To Explore Individuals' Experience of Depression.

2. Introduction.

This study will be an exploratory study to explore individuals' experience of depression.

The purpose of this study is to gain a phenomenological understanding of how individuals' who experience depression make sense of their experience.

This study will be carried out by conducting interviews with individual's who have experienced depression and overcame their experience.

3. Procedure.

Data will be collected using in-depth semi-structured interviews.

As a guideline, these interviews will be of forty-five to sixty minutes duration per person interviewed.

The interviews will be recorded using a Dictaphone, strictly for data collection purposes.

These interviews will be conducted in a designated private area in a day hospital or a location of your choice such as your home.

I propose the month of November for these interviews to take place.

Every effort will be made to be as flexible as possible with the time assigned to these interviews, to minimize any inconvenience to other commitments you have.

The data will be coded by the researcher; an identity number will be generated for each participant (e.g. I1). In this way all data/information will be anonymous.

4. Benefits.

Participants will be contributing to the body of knowledge regards mental/ emotional health and will contribute to mental health clinicians understanding of depression.

By undertaking this study a greater understanding of individual's experience of depression will be revealed which may shape how mental health clinicians work with those who experience depression.

Additional supports in terms of education and training may be identified by undertaking this study.

5. Risks.

Adverse effects are not expected in this study however if emotional distress is evident the following steps will be taken.

1. You can withdraw from the interview process at any time.

2. You will be given time at the end of the interview to reflect and ventilate any adverse feelings with the researcher who is an experienced registered mental health nurse and psychotherapist.

6. Exclusion from participating.

You cannot participate in this study if:

1. You are under 18 years of age.

2. You have not experienced depression

3. You are currently depressed.

7. Confidentiality.

All information gathered during these interviews would be strictly confidential, as would the origin of the geographical location.

Confidentiality will be ensured in the following manner:

A. All data will be coded.

B. All data will be seen only by the researcher and academic supervisors.

C. All information will be held in a computer and will have a password to access information in the researcher's home.

D. All data kept on hard copy will be kept in a locked drawer in the researcher's home and all transcripts and recordings of the interviews will be kept in a locked drawer in the researcher's home.

8. Voluntary Participation.

Participation in this study is voluntary. You can withdraw from the process at any time.

9. Permission.

This study has been approved by The Cork Hospital Ethics Committee for this study to be conducted.

10. Further information.

You can obtain any further information or answers to your questions about the study or concerning your participation in the study by contacting James O Mahony (RANP). Interested participants are advised to contact 087xxxxxx and you will be given a copy of the informed consent form and your details will be taken and a time at which to attend for the interview will be given.

I understand how busy you are, and therefore will greatly appreciate the time you are willing to give to me to aid my study

Thank you for your time.

Yours sincerely,

_____.

James O Mahony MSc, Pg Dip CBT, BSc, RANP

Appendix 5

Letter from the Director of Nursing of North Lee Mental Health Services granting permission to conduct the study.

(Omitted for reasons of confidentiality and anonymity)

Appendix 6

Informed Consent Form

INFORMED CONSENT FORM

1. Study title: A Phenomenological Study: To Explore Individuals' Experience of Depression.

Principal Investigator: Dr Harry Gijbels

Co – Investigator: James O Mahony

2. Introduction.

The aim of this study is to gain a phenomenological understanding of how individuals' who experienced depression made sense of their experience. In particular it aims to shed light on how individuals understood their experience of depression. Participation in this study is strictly of a voluntary nature. Participants can withdraw from the study at any given time.

3. Procedure.

Data will be collected in the form of in-depth semi-structured interviews. As a guideline, these interviews will be of forty-five to sixty minutes duration per person interviewed. I will be using a Dictaphone in these interviews, strictly for data collection purposes. The data will be coded by the researcher; an identity number will be generated for each participant (e.g. I1). In this way all data/information will be anonymous. All data collected in this study is strictly confidential unless the researcher believes that the participant or another person known to the participant is in danger. Then the researcher is obliged to inform the appropriate bodies. Finally all data is coded and securely stored.

