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The Appropriation of the Prospect of Taking Medication for Psychological Complaints: An Empirical-Phenomenological Investigation

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The Appropriation of the Prospect of Taking Medication for Psychological Complaints:
An Empirical-Phenomenological Investigation

A Dissertation
Submitted to the Department of Psychology
And Graduate School of Duquesne

In partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

by

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Dedication

To Irene, for her love, like pure water, that has never ceased to flow in thirty-five years.
To Helene, for her strength, which has been the earth, the ground on which I've stood.
To Juliet, for her spirit, which has been the fresh breath of Life to me all along.
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Abstract

The purpose of this investigation was to describe the lived experience of being confronted with the prospect of taking medications for a psychological complaint, namely a depressive disorder. Descriptions of such experiences were obtained from adult participants and were analyzed qualitatively in order to explicate the themes and meanings that were most significant to forming the experience as such.

The findings of this study were dialogued with literature on medication taking, the doctor-patient relationship, dialogic psychology and the construction of the self, and theories of willing, motivation and identity. This analysis contributes to the current literature by illuminating the lived significance of confronting the prospect of taking medication as it related to the experiences of these subjects relations with themselves, other people, and the worlds around them. The implications of these findings with regard to prescribing medication were also discussed.

Data was organized into units of significant meaning and was then rendered into a situated structure for each individual subject. A general structure that encompassed all three subjects was developed and as such revealed the phenomenon of appropriating the prospect of taking medication as grounded in the referential totality of the world of the person who is confronted with this possibility. Concretely, this means that one who is confronted with this possibility engages this prospect from out of the contexts of one's relatedness to others, of the projects of one's life, of one's understandings of who one is, and of the history, culture and society in which one finds oneself rooted. Having to confront this prospect brought these subjects into contact with their very senses of identity whether they were able to positively appropriate this possibility or not.

THE APPROPRIATION OF THE PROSPECT OF TAKING MEDICATION FOR PSYCHOLOGICAL COMPLAINTS:

AN EMPIRICAL-PHENOMENOLOGICAL INVESTIGATION

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The Appropriation of the Prospect of Taking Medication for Psychological Complaints: An Empirical-Phenomenological Investigation

Throughout history, medications, drugs, apothecary, proprietaries, pharmacon, elixirs, balms and remedies have been a part of human existence. The use of medication can be found nearly as far back in history as one can trace. Medications are mentioned in the Old Testament (Jeremiah 46:11; Ezekiel 47:12, New American Bible). Ethical guidelines for their administration are found in the Hippocratic Oath (c. 400 B.C.). These are not even the most ancient of references. Through each successive age of history, medications have held a place in human life and culture. Certainly, in the last century, this has not changed or lessened.

In the age of technology and technologized medicine, medications and their use have achieved a place of unprecedented prominence. The fields of psychiatry and psychology have seen this development as well. Over the last fifty years, the pharmaceutical industry has risen to the level of a multi-billion-dollar-per-year enterprise. Much of this business is in the area of psycho-pharmaceutical medications. In 1996, sales for Prozac alone exceeded $1.7 billion in the United States, $2.5 billion worldwide (Valenstein, 1998, p. 174). In 1997, sales of psycho-pharmaceuticals exceeded $8 billion in the United States alone (p. 166).

American culture is saturated with references to psychology and psychiatry in general, and to medications in particular. This pervasiveness is evident in a myriad of ordinary experiences including images, advertisements and everyday expressions. It is not uncommon to hear people referring to others with psychological diagnostic terms: fastidious people are “anal retentive” or “OCD;” emotionally open or publicly expressive people are “bipolar;” people that are confused or have broken away from typical behaviors and perceptions are “unbalanced.” Common language is rife with references that have their origin in medication and its use. “Take a chill pill,” “Did you forget to take your meds this morning?” “Mother’s little helper,” and “Prozac nation” all hearken to a growing prominence of medications and their place in the fabric of American culture. Advertisements bombard the collective cultural consciousness on television, on the radio, in newspapers and magazines, and most recently over the Internet. Every day, 30 million Americans take antidepressants (Shogren, 2004, p. A1). “In the year 2000 in the U.S. alone, drug companies spent $8 billion and employed 83,000 sales representatives to woo doctors with gifts, meals, trips, and spent another $8 billion in free drug samples” (McBane, 2003, p. 8). In the 1990s, antidepressant use grew by 800 percent (Foote and Etheredge, n.d., p. 2). These expressions and statistics underscore the level of pervasiveness at which psychological medications maintain in the current American cultural consciousness.

The decade-long power struggle that still continues over prescription privileges powerfully illustrates the enormous attention and importance that has been placed on the use of drugs in treating psychological disorders. And yet, in the face of this cultural inundation, there exists no research on the experience of being given a prescription for psychoactive medication or on what it means to an individual to receive a prescription.

“Medication always takes place in some… context, and these contexts are often decisive…. It is astounding that such issues are absent from research” (Keen, 1998, p. 105). This study aims to illustrate the phenomenon of medication-taking (and -refusing) and explores the very idea of its meaning.

From the Initial Emergence of Ideas to the Definition of the Phenomenon in Question

This study is concerned with the ways people make sense of the prospect of taking medication for psychological complaints. Furthermore, it is interested in how this prospect impacts a person’s life. The intent of this work is to understand and show how the prospect of taking medication for psychological complaints is incorporated into the referential contexts of an individual person’s meaningful relations to his or her world. In other words, how do people fit the prospect of taking medication into their existing understanding of who they are and how they are engaged in the projects of their lives? The research will show that this prospect is not only closely situated relative to the field of will and volition, but even more importantly, that it is intimately connected to a person’s very sense of identity. With no less emphasis, it will also be shown herein that the dynamics of power (individual, institutional, social and cultural) shape the ways in which people understand themselves and each other. Ultimately, the investigation will “arrive at an understanding and circumscription of **what** this phenomenon essentially is as a lived human meaning (structure), and **how** it is lived by individuals in their everyday existential lived contexts (style)” (von Eckartsberg, 1986, p. 20).

“Questions grow out of a confrontation with ‘subject matter.’ And subject matter is *there* only where eyes are” (Heidegger, 1999, p. 4). Initial interest in this phenomenon was sparked by stories from friends and acquaintances that had come to be receiving psychological or psychiatric intervention of some kind or another. In each of these particular cases, the person was evaluated by either a medical doctor or a psychiatrist and, following the interview (sometimes after one or more hours/sessions, sometimes as brief as ten minutes), was given a prescription for medication. In each account, the person’s reactions to and feelings about the prospect of taking medication were quite strong, if not always clear. There was not a single instance when someone’s account was *indifferent* toward this prospect. It seemed that each person, regardless of whether that person had asked for medication or was (or was not) in favor of taking medication, had definite feelings about taking the medication. Each person’s confrontation with this prospect seemed to include, usually implicitly, some kind of initial understanding of the ***nature*** of that person's complaints. Also, there seemed to be included feelings about each person’s sense of his or her own being-able-ness, in general and especially in relation to that person’s presenting difficulties. These observations coincided with and were colored by initial presuppositions.

To be sure, this study is an interpretive study, a hermeneutic endeavor. The precise meaning of this will be fully elucidated in the Methodology section below. For now, it will suffice to say that “what is necessary is to bring this phenomenon… into view… with regard to definite characteristics of its being…in a more explicit manner than previously” (Heidegger, 1999, p. 61). Furthermore, those

> [l]ooking toward something and seeing it and the defining of what-is-held-in-sight…already in advance "have" what they wish to look into as such and such a being – what is had in advance in this manner… is found in each instance of accessing and dealing with the matter in question. (Heidegger, 1999, p. 61-2)

The first task is to establish a working definition of the phenomenon under investigation, starting with a thorough consideration of how a person comes to receive a psychotropic drug. Drawing from this researcher's experiences in the field of psychology over the last ten years, consideration was given to the process that brings about the prescription of psychoactive medication at its most basic level with an eye toward understanding the operative meanings in this process. There are a myriad of circumstances that can result in the medication of an individual, some of which are involuntary. The need for differentiation regarding these and many other variables is clear. Initial reflection on the general process yields preliminary clarification of some of these variables and prompts a deeper, more focused level of investigation.

It is not uncommon to hear people speak about taking psychoactive medication. While it may be uncommon (outside of the field of psychology) to phrase it exactly in those words, one hears such stories regularly. In the typical version, a person experiences some kind of distress (for example, a panic attack) and then goes to a health professional of one kind or another. This professional suggests medication and the person responds to this suggestion, perhaps negatively, perhaps with resentment, saying, "I don't need to take drugs! How could this person know that something is wrong inside me after talking to me for one hour? I'm not taking any medications!" It is equally common to hear accounts of this scenario wherein the reaction mentioned above had the character of relief (or something similar) rather than resentment or resistance.

Whether the initial reaction is negative or positive, it remains that there is a ***response*** to the suggestion to use medication. It seems that from this response there consistently emerged a decision to accept or reject the prospect of taking medication. The core of this response seems to center around understanding or fitting in this new prospect in a meaningful way. One woman's experience stands out in particular. She related her doctor's explanation by tapping her index finger on her forehead and saying, "Something is wrong with my thermostat." She went on to relate how the medication he prescribed "puts her thermostat back in balance." Her case presents a simple example of how this prospect is meaningfully incorporated. Her doctor's metaphor became a way—her way—of making sense of the significance of taking medication. Each time that accounts like this occurred they were accompanied by powerful feelings and attitudes toward the prospect of taking medication. These feelings and attitudes, in their own forcefulness or definiteness, are what prompted this study.