DECLARATION:

This study and this consent form have been explained to me. The investigator has answered all my questions to my satisfaction. I understand what will happen if I agree

to be part of this study. I have read, or had read to me, this consent form. I have been provided a reasonable time to consider my participation in the study. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand I may withdraw from the study at any time.

PARTICIPANT'S NAME: _____

CONTACT DETAILS: _____

PARTICIPANT'S SIGNATURE: _____

Date:……..

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S

SIGNATURE:……

Date:…….

Appendix 7

Interview Schedule

Interview Schedule

Topic Guide.

Interview Questions

1. When I use the word depression what comes to mind to you.

Prompts:

What is your understanding/interpretation of it?

What comes to mind?

What does the term depression or depressive disorder mean to you?

What does the feeling depression mean to you?

2. Can you describe your experience when you were depressed?

Prompts:

How did you make sense of your experience?

What did it mean to you to experience depression?

What images come to mind that reflect your experience?

How did you find understanding in what you were experiencing?

How did you make sense of the emotions of depression?

How did you express your emotional distress?

In your experience how did you feel about how they are treated by family, friends or services?

Do you feel your emotional distress was understood by yourself firstly and by others secondly?

What was the purpose of your emotional distress do you think?

3. What is your view of why individuals experience depression?

Prompts:

What do you think leads to depression?

What do you think lead to your recovery of depression?

Was there anyone significant that helped you overcome your experience of depression?

What helped you overcome your experience of depression?

How did you know you were recovering from depression?

What told you that you had worked through it?

How did that feel?

4. What do you think influences your view of depression?

Appendix 8

IPA Checklist

IPA Data Analysis Process Checklist

Instructions

Repeated Reflection on the phenomenon:
Description, horizontalisation and vertification. This is achieved by listening repeatedly and reading repeatedly interviews and transcripts.

Initial noting:

1. Descriptive comments (normal text)
2. *Linguistic comments (italic text)*
3. <u>Conceptual comments (underlined text)</u>

Using phenomenological concepts and theory to further deepen analysis:

1. Embodiment: how does the situation alter ones relationship to and understanding of ones body?
2. Temporality: how is ones sense of time, biography, duration affected?
3. Spatiality: How is one's understanding of places and of space affected by the situation?
4. Sociality: How is ones relationship with others changed by the situation?
5. Selfhood: What does the situation mean for one's sense of self, one's identity and agency?
6. Project: How are the things one is committed to and which are central to one's life affected?
7. Discourse: What language/ discourses are used to describe – and live – the situation?
8. Mood: How does one's mood alter one's way of being – in – the world?

Emergent Themes:
List on left-hand column of script.

Emerging Themes in Chronological Order:
Cut each emergent theme from list so each theme is on a separate piece of paper and place on floor and place themes with similar understanding together.

Identifying Patterns and connections between emergent themes:

1. Abstraction
2. Subsumption
3. Polarization
4. Contextualisation
5. Numeration
6. Function

Bringing it together:

1. Graphic representation of the structure of the emergent themes.
2. Done by creating a table or figure. Identifies super-ordinate themes which emerged from the analysis.
3. Include page/ line numbers and key words from the participant.

IPA Data Analysis Process Checklist

Participant Initials and Pseudonym:

Interview no:

Repeated Reflection on the phenomenon:	**Yes**	**No**
Initial noting:		
Descriptive comments (normal text)	**Yes**	**No**
Linguistic comments (italic text)	**Yes**	**No**
Conceptual comments (underlined text)	**Yes**	**No**
Using phenomenological concepts and theory to further deepen analysis:		
Embodiment	**Yes**	**No**
Temporality	**Yes**	**No**
Spatiality	**Yes**	**No**
Sociality	**Yes**	**No**
Selfhood	**Yes**	**No**
Project	**Yes**	**No**
Discourse	**Yes**	**No**
Mood	**Yes**	**No**
Emergent Themes identified:	**Yes**	**No**
Emerging Themes in Chronological Order:	**Yes**	**No**
Identifying Patterns and connections between emergent themes:		
Abstraction	**Yes**	**No**
Subsumption	**Yes**	**No**
Polarization	**Yes**	**No**
Contextualisation	**Yes**	**No**
Numeration	**Yes**	**No**
Function	**Yes**	**No**
Bringing it together:	**Yes**	**No**

Appendix 9

IPA Evaluation Guide (Smith, 2011)

IPA quality evaluation guide (Smith, 2011)

Acceptable

The paper meets the following four criteria:

- Clearly subscribes to the theoretical principles of IPA: it is phenomenological, hermeneutic and idiographic.
- Sufficiently transparent so reader can see what was done.
- Coherent, plausible and interesting analysis.
- Sufficient sampling from corpus to show density of evidence for each theme:

  N1_3: extracts from every participant for each theme;

  N4_8: extracts from at least three participants for each theme; and

  N_8: extracts from at least three participants for each theme_measure of prevalence of themes, or extracts from half the sample for each theme.

Overall the paper is judged sufficiently trustworthy to accept for publication and include in a systematic review.

Caveats

Compensation

Evidence base and interest factors considered together so that, e.g., a paper with particularly interesting data may gain compensation for a less than ideal evidence base.

Partial acceptability

A paper may be deemed acceptable if it has partial but discrete pockets of

acceptable, e.g.,

1. Paper may present four themes, two of which are interesting and well evidenced while two of them are not. In this case, the paper can be considered acceptable as the two good themes make a sufficient contribution in their own right.

2. Paper may have number of themes but evidence each with data from the same single participant. This paper may be considered acceptable if the account of the individual is sufficiently coherent that it can be read as an interesting idiographic case-study.

3. Paper may present data from two participant groups, e.g., males and females and be deemed acceptable for one participant group but not the other.

Safe or borderline?

A paper showing sufficient sampling as described above is deemed safe.

A paper with a sample over eight with extracts from enough participants to illustrate variation but without detail of prevalence or enough evidence of density of themes is deemed borderline.

Unacceptable

The paper fails on one of the four criteria for acceptable. It may be:

- not consistent with theoretical principles of IPA;
- insufficiently transparent for reader to see what was done;
- not of sufficient interest; and
- poorly evidenced.

Predominantly what lets a paper down is the poor evidence base. Typical ways this can occur:

- large number of descriptive/superficial themes from a large number of participants;
- each theme has short summary and one or two extracts without interpretation;
- insufficient extracts from participants to support the themes being illustrated;
- no explanation for how prevalence of the themes was determined; and analysis is crude, lacks nuance.

Overall the paper is not trustworthy and would not be judged acceptable for publication.

Good

Paper must clearly meet all the criteria for acceptable. It then offers these three extra things:

- well focused; offering an in-depth analysis of a specific topic;
- data and interpretation are strong; and
- the reader is engaged and finds it particularly enlightening.

Overall the paper could be recommended to a novice as a good exemplar of IPA.

Appendix 10

Copy of Derek's Transcript

Comments Stage

(Omitted for reasons of confidentiality and anonymity)

Appendix 11

"Staying True to IPA"

Interpretative Phenomenological Analysis

MOVE from DESCRIPTIVE to INTERPRETATIVE

REMEMBER ANALYSIS PROCESS IS AN INDUCTIVE PROCESS

RESULT IS AN ACCOUNT OF ME MAKING SENSE OF THE PARTICIPANT MAKING SENSE OF THEIR EXPERIENCE

(DOUBLE HERMENUETIC)

HERMENEUTIC CIRCLE

The PART is INTERPRETED in relation to the WHOLE and the WHOLE is INTERPRETED in relation to the PART

Appendix 12

Development of Emergent Themes - Derek

(Omitted for reasons of confidentiality and anonymity)

Appendix 13

Emergent Themes in Chronological Order

Derek - Emerging Themes in Chronological Order

Questioning of self
Empathy
Sadness
Family & friends
Illness/ disease
Diagnoses
Questioning medical/ societal label.
Hopelessness
Self questioning
Despair
Validation
Personal sense of responsibility
Time
Factors affection mood
Panic
Loss of life and self once known
Biased thinking
The self as performance
Finding the self
Hopelessness
Quality of life
Societal/ political context
Fairness
Loss of future
Biological symptoms of depression
Excessive thinking- rumination
Imagery to understand and explain experience
Hopelessness
Work of managing the self/ finding self
Societal, medical, media discourses on understanding
Distress about distress
Anxiety fear
Shift in focus
Impact of diagnoses
Medical model of understanding