It should be noted that these initial stories were unsolicited and did not occur in a clinical setting, nor were they protocols. They are simply an ***access point*** into the phenomenon. These accounts had some context. Many of them occurred as a result of people's realization that they were in conversation with a psychological professional. As Heidegger notes,

> The initial hermeneutical engagement and bringing into play – that with respect to, on the basis of, and with a view to which everything is like a card in a game staked – thus *the "as what"* in terms of which facticity is grasped in advance and stirred… arises and develops out of a fundamental experience and here this means a… wakefulness, in which Dasein is encountering itself. (Heidegger, 1999, p. 14)

As a student of psychology, it is equally true that this research was affected similarly. Professional psychological experience has certainly influenced this research. Part of the work that follows is a dialogue between the initial understandings and presuppositions about the phenomenon and the results of the data that were gathered.

In the context of these patients' accounts as well as ongoing studies in psychology it became apparent that this issue of patient response could be researched and that there was some fine-tuning required to hone in on the specific phenomenon. In the course of this fine-tuning, a number of realizations must be pointed out. First, it is noted that one of the essential elements of the process of receiving a prescription is that the person initially *experiences some kind of distress*. At that point then, it becomes critical to consider whether the particular nature of distress is relevant. Imaginative variation of the circumstances posits whether or not it would make a difference if the person were seeking treatment for anxiety versus depression or hearing voices, etc. Reflection seems to indicate that there *would* be.

Given that the nature of the complaint seemed to have gravity, it becomes important to focus on a specific type of complaint. Philip Zimbardo (1997) refers to depression as the "common cold of psychopathology" (p. 527). Furthermore, a recent release from the National Institute of Mental Health (2001, p. 1) indicates that, as of 1998, "approximately 18.8 million American adults, or about 9.5 percent of the U.S. population age 18 and older in a given year have depressive disorder" (p. 1). "Depressive disorder" is here defined by the *Diagnostic and Statistical Manual for Mental Disorders, fourth edition* (American Psychiatric Association, 1994). Of that number, "nearly twice as many women as men are affected by a depressive disorder in a given year" (NIMH, 2001, p. 1). Depressive disorders are, far and away, the most prevalent of mental disorders in this country, comprising nearly half of all diagnosable mental disorders in a given year. For these reasons, the focus of my investigation was deliberately given to participants with a depressive disorder. In selecting participants and choosing protocols, consideration was given to the ratio of participants, female to male.

What arose from considerations pertaining to a disorder-specific approach were more questions. Would the focus be only on people who are bringing themselves to professionals for help, or would it include those who are involuntarily brought in? If it were going to focus on only the former, would it distinguish between those who went for help asking for medication and those who did not (i.e. those who either had not previously considered the possibility or had considered it and were hoping against it). Here again, while all of these possibilities were interesting, focus was placed on those who came for help voluntarily and were not explicitly asking for medication. The primary reason for this is simply the need for focus and clarity of direction. Plainly put, this means keeping to what is at the heart of the interests that originated this work, interest in the phenomenon at hand, in the feelings and attitudes toward the prospect of taking medication.

Someone who is involuntarily brought in for treatment, as in the case of involuntary commitment to a psychiatric hospital, is neither choosing medication, nor any of the circumstances that precede that. These circumstances are forced upon them. Medication here isn't so much of a prospect that one can freely accept or reject. In involuntary circumstances, patients remain subject to repercussions for refusal from the very force that imposes the medication upon them. Moreover, these cases involve other elements that, while interesting and important, would over-complicate the focus of this study. Finally, these cases are few in comparison to those involving persons who voluntarily seek help for themselves. Incidentally, it is for very similar reasons that this study will not consider this phenomenon as it is experienced by minors.

While it seems clear that people who *are* asking on their own for medication do, in fact, have feelings, attitudes and understandings of the prospect of taking medication, it seems equally clear that these feelings, understandings, and so on are already in place. And while there are many different ways in which these attitudes may have come to be in place (e.g. previous experience in therapy, social exposure to others whose take such medications, or a desire for a quick, familiar or simple solution like a pill, etc.), focus was placed on these ideas and feelings as they were first formed when initially confronted with the possibility of receiving a prescription. Considering again the specific boundaries that determine the exact definition of what is being studied here, it is a sense of the ***incorporation or appropriation of the meaning of medicating, of the meaning of taking the medication*** that is the phenomenon investigated.

The typical accounts include seeking or going to get help. The decision to seek help is a part of the phenomenon. What is it to “seek help”? What does it mean? How is it lived out? To need help, to seek help seems to involve a recognition that somehow one is *unable* to live one’s life or accomplish one’s projects on one’s own. Try to imagine scenarios that are otherwise. Does one ever *seek* help, especially of a psychological nature, when one doesn't *need* it? Are the recognition of needing help and the decision to seek help *necessary*, or perhaps what one might call *structural,* preconditions to the phenomenon of taking medication? It does, at this point, seem so.

Persons approaching a doctor for help have expectations of being helped in a certain way and therefore have implicit understandings of the nature of their problems. Quite simply, one knows that something is wrong. What follows are questions of selectivity and trust. Certainly, it seems that trust is a central or at least highly significant facet of this phenomenon. Also, the way a person selects or chooses a doctor seems important. What is it about this doctor's credentials or that doctor's demeanor that affect the decisions of the person looking for help?

Another issue that emerged as the investigation of this phenomenon continued was the question of the *framework* of the suggestion, by the health care professional, of the prescription for medication. The rapport that is developed, if any, serves as a large part of the context for the meaning of the prescription *as it is received* by the patient. This component was a part of all of the accounts heard before initiating this study. Sometimes this aspect was reported in the form of a complaint. Some people said things like, "After just ten minutes, the doctor told me that I had to take such-and-such medication. How could he possibly know that? He never even asked me about...." Or, "I saw the doctor twice and he prescribed this medicine but he never said why I should take it or what or how it will help."

Other people expressed gratitude, most often when they seemed to feel that the prospect of taking the medication had an understandable place. For example, "The doctor told me that this is to help me calm down a bit so that she and I can talk about my problems without me breaking down and crying hysterically like I usually do," or "The psychiatrist explained that the medicine would help me from feeling so down and distracted all of the time so that I could at least concentrate enough to function at work and to sleep at night." Also, in this regard, some talked about how the professional taught them, so to speak, about the nature of their problems. Again, the woman with the "out-of-kilter thermostat" comes to mind. In all of these, one can see that the particular presentation of the prospect of taking medication, as made by the doctor and as received by the patient, has great import in the patient's formation of the meaning of this very prospect.

This question of the context or presentation opens up this dimension of the inquiry in greater detail, for here one can begin to see that the doctor-patient relationship is crucial in this situation. Surely, there are many facets to this relationship. How does the patient perceive the health care professional? To what extent, if any, is the professional seen as the expert or authority and what role does that have with regard to the patient's attitudes, especially toward medication? What does the prescriber do, if anything, to present the suggestion of medication within a framework that is comprehensible to the patient? Further, what, if anything does the prescriber do to make room for or dialogue with the patients' understandings of their own problems and expectations of what help the prescriber can offer? Finally, how do patients hold this framework given by the prescriber up against their own initial understandings and expectations?

A Working Definition of the Phenomenon in Question

Henceforward what will be referred to as "the phenomenon" of inquiry is the way in which a person encounters the possibility of taking medication in its manifold meaningfulness. Said another way, the phenomenon under investigation here is *the initial appropriation of the prospect of taking medication for a psychological complaint, specifically a depressive disorder, as it is lived by a person who has voluntarily approached a health professional for help and as a result, has received a prescription for medication*.

Review of the Literature

In addressing the debate over the combining of psychopharmacotherapy and typical psychotherapy (i.e. what is often called "talk therapy"), Earnest Keen (1998) quotes Toksoz Karasu:

> Controversy still exists not only with regard to the outcome (i.e. if, when, for whom, and to what extent each works)… but with regard to mode of action (i.e. how each works). This refers to the degree of specificity versus non-specificity of their respective therapeutic ingredients, including the symbolic meaning of treatment, the place of positive expectations, the influence of historical, psychological and social variables, the role of the physician-patient relationship, and the overall so-called placebo effect. (p. 52)

As was mentioned at the outset, there is precious little research relating to the meaning of medication taking from the perspective of the patient, even less on a person's experience of being given a prescription for medication. The present investigation concerns the way a person lives out the meaning of being given a prescription for medication as an answer to a psychological complaint. The literature reviewed below is organized thematically according to how the phenomenon has been discussed and explicated thus far. The review below explores the themes of this phenomenon within psychological literature and illustrates the shortcomings and/or gaps in the existing body of knowledge.

The "Meaning of Medication"

Until recently in the history of psycho-pharmaceuticals, the issue of how a person dealt with or experienced the prospect of taking a prescribed medication was subsumed under the rubric of "medication compliance." Compliance has been defined as a measure of the degree to which the patient adheres to a doctor's advice, including the taking of medication. Most of the literature on compliance states that compliance is "strongly related to patients being able to understand not only the nature of their condition but also the advised treatment regimen and the process involved in such treatment (Curtis, 2001, p. 79). Compliance is the following of the advice of the doctor. Conversely, the prevailing viewpoint has understood non-compliance negatively as resistance against the authority of the prescriber.

By the mid-1980s, the understandings of compliance and non-compliance began to shift. Peter Conrad (1985) published a study with what he calls "a patient-centered approach" (p. 29) to the subject of taking medications. This study involved epilepsy patients, and therefore is only somewhat close to the phenomenon in question here. His work contains many profound insights. He notes that non-compliance is statistically higher for, among other things, psychiatric disorders. His study notes little or no difference between compliance and factors such as age, race, socio-economic status, etc.

Conrad acknowledges the import of the doctor-patient relationship, but suggests that it is limited in its influence on the taking of medications. He asserts that patients following or regulating their own medication regimen has to do with establishing a sense of control over an otherwise uncontrollable condition. Patients, he claims, will modify their levels of compliance in accordance with "the meaning of the medication in everyday life [more so] than compliance with physician's orders and medical regimens" (p. 29).

This is especially true with regard to the experience of the threat or fear of stigmatization and in controlling one's perceived dependence on the doctor and/or the medication itself. Conrad notes the irony of this, saying, "Although medications can increase self reliance by reducing seizures, taking medication can be experienced as a threat to self reliance. Medications seem almost to become symbolic of dependence created by having epilepsy." (p. 33) Conrad's work illustrates the yet-to-be-determined nature of medication for an individual and he works to overturn the existing negative general attitudes toward the issue of non-compliance. He illustrates that stigma is a factor in taking medication, at least for those with a "stigmatized illness" (p. 34) such as epilepsy. Finally, he shows that self-efficacy, or one's experienced sense of self-reliance, is a part of the issue of taking medication.

Conrad's article is limited in what it can illuminate in the present study. Aside from the fact that it is a study of epileptics, Conrad does not explicate the process by which a person comes to find a particular lived meaning in the taking of medications. In fact, he categorizes the different lived meanings that he describes as "social meanings," forgoing discussion of what one might call more personal, private or individual meanings.

In a work contemporary to Conrad, Michael Montagne (1988) also explores "meaning and the act of drug taking" (p. 143). Similarly, he sees it as a phenomenon of primarily social significations. "The act of drug taking becomes, then, a social phenomenon with defined interactions between self, others and society…" (p. 143). He refers to the decision to take the drug as a "determination" that is influenced by the drug's reputation in a culture, affected by things like advertising and social outlooks and understandings on such things. Montagne points out the symbolic aspect of the drug, indicating that drugs have no particular predetermined meaning, only that which is determined by the individual. As with Conrad, Montagne says nothing about the living out of or formation of these meanings.

Joseph Hyland's article on "Integrating Psychotherapy and Pharmacotherapy" (1991) is similar to Conrad and Montagne, with the addition that he allows for personal, individual meanings, or what he calls "intrapsychic" experience, wherein the medication can be perceived as "an introject possessing magical, powerful properties…." (p. 212) Hyland also emphasizes the influence of the doctor-patient relationship on this experience. Hyland argues for integration of drugs and talk therapies on the basis of the individual effectiveness of each. Furthermore, he maintains that communication about the medication should be frequent and clear to both parties. Hyland's is an argument for efficacy and, as it stays solely within the framework of the doctor-patient relationship, it falls short of yielding many insights into the phenomenon of this study beyond what has already been mentioned.

Another article, by C. Brooks Brenneis (1994), addresses the place and value of meaning in general within the field of psychology. Brenneis offers a critique of the medicalization of psychiatry and issues a call to psychologists and psychiatrists in their understandings to increase the value given to meaning as it is lived. “This is not a choice between hard science and soft heart,” he says (p. 71). Brenneis points out the mutual influence of the biological and the psychological, arguing against the way that preference is generally given to the biological. Referring to the over-medicalization of psychiatry, he wryly says that when “all one has is a hammer, everything looks like a nail” (p. 72). While Brenneis makes a convincing argument and illustrates the centrality of meaning in all psychological phenomena, he does not treat the issue of medication as experienced. Furthermore, he seems to operate from a natural-attitude anthropology wherein the human “mind” and “body” are separate entities, which presents a great many difficulties, for the likes of which there is no room here.

In the “Psychology of Prescribing and Taking Medication” (Busch & Auchincloss, 1995), the authors take a position similar to Hyland. Using a thoroughly psychodynamic framework of the person, the authors situate the taking of medication squarely in the center of the doctor-patient relationship. Like Montagne, they do so from a pro-patient point of view that argues for the physician to adopt a more collaborative, less authoritative stance on the matter of a patient’s acceptance of medication. The authors discuss briefly possible meanings that could be in place for people who have been given a prescription for medication, including the perception of a physical diagnosis that could signify relief in that the person could blame something other than himself for the symptoms he experiences. Other patients may experience the medication as a symbol of being ill and experience this painfully, as with a narcissistic wound resulting from being seen by the therapist, and possibly others, as sick, weak or unable to care for themselves. This work illustrates, like others above, that the meaning of medication is made by the individual confronted with taking it. It also points toward the relevance of information on stigmatization, but does not address the question of how or in what contexts (aside from the dynamic of transference and counter-transference) these meanings are formed. Further, it does not comprehend the meanings as lived experiences, but only as epiphenomenon that are the by-product of psychodynamic interaction.

More recently, a study of asthma patients in South Wales in 1997 addresses particularly relevant issues, but with the addition of the element of identity. Just as the work on epilepsy patients yielded insights that have significant implications, so too does the work of Adams, Pill and Jones, in their article, “Medication, Chronic Illness and Identity: The Perspective of People with Asthma.” They conclude that

> respondents’ attitudes to medication and medication practice are intimately linked to their beliefs about their condition and coping strategies which, in turn, are associated with the extent of their acceptance and rejection of the identity of “asthmatic.” We suggest, therefore, that the concept of identity is consequently the most appropriate framework to analyze the respondents’ experiences of being asthmatic…. (p. 199).

Unlike any of the previous literature, this study represents not only the first significant recognition of the component of identity in the phenomenon of medication taking, but it actually centers the phenomenon in this framework. This is exactly the argument that the present study makes, except that this study regards those that suffer with depressive disorders, as opposed to asthmatics.

Drugs, Therapy and Professional Power (1998) written by Ernest Keen, most closely addresses the phenomenon under investigation here. As a psychologist well versed in the phenomenological psychology tradition, he touches on the entire phenomenon brought forth by this literature review and does so from an understanding of the fullness of human being. In the following quotation, Keen actually names the moment that this study explores. The “three levels” to which he refers are levels of psychological analysis (i.e. the doctor-patient relationship, the level of individual beliefs about medication, and the level of culture). Keen says,

> Although these three levels are artificially separated for our analysis, they clearly interact in complex ways in actual lived experience. For example, at the moment when the doctor actually introduces the client to the pills, such as offering samples preceding a filled prescription, each glances or stares at these small but powerful objects, and what each sees is conditioned by all three levels. The pill may enter the dialectic relationship as the doctor’s evidence that he has material solutions to problems the client presents, and thus that he has power and expertise that the patient does not have. The patient may acknowledge this or be suspicious, and each will know or guess what the other thinks about such things, what each thinks the other thinks about him or her, and so on. (pp. 125-26)

Taking medication, as Keen illustrates, is the culmination of a complex interplay of relationships and the particular ways that the doctor and the patient inter-act with and towards each other and how each construes both the problem and the solution and finally, the extent to which each has the freedom to communicate these understandings. This and many other insights of Keen’s significantly influence the study at hand.

The Doctor-Patient Relationship: Issues of Authority and Power

The basic situational framework by which one typically comes to receive a psychological prescription includes the fact that one goes to see a doctor, a health-care professional licensed to prescribe medications. The person going to a doctor for psychological help does so precisely because of the doctor's socially acknowledged position as an authority. A person might come to a particular doctor because of a friend's referral, a professional referral, an ad in the phone book, or perhaps for some other reason. What is important to note though is that the person has come, not to the dermatologist, not to the podiatrist, not to a carpenter, not even to a priest or friend, but to the psychologist or psychiatrist. The doctor is approached because of her/his supposed expertise. This expertise puts the doctor in a position of power. The doctor is the "authority." Power here refers to "the ability to have one's own version of reality dominate other versions" (Sampson, 1991, p.18). Said another way by Michel Foucault, power

> is the moving substrate of force relations which, by virtue of their inequality, constantly engender states of power, but the latter are always local and unstable…. Power… is simply the overall effect that emerges from these mobilities…. [I]t is the name that one attributes to a complex strategical situation in a particular society. (Foucault, 1978, p.93)

Power is enacted in a relationship of inequality and engages each party in a discourse that shapes the understandings of each party in the interaction.

Before proceeding to medication-specific literature on the doctor-patient relationship, it is important to discuss the overall nature of that relationship. Foucault's work is of great import on the matter of this relationship, especially with regard to the history, meaning and place of power within it. Foucault (1997) traces the history of medicine over the last 250 years or so, noting that in the mid-eighteenth century there is a shift in understanding about the physician's essential task. Initially, the physician's role was twofold: he was an investigator of hidden truths of illnesses; and he was a tester of truths that he reproduced in the laboratory/hospital. With the emergence of Pasteur and the awareness of microbial agents, the doctor was no longer a producer of the truth of an illness. In fact, he even became a potential carrier of illness! "By asepticizing the physician and the hospital, one gave them a new innocence, from which they drew new powers, and a new status in men's imagination" (Foucault, 1997, p.41).