Conflict with self and what's known
Impact of past experiences
Recovery
Discourses impact
Medication
Media influence on information and understanding
Loss of self identity and meaning
Sources of information.
Loss of self
Search for self and meaning
Causal factors
Impact of medical and societal discourses on understanding
Personal relationships as problematic.
Escape – coping strategy
Guilt selfish
Conflict
Perspective
Self critical evaluations
Loss of self
Loss of control
Locus of control outside his realm
Loss of self once known
Loss of self esteem
Media influences
Function of emotion
Sense of identity
Time period
Hopelessness
Helplessness
Biological impact
Change in functioning
Loss of interest and concentration
Work and social relationships problematic
Rumination
Comparisons
Duty love
Obligation

Fairness
Discourses
Disengagement and detachment
Self isolating
Coping strategy
Loss of self worth
Distorted thinking patterns.
Societal/ media influence
Normalising
Recovery
Family reaction due to various discourses.
Lack of validation
Communication / support
Thinking about thinking
Impact of diagnoses
Normalisation
Acceptance linked to recovery
Self empowerment
New meaning/ reappraisal of situation
Personal values
Time
Communication
Connectiveness
Biological functioning
Psychological functioning
Hope
Reappraisal of situation
Discourses
Acceptance and recovery linked
Discourses
Self esteem
Discourses
Hope
Medical discourses
Normalisation
Medical, cultural, societal discourses
Acceptance and recovery

Discourses
Discourses
Acceptance closely linked to recovery
Discourses

Appendix 14

Connections across Emergent Themes

Data Analysis IPA – Derek

Patterns and Connections between Emergent themes

Abstraction leading to the development of a super-ordinate theme	
Number from Emergent Theme List	*Psychological Consequences of Experiencing Depression*
8,20,28,63	Hopelessness x 4 (Numeration)
75	Disengagement and detachment
58	Loss of self esteem
67	Loss of interest and concentration
53	Self critical evaluations
50	Guilt/ selfish
79, 17	Distorted thinking patterns/ Biased thinking x 2(Numeration)
78	Loss of self worth
76	Self isolating
70	Comparisons
77	Coping Strategy
49	Escape – coping strategy
64	Helplessness
3	Sadness
32	Anxiety/ Fear
26, 69	Excessive thinking – rumination x 2 (Numeration)
2	Empathy for others
15	Panic
10	Despair
21	Quality of life
31	Distress about distress (Meta-emotion)
97	Psychological functioning
86	Thinking about thinking
	Phenomenological Concepts evident above:
	Embodiment
	Mood
	Selfhood
	Temporality
	Discourse

Abstraction leading to the development of a super-ordinate theme	
Number from Emergent Theme List	*Biological Consequences of Experiencing Depression*
66 46 65 66 96	Biological symptoms of depression Casual factors Biological Impact Change in functioning Biological functioning
	Phenomenological Concepts evident above: Embodiment Spatiality Temporality Project

Polarization leading to the development of a super-ordinate theme	
Number from Emergent Theme List	*Embracing myself and my Mind - Transformation of the self*
45 52 61 81,88, 107 33 29 98, 105 90 92 95 103 91,99 89, 101, 109, 112	Search for self and meaning Perspective Sense of identity Normalising x 3 (Numeration) Shift in focus Work of managing the self/ finding self Hope x 2 (Numeration) Self empowerment Personal values Connectiveness Self-esteem Reappraisal of situation/ circumstances Acceptance closely linked to recovery
	Selfhood Temporality Discourse