With this historical shift as his starting point, Foucault goes on to illuminate the parallel shift in psychiatry and psychiatric power. By the end of the nineteenth century,

> "the 'truth-production' function intensifies around the figure of the physician. And this occurs in a process revolving around the inflated power of the physician…. Henceforth, the physician's power enables him to produce the reality of mental illness characterized by the ability to produce phenomenon completely accessible to knowledge." (Foucault, 1997, p.44)

The doctor is the one who determines the psychiatric phenomena he designates. He is also the one who provides the theories that explain these phenomena. "In question was the way in which the physician's power was involved in the truth of what he said and, conversely, the way in which the truth could be manufactured and compromised by his power" (Foucault, 1997, p.45).

With the sterilization of the hospital, the psychiatrist also becomes sterilized, so to speak, as he becomes the source of truth, the objective observer unsullied by the limit of perspective or lack of knowledge. From this position, the psychiatrist will not only dominate over the patient, he will be the agent of reducing the patient's illness to its "strict minimum" (Foucault, 1997, p.46). Foucault calls this approach a "zero-production psychiatry" and adds that "psychosurgery and pharmacological psychiatry are its most notable forms" (Foucault, 1997, p.46).

Foucault posits that power is deeply rooted in psychiatric practice. The history of psychiatry is, to some extent, a history of the changes of its power dynamics and its determination of what constitutes mental illness and its treatments.

> Power relations constituted the a priori of psychiatric practice. They conditioned the operation of the mental institution; they distributed relationships between individuals within it; they governed the forms of medical intervention…. It is this threefold power that constituted madness as an object of possible knowledge for a medical science, that constituted it as an illness, at the very moment when the 'subject' stricken with this illness found himself disqualified as insane—which is to say, stripped of power and any knowledge concerning his illness. (Foucault, 1997, pp.48-9)

The position of psychiatry asserts its claim to authority on the basis of its knowledge, by which it declares its own superiority. "Now, what is involved in these power relations was the absolute right of nonmadness over madness" (Foucault, 1997, p.48). By arrogating for itself the exclusive dominion over such matters, psychiatry dominates and even determines the very fields of mental health and mental illness. Foucault ends his discussion with the remaining question of freeing "madness" from the domination of psychiatry. "Psychopharmacology…seem[s] to derive from an overmedicalization of madness. And now, at last, the problem is posed of the eventual freeing of madness from that singular form of power-knowledge which is expertise" (Foucault, 1997, p.49)

Some of the vast literature on the doctor-patient relationship is focused on this relationship as it pertains to the prescribing of medication. More often than not the information found here pertains to the "when's and when-not's," the "do's and don'ts," of prescribing medication. For the most part, this carries as a given the presupposition of the authority of the doctor. Noncompliance is generally understood privatively and negatively. And yet there are insights to be gained from some of this literature. Works by Gutheil (1978) and Nevins (1990) are both representative of the most typical literature and, as such, both situate the phenomenon of taking medication under the purview of the doctor-patient relationship. Gutheil operates from a psychodynamic perspective, framing compliance in terms of transference. His work is mostly a description of possible manifestations of both the transference and counter-transference that can occur around the issue of prescribing medications. Gutheil's work does offer the insight that doctors have attitudes about the medications that they prescribe and thus it has meaning as such. Furthermore, he argues for a more collaborative approach in the giving of a prescription (which is suggested for the sake of greater patient compliance). What Gutheil fails to show is that the medication has meanings for the patient that are significant, relevant and contributory to whether or not the patient will take or refuse the medication.

Nevins operates from the same essential psychoanalytic understandings of the human being as Gutheil, though his are somewhat more sophisticated. He argues that several factors are essential to the phenomenon. Interestingly, Nevins does not take as given the power dynamic between the doctor and the patient, and points out ways in which the doctor is influenced, by the patient and otherwise. Unlike Gutheil, Nevins acknowledges the meanings of medication for the patient. Nevins discusses the possibilities of how giving a prescription carries the possibility of making obscure the "neurotic conflicts" within the patient (Nevins, 1990, p. 323). What Nevins does not mention is that the medication-taking, with all of its attendant meanings that a particular patient may hold, is a phenomenon whose values and meanings are informed from a broad spectrum of influences, including personal history and experience, societal values, interpersonal relationships, and even political and economic contexts.

Keen also discusses the doctor-patient relationship relative to the prescribing and taking of medication. For Keen (1998), this relationship serves as a context that lends itself to the establishment of the meaning of the act of taking medication. That an act depends on its context for meaning is the basis for the "understanding of myself as a particular character in a story, the story of my life — my narrative grasp of who I am" (p. 200). He states this relationship is based on authority and that authority is interpersonally and culturally confirmed. The doctor defines the roles of the situation of the visit, identifies and delineates the patient's diagnosis and puts forth the plan to treat/address the patient's complaints. The patient can resist or accept the doctor's assertions or suggestions, but more than likely, the patient will have no say in the formation of roles of the relationship, the diagnosis or the plan of treatment. In a situation wherein the patient is precisely at a point of vulnerability and lack of power, the doctor's authority can actually further disempower the patient. But it can also be, if "the prescribing physician is not authoritarian," an "experience of… increasing one's own control over one's body and mind, which otherwise seem out of control" (Keen, 1998, p. 105). It is a matter of how the physician and the patient co-navigate the interpersonal, shared space of their relationship and encounter.

Keen is quick to point out that this space is shaped by the balance of power, and the sense of the doctor's authority and of the patient's autonomy. The patient's sense of self-as-ill, in addition to his or her previous experiences with others in power, comes strongly into play. “Medication always takes place in some… context, and these contexts are often decisive for the action of the chemicals themselves. It is astounding that such issues are absent from research” (Keen, 1998, p. 105). As the interplay between doctor and patient typically unfolds,

> The person enacting their roles did what they did in role, as a move in a structured space between doctor and patient…. [W]e see people enacting medical themes like treatment, martial themes like pushing back the evil forces of disease, protective themes like making the streets safe for sane people, and even educational themes like telling people something they didn’t know. Both parties did what they did within a limited set of plot-consistent possibilities. (Keen, 1998, p. 105)

This is not to say that biological facets of the situation are not present or relevant. Indeed, one’s “body’s emotional machinery is the means by which [one’s] narrative constructions assume the motive force that makes them matter” (Keen, 1998, p. 111). This is only to say that medication too is a means: a means by which one may proceed toward the projects and engagements of one’s life more ably or freely. This is not by any means at all similar to the use of medication *as* a treatment for “brain imbalances.” Taking up the possibility of medication as a means emerges out of a particular doctor-patient relationship that does not base itself only on the doctor’s authority. Instead it also recognizes that the patient is a person who is in the midst of his or her world of relationships and concerns, moving toward the particular goals of his or her life. The doctor-patient relationship, as both parties play it out, either provides the ground for taking up medication as a means, or fails to do so by being grounded solely upon the authority and power of the doctor. Keen discusses the hegemony of psychological discourse, which he details on four distinct levels:

> (a) in professional pronouncements that shape popular conceptions that define human suffering, (b) in therapeutic practices by professionals that define what is "other" to "health" and thus must be eliminated, and in the (c) theory and (d) professional roles that lead us into complicity with institutions, especially corporations, which inadvertently but mindlessly control conceptions and practices by controlling money. (Keen, 1998, p. 173)

Here it is demonstrated that power infiltrates what and how culture and society determine what is normal and abnormal and how that can be (and usually is) fortified in the therapeutic encounter. Keen goes on to illustrate that psychology's approaches and roles, formulated on the basis of these underpinnings go hand in hand with institutions of power (i.e. insurance companies, etc.). His point brings into sharp focus how psychology, and likewise its doctors, is able to reinforce its power stature exponentially by virtue of its corporate relationships. A person's suffering is defined by the doctor; its meaning is determined by the doctor; the solution is rendered by the doctor. Furthermore, "[i]n the act of prescribing… medicine," the doctor, in this manner, "expresse[s] and consolidate[s] a dependency and thus a power hierarchy…" (Keen, 1998, p. 173). The literature below on the construction of self and other, taken from the view of dialogal psychology, further explores this play/interplay of power.

The works of Howard Waitzkin (1991), and Graham Scambler and Nicky Britten (2001) address the doctor-patient relationship in its social and political complexities. Waitzkin points out that in the examination room in typical encounters between doctor and patient there is no room for examining the patient's lived social contexts of the personal distress that has brought the patient to the doctor in the first place. These issues "remain little known or discussed" (Waitzkin, 1991, p. 7). Doctors tend to keep the focus on the patient's ability to function, to take up his/her everyday social roles in society. Lost are the contexts out of which arise some of the very difficulties that the doctor is called upon to address: substance use and addiction; severe emotional difficulties; hypertension and stress and so on. Waitzkin adds,

> [w]hen contextual issues arise in medical discourse, messages of ideology and social control often appear as well. Ideology involves the ideas and doctrines of a certain social group. Social control refers to the ways that a society achieves adherence to norms of appropriate behavior. (1991, p. 7)

By keeping the focus of treatment on functionality and thus the understanding of the essence of illness as such, doctors

> often lead patients to act in ways that are socially less troublesome. In short, through messages of ideology and social control, and through a lack of contextual criticism, health professional subtly direct patients' actions to conform with society's dominant expectations about appropriate behavior. (1991, p. 8)

Furthermore, "doctor-patient encounters become micropolitical situations that reflect and support broader social relations, including social class and political-economic *power* [italics added]" even though the persons involved do not often even recognize these situations as such (Waitzkin, 1991, p. 9). In this framework, the voice of medicine communicates an ideological message. Illness is reduced to a problem of functionality and social, lived contexts are stripped away. The treatment equally becomes a matter of restoring functionality through medication.

> Specifically, polypharmacy converts a socioemotional problem to a technical one. Drug treatment objectifies… a complex series of psychologic and social questions. Symbolically, scientific medicine shifts the focus to the physical realm, depoliticizes the social structural issues involved, and mutes the potential for action by the patient to change the conditions that trouble him. (Waitzkin, 1991, p. 81)

Tranquilizers replace tranquility (and all searching for it) and the patient soon comes to know that such "solutions" are available. Then these solutions are integrated into a general understanding of how distress is to be addressed. "Contextual sources of distress remain unexplored and thus become reified through the exclusive emphasis on pharmacologic treatment. It seems enough that the patient is sleeping better, gaining weight, and dragging and sagging not quite so much" (Waitzkin, 1991, p. 162-3). The import of Waitzkin's work is that the doctor-patient relationship is only understood as taking place within the greater contexts of broader social structures.

Scambler and Britten's (2001) article focuses on the issue of trust in its varied facets in the doctor-patient relationship. Building on previous works that highlight the asymmetry of this relationship and the "clash of perspectives" between the "patient's definitions and evaluations of their situations, and how these *lay* constructions might vary independently of the *professional* or *expert,* and culturally authoritative constructions of doctors" (p. 45), Scambler and Britten's work gives attention to the need to understand the doctor-patient relationship from a perspective that appreciates a "macro-sociological" as well as a "micro-sociological" analysis. Furthermore, this work endeavors to explore the types of exchanges and encounters that take place between doctors and patients. Lastly, consideration is given to theories of trust.

The analysis of the doctor-patient relationship begins at the "micro-sociological" level, considering it as a situation structured between two individuals. It quickly notes that this encounter is couched in the greater contexts of society, macro-sociological contexts. But Scambler and Britten go beyond this analysis to point out that the doctor-patient relationship contains the possibilities of both differentiation and association, of opposition and cooperation, “which means that it is at the same time both stratified—in terms of power—and cooperative—in terms of interchange” (Scambler and Britten, 2001, p. 51).

Scambler and Britten seek to integrate the analyses of the micro-sociological and the macro-sociological by way of employing the theory of communicative action developed by Jurgen Habermas. Habermas posited that “communicative acts—that is, speech acts or equivalent nonverbal expressions—take on the function of coordinating action and make their contribution to building up interactions” (Habermas, 1984, p. 279). In other words, acts of communication serve to express, but they also serve to inform, persuade, deceive, impose, confuse and achieve, depending on the situation and intention of the speaker and hearer. “Communicative action is dependent on situational contexts, which represent in turn segments of the life-world of the participants in interaction” (Habermas, 1984, p. 279). In preparing to apply Habermas’ notion of communicative action to the particular question of doctor-patient relationships, Scambler and Britten summarize as follows:

> For Habermas, “communicative action” is linguistically mediated interaction in which all speakers pursue illocutionary aims in order to reach “an agreement that will provide the basis for a consensual coordination of individually pursued plan of action.” “Strategic action,” on the other hand, occurs when at least one speaker aims to produce perlocutionary effects on his/her hearer(s). Perlocutionary effects ensue “whenever a speaker acts with an orientation to success and thereby instrumentalizes speech acts for purposes that are contingently related to the meaning of what is said.” Communicative action, in short, is oriented to understanding, and strategic action is oriented to success. (2001, p. 52)

Simple requests and demands are understood as illocutionary acts, which while oriented toward success and made with a claim to power, are carried out in the open, so to speak and are thus designated “open strategic actions” in Habermas’ theory. However, speech acts (e.g. acts of deception, whether conscious or unconscious) employed for perlocutionary purposes have “the peculiarly asymmetrical character of concealed strategic actions” (Habermas, 1984, p. 294). With both types of strategic actions, “potential for the binding force of … good reasons… remains unexploited. This potential is only realized in communicative actions” (Scambler and Britten, 2001, p. 52-3).

Confusion between communicative action and strategic action brings about what Habermas calls “pathologies” of communication. With regard to acts of conscious deception (a concealed strategic action), one person is acting in the interest of success while the other person or persons are operating under the assumption that what is being said is said in the frame of a communicative action. Acts of unconscious deception (also a concealed strategic action) are designated as “systematically distorted communication” (Habermas, 1984, p. 332).

Applied to the doctor-patient relationship, Scambler and Britten use these understandings to illustrate various styles that doctors take in this relationship. A doctor may take open strategic action, (i.e. “I am the doctor—I know best”), or perhaps a more concealed style of strategic action (i.e. browbeating the patient with sophisticated jargon, or more unconsciously with a systematically distorted communication). “The concept of systematically distorted communication allows for doctors… [or more rarely, for patients] to act with an orientation towards success, not understanding, but yet sincerely and in good faith” (Scambler and Britten, 2001, p. 54).

"The voice of medicine… is characterized by strategic action" (Scambler and Britten, 2001, p. 55). It has come to a position of privilege and power over other perspectives and has triumphed the scientific attitude to the point of dominant control over the entire field. The voice of medicine has the power to decide upon the meanings of all matter of events and does so in a way that often strips events of contexts, both personal and social (Scambler and Britten, 2001, p. 55).

> When a doctor, wittingly or otherwise, dominates or controls an encounter with a patient this typically has the effect of absorbing and dissolving the patient's self-understanding into a system of purposive-rational action, namely, the framework of technical (bio)medicine…. In sum, the voice of medicine has developed and retains a tendency to suppress and colonize the *voice of the lifeworld*: lifeworld rationalization and decolonization require patient empowerment…. [This work suggests that if doctors were to take a more communicative action-oriented approach,] they would become not only more humane but more effective practitioners. (Scambler and Britten, 2001, p. 55)

In such an approach, the doctor would allow the patient a measure of equal footing on the level playing field of the voice of the lifeworld. Said another way, elsewhere, by Heidegger (2001), "As a physician one must, as it were, stand back and let the other human being be." For as long as a doctor engages in a strategic action approach, the doctor constitutes the patient "as an object, then being human and being-with are lost" (p. 211).

Scambler and Britten's application of Habermas' notion of systematically distorted communication further resonates with the phenomenon at hand as does their discussion of trust. They begin by mentioning the inverse relationship trend juxtaposing a decline in doctor-patient trust with a rise in consumerism. Increasing incidents of litigation against physicians and legislation for more and more limitations on practices (especially experiments) are just two significant indicators of the decrease in the patients' general trust of doctors. If trust is indeed intended to reduce social complexity, and increase social stability, cohesiveness and collaboration (Scambler and Britten, 2001, p. 59) then the decline in trust signals a compromise in the general sense of security with regard to the institution of medicine.

What has brought about these developments? Scambler and Britten suggest that macro-sociological processes have influenced the status of doctors and of medicine itself. With the influences and impact of consumerism and clientism, and the overall

> postmodernization of culture… trust in doctors, in the medical profession and in medicine itself is every bit as susceptible and threatened in the new era of disorganized capitalism as is the unaccountable and opaque medical paternalism that typified the era of organized capitalism. (Scambler and Britten, 2001, p. 63-5)

Compliance with medication prescriptions has been an issue of importance, not only because of "obvious health concerns, [but for the] financial implications for non-compliance. For example, in 1980, between $396 and $792 million were 'wasted' in the USA because of non-compliance to prescribed drugs (Curtis, 2001, p.77). Scambler and Britten conclude their article by suggesting that any positive change that might be made to restore the diminishing trust of medicine will need to be done on a macro- as well as a micro-sociological level.

The above mentioned literature stands to show that the doctor-patient relationship, a critical facet of the phenomenon under investigation herein, is also contextually defined: first by the doctor and the patient themselves in their own particularities; secondly, by the institution of medicine itself; and lastly by the broader sociological structures of politics, economics and institutions of power.

Social Perspectives: Related Research on the Significances of the Other

Aside from the doctor-patient relationship, the patient also has a whole world of interpersonal relationships. These relationships underscore how the phenomenon is inherently lived socially. "It is the essence of Dasein to 'be with.' The 'world'…is ever and primordially one that I share with others. The world of Dasein is essentially *Mitwelt* [a 'with-world]. [W]e are all out there in the world together, primarily and from the beginning" (Boss, 1963, p. 55). Patients' relationships, with friends and family, as well as with strangers encountered in public, are also part of the lived context of reference for an individual. They are thus a part of the experience of appropriating the prospect of taking psychoactive medications. "Others—definite others who are defined at particular times and for a while from out of temporality—are there in what is being encountered in everydayness" (Heidegger, 2001, p. 76). Others are encountered in this with-world in such a way as to reflect one back to oneself as projected, as already being within a context of relatedness.

Heidegger speaks also about the disturbance and distress of the familiarity of the everyday. For Heidegger, one can become *absorbed* in the everyday, into a "leveled-off there… which concernfully attends to the world…. On account of this, the possibility ever remains that distress will suddenly break forth in the world. The world can be encountered as something distressing only insofar as it is a world which is of significance to us." When the familiarity of the everyday had been shaken up by the "the strange," the everyday then takes on the character of unfamiliarity; the everyday world becomes disturbed (Heidegger, 1999, p. 79-80). What is important to note here is the character of absorption, for it gives a clue as to how one can “be constructed by another.”