Subsumption leading to the development of a super-ordinate theme	
Number from Emergent Theme List	*Broken Self - Experience of depression transforming the self*
44, 54	Loss of self x 2(Numeration)
1	Questioning of self
56	Locus of control outside his realm
57	Loss of self once known
34	Impact of diagnosis
42	Loss of self identity and meaning
36	Conflict with self and what's known
6	Diagnosis
16	Loss of life and self once known
9	Self questioning
24	Loss of future
18	The self as performance
40	Medication
19	Finding the self
12	Personal sense of responsibility
60	Function of emotion
14	Factors affecting mood
11	Validation
38, 82	Recovery x 2 (Numeration)
43	Source of information
37	Impact of past experiences
	Phenomenological Concepts evident above:
	Selfhood
	Temporality
	Discourse
	Sociality
	Project
	Spatiality

Contextualisation leading to the development of a super-ordinate theme	
Number from Emergent Theme List	*The Worlds Conversations and Me - Engagement with Social Discourses*
59 80 47 74 13, 62, 93 68 48 72 71 30 73, 23 35 7 39, 87 5 41 4 51 22 85, 94 84 83, 100, 102, 104, 106, 108, 110,111, 113	Media influence Societal/ media influence Impact of medical and societal discourses on understanding Discourses Time period x 3 (Numeration) (Temporality) Work and social relationships problematic Personal relationships problematic Obligation Duty love Societal, medical, media discourses on understanding Fairness x 2 (Numeration) Medical model of understanding Questioning medical/ societal label Discourses impact Illness/ disease Media influence on information and understanding Family and friends Conflict Societal/ political context Communication/ support Invalidation of experience Medical, cultural, societal discourses
	Phenomenological Concepts evident above: Temporality Discourse Sociality Project Mood

Metaphor and Hermeneutics leading to the development of a super-ordinate theme	
Number from Emergent Theme List	*The Descent - "Lost and Trapped and Searching for my Way Out"*
27 55	Imagery used to understand and explain experience Loss of control
	Phenomenological Concepts evident above: Mood Temporality Discourse Sociality

Appendix 15

Table of Super – ordinate Themes and

Subordinate Themes

Data Analysis IPA - Derek

Table of Super-ordinate Themes and Themes

Table of Super-ordinate Themes and Themes from participant DC		
Themes (*Super-ordinate* & Emergent Themes)	**Page & Line number**	**Key Words**
Psychological Consequences of Experiencing Depression		
Hopelessness x 4 (Numeration)	2.14, 3.57, 4.79, 12.249	Things not improve. All crap Constant dark cloud.
Disengagement and detachment	13.292	Didn't express how I felt
Loss of self esteem	11.231	I will never get out of this
Loss of interest and concentration	12.265	Daydream a lot
Self critical evaluations	10.212	Feel worse as a person
Guilt/ selfish	9.199	Thinking about leaving
Distorted thinking patterns/ Biased thinking x 2(Numeration)	3.48, 14.308	She will get over me
Loss of self worth	14.308	She will get over me
Self isolating	13.297	Avoid colleagues
Comparisons	13.275	Dealing with it better than me
Coping Strategy	14.302	Thoughts of killing myself
Escape – coping strategy	9.194	Pack up and leave
Helplessness	12.252	Do I even want to?
Sadness	1.5	Sad for people
Anxiety/ Fear	6.104	Frightening stuff
Excessive thinking – rumination x	4.68, 12.273	Head feeling full. Home

2 (Numeration)		thinking how I am feeling
Empathy for others	1.5	How sad it is for people
Panic	3.42	Panicking
Despair	2.19	Totally hopeless and despairing
Quality of life	3.59	Not paying to work now
Distress about distress (Meta-emotion)	5.99	Scared the life out of me
Psychological functioning	20.357	Belief I would get through this
Thinking about thinking	17.350	think things changed when I stopped thinking
Biological Consequences of Experiencing Depression		
Biological symptoms of depression	12.262	looked tired
Casual factors	8.171	wife losing job
Biological Impact	12.256	not eating anything
Change in functioning	12.262	looked tired, no energy
Biological Functioning	19.347	hungry and enjoyed food again
Transformation of the self		
Finding the self	3.53	having no time for self
Search for self and meaning	8.168	didn't make sense of it for a good while
Perspective	10.206	roles reversed, talk to self
Sense of identity	11.242	a disorder, not comforting
Normalising	14.324	most people
Shift in focus	6.108	focus then shifted
Work of managing the self/ finding self	4.83	life had taken it out of the room
Personal sense of responsibility	2.24	my problems, what's the