Boss echoes Heidegger’s understanding of this “absorption” of one person by another as a possible mode of relatedness to the other. He states,

> [O]ne may… “fall prey” to the will of other individuals by following *them*, by accepting and fulfilling *their* taboos and prescriptions as if *their* attitudes and conditions were one’s own. …[In] falling prey to the wills and ways of others, to losing the freedom to be one’s own authentic self…. [H]uman being may so easily lose sight of its own original freedom and openness by falling victim to the verdicts and views of others. (Boss, 1988, p. 70)

Elsewhere in his work, Boss makes clear that human beings all take part in a shared world with others that includes the possibility of taking part in the shared world in an unfree, unhealthy way. He says,

> [N]o psychological symptom will ever be fully and adequately understood unless it is conceived as a disturbance in the texture of the social relationships of which a given human existence fundamentally consists, and that all psychiatric diagnosis are basically only sociological statements. (Boss, 1963, p. 56)

Human beings are essentially with-others. In the case of psychological dis-ease (and by extension, receiving a prescription for psychoactive medications), the character of one’s interrelatedness with others can take on the character of difference, weakness, of being less than a full human being. This being-seen, as such, represents another characteristic of the phenomenon.

Makal’s research (1999) on *Living with the Stigma of Mental Illness* clearly illustrates the experience of being viewed by others as different and less than normal. Makal’s study and this project share common themes, not the least of which is that the subject of each inquiry is confronted with the situation or condition of being regarded by others and/or by self as being different, ill, less than a normal, able person. Makal's study illustrates that being given a mental illness diagnosis most often results in the patient's experience of "feeling dehumanized, devalued and deeply saddened. They have felt misunderstood, reduced in their totality…. They no longer enter the world with ease…. They feel partially estranged from others, unable to be themselves" (Makal, 1999, p. ii).

In order for a person to receive a prescription, he or she must first have a formal diagnosis. Thus, Makal's work would appear to have direct bearing on this study. As he explores the meaning of living with a diagnosis, he discovers that those who lived with having been diagnosed with, and so *identified* as, having mental illness come to live a particular way of being-with-others, a way in which the freedom of typical interpersonal intercourse is narrowed down. In experiencing others as relating to oneself as reduced, devalued or defective, the ability to encounter the other on a level playing field is either diminished or nullified. Makal's research brings to light the denial and shame that often follow receiving a mental illness diagnosis. Does a person who has been given a prescription for psychoactive medication experience this sort of alienation from others and from self? How a person's relations with others are lived out in the experience of confronting the possibilities of taking medication for a depressive disorder receives careful attention in the research data of this study.

In her dissertation on trust, Carolyn Gratton (1975) shows that trust emerges from a prior intersubjective dimension of relatedness, a social facticity or co-existence that is grounded in a doxic confidence. She asserts that when the therapeutic situation inherently jolts one out of that confidence, thus creating an awareness of one's own vulnerability. The initiative to trust, then, is inherently connected to the one to be trusted. The opportunity for the patient to trust is like a gift that can be accepted or rejected. In that acceptance there is a decision-making, an appraisal on the basis of which the patient may move through the tension of risk, perhaps through an admission of a lack of control, to a new presence to the other, not a regression to mere doxic confidence, but a lived experience of trust. Beyond doxic confidence, and even beyond everyday social reliability, there is interpersonal trust. It is this trust that is arrived at through the decision to accept the one to be trusted. One might well ask if a prescription be interpreted as a gift. Can the same be asked of therapy itself? It seems so. This theme is reiterated by Busch & Auchincloss (1995), "For example, pills may represent something positive from the therapist, such as a gift or food."(p. 408)

Clearly, the issue of trust greatly impacts the specific situation of giving/receiving a prescription and the doctor-patient relationship in general. Daniel Burston (2001) articulates these implications in explaining the non-compliance of 80% of the patients suffering mental illness in the United States. Burston's considerations lead beyond simple patient mistrust to a generally pervading attitude of non-compliance. His insight warrants quoting at length.

> This brings us to a very peculiar problem. For reasons that are not yet clear, some people are actually quite relieved when they are told that their anguish, confusion and despair, their sense of helplessness, futility and self-loathing, and so on, are simply the by-products of neurological dysfunction. This verdict gives them palpable hope for improvement, and they are only too glad to tinker with dosages and to try new medications till the right one materializes, eventually. For these people, the loss of dignity, of self-command and of hope that they suffer while

> symptomatic are viewed as temporary setbacks, to be conveniently erased when their neurological integrity is restored, more or less….
>
> Other patients are averse to this whole approach. They feel that this way of construing things trivializes and demeans them, that it defines and deforms their experience in ways that are at variance with their deepest, though often groping and inarticulate sense of who they *really* are. Whether they know it or not, people like these are often looking for something akin to a religious experience as a solution to their difficulties -- an new experience or a fresh perspective that will elicit or confer deeper meaning on their suffering, giving it some ennobling *raison d'être*, assuring them it is actually *in aid of* something. It doesn't take much insight to see why. They feel that their lives have been hijacked or derailed somehow. They don't just want their suffering to *stop*, or to see some light at the end of the tunnel. They desperately want that tunnel to be a necessary rite of passage to a new and better place than the one they left behind, one which they are loathe to return to.
>
> In addition to patients (or prospective patients) like these, there are people who shun conventional psychiatric remedies because they feel shattered by the blows of life, and look to the psychotherapist to address their deep sense of victimization at the hands of others, to enable them to clarify and cope with it more satisfactorily than they can at present. If the psychiatrist isn't listening, or isn't helpful in this respect, they will not stay the course.
>
> Finally, many candidates for a psychiatric diagnosis have *both of* the aforementioned tendencies in extremely pronounced form. Being told that what they feel or experience is purely the result of a disordered brain is quite distressing for them, and prompts deeper self-doubt and/or distrust of others. In Laing's terminology, they feel "invalidated" by a summary appraisal like this, and fear that their mental-health worker is colluding with all the others who neglect or oppress them, despite their overt or conscious intentions. Rightly or wrongly, then, they are likely to experience the standard treatment approach as disrespectful and coercive, and they've had quite enough of that already, thank you very much. As a result, they are far more likely to go astray with conventional psychiatric treatment. And their numbers are legion. (pp. 22-24)

Clearly, the meaning of being given a diagnosis (upon which rests the situation of being given a prescription) is constituted by both the person who is suffering and the other who is construing the patient’s dilemma. The other, in some framework or another, approaches the patient with reference to “culturally indexed, historically limited” understandings. (Sipiora, 1997, p.20) In any case, both the suffering person and the other (e.g. the doctor) take the situation to *mean something*. This meaning may be agreed on or disputed, but it is, in any event, interpreted by both parties. As surely as the medical doctor's view is influenced by the agendas and politics of modern medicine, likewise view of the non-medical other is influenced by culture in general and particularly by the ways in which psychological theories have permeated this culture. Seeing the person only in terms of theoretical dynamics or neurological processes or even pedestrian understandings of these same as they have infused our modern daily culture is to ignore the personhood of the individual. "Such data are all ways of *not* understanding [the person]." (Laing, 1960, p.33) In this relationship, there is no "reciprocal recognition" (p.35) on an equal or level basis. The "incongruity" (p. 36) serves as a point at which the suffering person ***as*** a human person (with whom we share the world) is forgotten or left behind. Instead it takes personhood for granted and attends only to the person as less than whole, as alienated or as estranged.

One may take culture to be "the visibility of the dialogues particular peoples have with the question of what it is to be human." As such, it renders "the givens of existence (such as temporality, embodiment, world, being-with-others and being-alongside things)… concretely manifest." The particular expressions of these givens, we may designate as a culture's "logos… its latent intelligibility which is the ground of the mundane occurrences of the culture… both revealed and concealed in the taken for granted, prescribed circum-scription of significance in terms of which the individual is as everybody is in average everydayness." (Sipiora, 1997, p. 11) Thus grounded in a perspective that levels things down to only "the socially prescribed, necessarily circumscribed significance that is operative in everydayness," (Sipiora, 1997, p. 12) the meanings of being given a diagnosis and being given a prescription come to be ways in which certain significances and ideals are produced and reproduced by virtue of the priority that they acquire in the taken for granted of the everyday.

Constructing the Self, Constructing the Other: Dialogic Psychology

"The particular freedom allotted to human being-in-the-world in a given era is not equally favorable to all human beings. At times, the historical destiny delimiting human response favors certain kinds of people over others…." (Boss, 1994, p. 194). Keen (1998) echoes Boss in a way that points us directly to the phenomenon of this study.

> What I am saying, then, is that psychological questions associated with psychopharmacology are about more than psychopharmacology and that they bring to the table existential issues that get resolved culturally—in that complex interplay of discourses, value positions, political positions, scientific findings, professional pronouncements, legal decisions, governmental policies, and corporate practices that make up our culture at the turn of the twenty-first century. We must pay attention, lest our practice of using drugs in psychiatry and psychology becomes independent of thinking about the contexts. (p. 169)

Of the selected literature on this theme, the most notable is the work of Edward Sampson. Sampson, like Boss and Keen, also urges psychology and psychiatry to re-examine the values and understandings that give ground to their practice and to their contribution to the construction of culture itself. Sampson's work spans more than three decades, his contribution starting with an awareness and critique of the dominant paradigms of psychology. He lays bare the ways that psychology proceeds as though its viewpoint stands somehow apart from any influences in the ways it views its subject. A "God's-eye view" is not possible. Rather, Sampson puts forth,

Psychology is not simply a messenger, nor is it a passive vehicle; instead, it is a

> means of shaping and constituting properties. Psychology's messages participate in sustaining the very culture from which those messages emerge. Psychology's reflections help reproduce the reality it studies and reflects. (Sampson, 1983, p.47)

What is this "message" of which he speaks? Its message is the ideal of the individualized self. Sampson (1983) suggests

> that an ethos of self-contained individualism pervade[s] both U.S. society and psychology's understanding: Our culture emphasizes individuality, in particular a kind of individual self-sufficiency that describes an extreme of the individualistic dimension…. The self-contained person is one who does not require or desire others for his or her completion or life; self-contained persons either are or hope to be entire to themselves. Self-containment is the extreme of independence: needing or wanting no one. (p. 47)

What is valued in American culture is precisely this kind of self: self-contained; in control of itself; in possession of one's own person and the boundaries thereof. This is not only a matter of psychological theory. It is part of the nation's cultural fabric. It is not uncommon to hear references to "boundary issues" when it is perceived that people are less than able to contain themselves and their emotions, thoughts and perceptions.

In a reading of psychology's major approaches, from Freud to Behaviorism to Humanism to Lacan and Object Relations theories, Sampson (1993) illustrates that psychology has not only been interested in the self as described above, but in various ways has forwarded this principle of the individualized self. Sampson notes that "without a field like psychology it would be difficult to sustain the belief that the self-contained individual holds the key to unlocking the major secrets of human nature and is the raison d'_tre of society itself" (Sampson, 1993, p. 42). The figure of the individualized self takes its place in culture, not as a particular style or conception of the human person, but as *the* conception of the human person. Anything other (Other) is understood as a privative version of this same self. What follows the elevation of the conception of the self, as an *essentially* self-contained being, is the diminution or covering over of human relatedness. As a result, interpersonal, social, cultural and historical contexts are relegated to secondary status.

Sampson understands that the elevation of a particular version of the self is accomplished through the power.

> One potent form of power is the ability to control people by governing the ways in which they understand the world they live in, including themselves and their places in it. Power comes from being able to define the rules of the game that people play in their daily lives. (Sampson, 1991, p.18)

Sampson points out that psychology itself is a player in this game. It is certainly a definer of rules: in the obvious sense of defining the criteria of what is “abnormal” and, less clearly what is “normal” or healthy; and also in the more subtle way of defining what is good and desirable in the qualities of personality, cognition, emotionality and comportment. Psychology tells its culture how it should think, feel, act and be styled and it does so in a way that preserves, sustains and even increases its own power and authority. When psychology proceeds from a position of power, it uses reason, as it defines it, “as a way to keep other groups from having a voice…. Does not this…reason sound like yet another way to justify the advantages certain members of a society have over others?” (Sampson, 1991, p. 19). Foucault uses the same metaphor of a game when he says “this game involving a power relation… gives rise to knowledge, which in return founds the rights of the power in question, characterizes ‘classical’ psychiatry” (Foucault, 1997, p.49). To stray outside of the parameters of these conventions is to effectively be consigned to inferior status. As the “individualized self” is championed by psychology’s power it covers over important dimensions of human possibility, most notably the possibility of human relatedness.

The import of this covering over of human being's essential relatedness in favor of the conception of the individualized self is manifold. It marginalizes those who do not, who cannot, fit this ideal. The pervasiveness of this ideal of the self-contained individual is felt throughout culture and results in a "society of individuals" whose ways of relating to one another are leveled down. The common denominator to which all relations thus refer is power, in its multiform manifestations. Culture asks, demands in fact, that we seek to be in control of ourselves, firm on defending/maintaining our boundaries with others and able to go it alone, as it were, living for ourselves, by ourselves. To fall outside of this vision of the person is subsequently understood as abnormal, even pathological. The ends of this ideology become givens.

> Once ends become covertly adopted as givens and remain unquestioned in the background, the existing structure of domination and privilege remain unchallenged in public discourse…. Social problems are defined as matters of technical control and management rather than as issues demanding critical examination of the existing pattern of goals and interests. (Sampson, 1983, p. 65)

In this way, those who do not and cannot meet the ideal of the individualized self as it is inscribed in the culture become constructed as "serviceable others" who, in standing out as the negative example of the ideal, serve to promote the perpetuation of the ideal itself.

Sampson argues against this, and suggests a re-visioning of psychology from a perspective that celebrates the essential being-with of human being. Dialogue and genuine conversation are at the core of this approach. Importantly, this is not only "conversation" as understood in the everyday sense. Heidegger made the following observation about conversation:

> Here language is not understood as a capacity for communication but as the original manifestness of what is, [and] which is preserved by the human being in different ways. Insofar as the human being is being-with, as he remains essentially related to another human, language as such is conversation…. Insofar as *we are conversation*, being-with belongs to being human." (Heidegger, 2001, p.141, emphasis mine)

Sampson (1993) articulates four points in his discussion of conversation and dialogue. First he calls attention to the "between" nature of dialogue: it always takes place between two or more people. Secondly, like Heidegger, he emphasizes the public nature of conversations, insofar as they are languaged. Thirdly, they are specific, "…something we do… in order to accomplish social actions" (p. 97). Fourth, they take place in a variety of communicative forms, not only spoken words, but writing, signs, gestures and so on.

In the framework of dialogue, it is possible to understand that the psychology that keeps the ideal of the individualized self in place is actually partaking in a dialogue, albeit a dialogue in which psychology's position is made out to be privileged, both ontologically and epistemologically. This is a mistake. Sampson (1983), quoting McCarthy, asserts that to believe that "there is a self-sufficient world of facts 'conceals the transcendental basis of the world of facts, the generation of meaning from structures of experience and action'" (p. 74). He continues to distinguish between a natural science understanding of human being (which tries to explain the *objects* it observes) and a human science (which seeks to understand people and the ways they live) by saying, "In these latter sciences, the aim must be to grapple with the meanings that are central to human activity; meanings can only be grasped by an approach that employs *Verstehen* on the part of the investigator" (Sampson, 1983, p. 77). This last point not only coincides with the attitudes that base this study's approach to a methodology, but it also illustrates that whatever meaning medication might have or take, it will have its meaning(s) only in the social, cultural, and historical contexts of the person experiencing it… or the person researching it!

Sampson develops from this dialogic understanding the notion of voice: the ability to express one's opinion about a situation or determination that impacts oneself; to feel that this opinion has been heard and to feel that it has been given the consideration it deserves (Sampson, 1993, p. 1219). In a culture that minimizes certain aspects of human being (i.e. essential relatedness to others), and thus affords power to some and not to others, it is easy to see how the voices of those who are constructed as "serviceable others" are lost or marginalized. When the majority of people in a culture do not have a voice (in the sense just described) of their own, they are reduced to taking up the voice of the self-that-is-not-their-own. Constructed this way, the values of those who are in the margins become pathologized.

Applying these concepts to the phenomenon of this study, one can see that the situation of appropriating the prospect of taking medication is shot through with meanings and contexts on a variety of levels: there is the play of power between the doctor and the patient; there are the social, cultural, historical meanings of being seen by others as mentally ill; there is the person who receives the prescription who has been alienated in some way from her or his life-projects; and lastly there is the shadow of modern American psychology that looms over the other (who is not individualized, but is marginalized and disempowered) and perpetuates the very sources of alienation that bring people to disruptive junctures in their lives.

R. D. Laing

> argued that labeling the individual often has little to do with accurate assessment of the patient's real problems, and that the remedial interventions mandated by a specific diagnosis often serve complex *social* functions by equilibrating extant social-systems, i.e. maintaining the status quo. In short, clinicians frequently locate the cause of the disturbance in individuals to divert attention from the processes that actually engendered their disturbed behavior. If they did not, they would often construe the "signs and symptoms" of these diagnostic entities as intelligible responses to what Laing termed "unlivable situations" -- ones which the patient can neither understand, nor tolerate, nor change effectively. (Burston, 2001, p. 25)

Likewise, Keen observes,

> I'm not saying that there is no place for medical giving of orders. I am saying only that doing so is not a conversation between subjects; it is an authority subject treating the other like an object. Recognition of that fact does not automatically negate authority, but it does require that such authority be reaffirmed by willing obedience. This reaffirmation will be, or ought to be, contingent on conceptual clarity by professionals—about power and how it comes from dependency. (1998, p.197)

Applying this to include pharmacological orders, Keen states,

> For me to apply a technology and thus to change your goals is to cause, in a scientific sense, you to change in a certain way. For me to have a conversation that leads you to change your goals is not the same process at all. Constructivist psychology cannot settle for the first as a description of therapy because we are committed to the second, which states that we must and, clearly or obscurely, we all, patients and therapists alike, simply do intend and construct the ends toward which we move. (1998, p. 112)

The contribution of dialogic psychology, and Sampson in particular, illustrates that meaning indeed is based on the contexts of culture, society and history. Even more importantly, dialogic psychology in general, and Sampson in particular, illustrate that these contexts are shot through with the dynamics of power and construction of self by self and by others. The research data of this study demonstrate how these contexts and dynamics are lived out in terms of the phenomenon at hand.

Expectation: Selected Literature on Belief, Anticipation and Faith

The literature on medication taking with respect to belief, anticipation, and faith is gathered under the common heading of expectation. This characterization is justified by both the basic situational framework by which a patient typically comes to receive a psychological prescription, as well as by the literature presented thus far. Expectation can be examined as a pertinent aspect of the phenomenon of the appropriation of the prospect of taking medication. Much of this literature was culled from previous qualitative research done in the empirical-phenomenological tradition. This type of research is particularly sensitive to the experience of the participant. These works illuminate critical dimensions of the phenomenon under investigation in this study while remaining in alignment with the philosophical, anthropological and methodological underpinnings that ground this study.

Patricia Deegan's (1983) work, *The Use of Diazepam in an Effort to Transform Being Anxious,* appears to support the notion that the more general prospect of taking medication emerges from the phenomenon of being "blocked." She finds that whether one surpasses, transforms, or tranquilizes being anxious, the *being anxious* is the grounds for all three modes. In being anxious, one's "self-other-world projects and the self-understandings founded on them, had been rendered ambiguously uncertain" (p. 94).

"That from which subjects were blocked was their sense of an unproblematic *ability* to continue with or to resume their more familiar engagements. Thus, their sense of "'what I can do,' 'what I'm up to,' and hence '*who I am*' [italics added] were rendered ambiguously uncertain" (p. 96-97). Furthermore, "being blocked meant that subjects experienced themselves as being unable to be or do what was once possible for them" (p. 97). Finally, "being blocked and conflicted constituted the grounds from which emerged the possibility of transforming (with or without diazepam) or surpassing being anxious" (p. 98). Relative to the prospect of taking medication, Deegan finds that this prospect is grounded in the phenomenon of being anxious or, said another way, of being distressed or unable to pursue one's life projects.

Deegan discusses the use of diazepam as "a very special way of unfolding being anxious by fleeing from any further unfolding of anxious significations" (p. 118). She found that her participants had, in the course of coming to take diazepam, acknowledged that, without the use of diazepam, they were unable to cope with their distresses effectively. She also notes that because these participants took diazepam "as needed," "they had very definite ideas about when, and under what circumstances, they would use the drug" (p. 118-119). This also supports the assertion that people who come for psychological help know that their lives are not meeting the expectations that hey maintain for themselves. Thus they have definite understandings and feelings about the existence and nature of their own difficulties. Deegan's work does shed light on questions regarding the context or *presentation* of the prospect of taking medication. She notes, "How one comes to obtain diazepam from a physician and how one actually comes to use the drug in a particular situation are very important" (p. 122). Deegan does not, however, elaborate much on how patients first face the prospect of medication nor does she need to, as her participants *specifically sought out* diazepam for use in addressing their problems. While her work bears clear parallels to the study at hand, it provides a limited amount of material that can be put toward answering questions about how patients initially confront the prospect of taking medication.

Herb Daschbash's dissertation, *Being-in-Expectation as Experienced by Clients Initially Entering Individual Psychotherapy* (1986), illuminates an important dimension of the prethematic understandings of clients as they make the decision to undertake therapy: the clients' expectations and how they are structured. Daschbach finds that being-in-expectation emerges

> out of an ongoing flow of life events and lived experiences in the course of which they [clients], in the midst of constantly changing feeling states and states-of-mind, struggled to appraise "how they and their valued life projects were faring" with respect to the kind of future towards which they grasped their present as naturally moving.... [O]f special concern to them was the extent to which they experienced themselves as remaining "in control" and "on track" as their lives unfolded into the future. (p. 63)

From this ground or flow, there emerges "an unforeseen dramatic event or...the impact of a cumulative series of events which finally became overwhelming" in which one's sense of "being 'in control' and 'on-track'...was thrown into question" (p. 64). After the undertaking of therapy, the process of therapy itself becomes a part of the client's continuing re-appraisal of that client's situation, specifically as regards getting back "on-track."

Part of Daschbach's focus was how the client constitutes the therapist as being the one who knows, so to speak, the one who will orchestrate the necessary changes for the client's life. In other words, clients expect to get answers or to be told how to fix their lives, or perhaps even to "be fixed." When this does not happen, when clients' expectations are not met, they re-evaluate the entire prospect of the therapy itself. At this point clients, who have already surrendered themselves to the beginning of therapy, must decide whether or not to surrender further as they begin to see what the therapy is turning out to be. It is as though one says, albeit prethematically, to oneself, "I came for help because I thought I would be helped in this way, but it is another way instead. It is not what I anticipated. Does it still hold any promise of help for me and if it does, what will be required of me in giving myself over to it or in trusting it?"

Again, the issue of the presentation of the prescription arises. In considering how a therapist presents the goals and tasks of therapy to the patient, it is possible to see how the "re-evaluation" that Daschbach describes, comes about. Patients, with their initial expectations/ understandings, meet a therapist and receive the presentation that the therapist gives, however thorough or sparse it might be. At that point, patients must make their own expectations coexist with the received presentation. As patients reconstellate this, which is done continually, either rapport is formed or the therapist is rejected. It is important to note that even the issue of when a therapist introduces medication into the therapeutic picture can affect this outcome. So, at the same time that the prospect of medication becomes a part of the presentation by the doctor (whether or not an acceptable, understandable framework is given), patients are confronted with the task of appropriating such a prospect into their ever-reconstellating understanding of therapy. *How* a therapist conveys the goals and tasks of therapy to the patient appears to have great impact on whether or not the patient can open up to accepting both the therapy and the therapist.

As with Deegan, Daschbach's work also includes the issue of the lived sense of being able. He notes that his participants "also weighed, without exception, the factor of their own perceived level of potential ability to use personal effort in the accomplishment of their aims" (p. 99). Furthermore, the decision itself to get therapeutic help is "an acknowledgement of their own inability to deal by themselves with their mounting problems" (p. 99). Daschbach's work shows that the client, the person coming for help, is vacillating "between modes of wishing, wanting, imagining, and fearing, while trying to continually appraise how they and their valued life projects are faring with respect to the future(s) they perceive themselves as being-on-the-way-towards" (p. v). Out of this appraisal comes the assessment of one's "own level of personal power and resources, and…potentiality for meeting" the emerging contingencies of one's life (p. 75).

Speaking on the subject of beliefs and their relations to how we understand distress and its cures, Keen (1998) points out that, "In all cultures… ideas about the origin of depression, delusions, anxieties and antipathies are part of the cultural stock of knowledge" (p.128). What we understand of illness, in this case psychological dis-ease, is founded upon cultural ideas, understandings and values. These beliefs define what is sane and insane, what is normal and abnormal. They form the (mostly unexplored) ground of the etiology of psychopathology. Keen goes to say,

> such beliefs, [significantly here in the case of medication taking], will either be held in common between a modern patient and his or her psychiatrist or they will not, and this will matter in how the dialectical situation plays out. These beliefs, and their corresponding loyalties and commitments, make every two-person conversation some version of larger cultural conversations that contextualize the dialectic relationship.
>
> Each party enters into such a relationship from a common cultural background, but also with loyalties and commitments to very different parts of the pluralistic complex that is America. Though the dialectical relationship is the proximal nonchemical, psychological factor in what is happening in pharmacotherapy, it is also informed by an entire social structure, as it is seen by both patient and doctor and as it is enacted them both in that seeing, which is worked out in the dialectical processes between them. (1998, p. 128)

The dialectical processes Keen here refers to simply signify the ways in which people see and understand each other.

As noted above, Dasein is a world-with-others. This being-with-others is interpersonal; it is cultural; it is historical. As Keen points out how the influential, defining dialectic processes between two people mirrors larger processes, so Medard Boss (1994) says, “Every age grants to humanity a Da-sein, an existence as a perceptive open realm, whose limits are peculiar to that age.” The spirit of the times is what “allow[s] a being to be what it is” (p. 193). This is not merely a description of how people are different in different eras. It points out the fact that as an age grants a particular kind or way of being for all, it can do so in such a way that is more (or less) free, more (or less) open to healthiness in the sense of allowing people, all people, to be who they are in the fullest. There is the possibility of inequity, of an imbalance of freedom, opportunity and/or power. Boss’ discussion of this possibility was mentioned earlier in his remarks on the freedoms allotted in a given era. Elsewhere in his work, Boss makes clear that for human beings, all of whom take part in a *shared* world with others, there is included the possibility of taking part in the *shared* world in an unfree, unhealthy way. This unfavorable "destiny" can be a "destiny" for an individual or shared by an entire segment of a given population.

Heidegger, whose work was the inspiration for much of Boss's work, also speaks about disturbance and distress. For Heidegger, one can become *absorbed* in the everyday, into a "leveled-off there… which concernfully attends to the world…. On account of this the possibility ever remains that distress will suddenly break forth in the world. The world can be encountered as something distressing only insofar as it is a world which is of significance to us." When the familiarity of the everyday had been shaken up by the "the strange," the everyday then takes on the character of unfamiliarity; the everyday world becomes disturbed (Heidegger, 1999, p. 79-80). What is important to note here is the reference to absorption, for it gives another clue as to how one can "be constructed by another:" disturbed by "the strange," living as a stranger in one's own life/world, seen as strange, as a stranger or an alien in the gaze of another.

Willing, Motivation and Identity: Phenomenological Literature

What both Deegan's and Daschbach's works show is that the issues volition, self-efficacy, agency, in short, of the *will,* are inherent in the phenomena they researched. Interestingly though, neither of these works addresses at any length the issue of will. In fact, Daschbach does not even use the word "will" at all. Yet, it seems to be a central concern, deserving consideration of its own. The literature that follows is a selection from the broad expanse of literature on will and volition. As with the theme of expectation, literature was chosen here, not to provide an overview of this broad expanse, but to further illuminate a critical dimension of the phenomenon of study. The selected literature does this in a way that is consonant with the philosophical and methodological understandings on which this study rests. In considering will and motivation, the following questions arise: what part if any does the phenomenon of willing have in the experience of appropriating the prospect of taking medication? What does one mean by "willing" in the first place?

To begin with, there is the work of Alexander Pfänder, one of the original figures in the