		point in burdening someone else.
Hope x 2 (Numeration)	20.363, 22.420	Future was not so hopeless. Give hope.
Self empowerment	18.375	Dealing with it better. Pushed myself to do more.
Personal values	18.389	Started to see what I did have.
Connectiveness	19.399	Didn't feel so alone. We were a team.
Self-esteem	22.406	Back to enjoying life.
Reappraisal of situation/ circumstances	20.364	difficult yes but not a disaster
Acceptance closely linked to recovery	17.368, 21.379, 24.462, 25.495	I accepted things were different. Accepting my new circumstances.
Broken Self - Experience of depression transforming the self		
Loss of self x 2(Numeration)	8.165, 10.214	Middle of a massive street
Questioning of self	1.2	Myself and when I went through it.
Locus of control outside his realm	11.224	No control over it
Loss of self once known	11.229	"you're depressed, a loser"
Impact of diagnosis	6.115	Confusing, a lot out there
Loss of self identity and meaning	7.154	Scanned my self for depression
Conflict with self and what's known	6.126	Saying different things
Loss of control	10.129	Felt like cars were flying past me.
Diagnosis	1.8	Disease/ illness
Loss of life and self once known	3.45	Going to be hard
Self questioning	2.16	Stay the same/ get worse
Loss of future	4.65	You don't get anything back
The self as performance	3.50	Didn't want to have to deal with it.

Medication ***The worlds conversations and me -Eengagement with social discourses***	7.144	
Media influence	11.238	Newspapers, TV, radio, Dr's
Societal/ media influence	14.317	TV
Impact of medical and societal discourses on understanding	8.174	Made sense, feeling down
Discourses	13.288	Media/ culture
Time period x 2 (Numeration) (Temporality)	2.33, 12.246	Wake early, not sleep
Work and social relationships problematic	12.269	Avoid colleagues
Personal relationships problematic	9.177	Our life changed, life unpredictable
Obligation	13.281	Reassure her
Duty love	13.281	Reassure her things would improve
Societal, medical, media discourses on understanding	5.87	No radio about depression
Fairness x 2 (Numeration)	13.285	Happened to us again
Medical model of understanding	6.120	Drugs, side effects
Questioning medical/ societal label	2.10	If that's what you call it
Discourses impact	7.138	Papers, medication
Illness/ disease	1.8	Illness or disease
Media influence on information and understanding	7.148	YouTube
Family and friends	1.6	Family/ friends

Conflict	1.6	Family
Societal/ political context	4.61	Free houses, cant socialise
Communication/ support	16.341	Did talk to friends, wife
Invalidation of experience	16.333	"bringing everyone down"
Medical, cultural, societal discourses	20.373, 21.386, 22.410, 22.425, 23.450, 24.466, 24.472, 26.508	symptoms of depression and the signs of recovery. Prescribed medication
The Descent - "Lost and Trapped and Searching for my Way Out"		
Imagery used to understand and explain experience	4.71	Allowed up for air just enough before I would go under again
Function of emotion	11.241	Disease/ disorder
Factors affecting mood	3.38	Lost job
Validation	2.21	What's the point, cant do anything
Recovery x 2 (Numeration)	7.137	1st time depressed
Source of information	8.159	TV, newspapers, GP
Impact of past experiences	7.131	Felt strange and stopped taking them (medication)

Appendix 16

Identifying Recurrent Themes across Participant Accounts

Identifying Recurrent Themes									
Super-ordinate themes	**Derek**	**Alicia**	**Luke**	**Rebecca**	**Sophia**	**Laura**	**Jackie**	**Isabella**	**Present in over half the sample**
The Descent	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
The Worlds Conversations and Me - Engagement with Social Discourses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Broken Self - Transforming the Self	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Embracing myself and my Mind - Transformation of the Self	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes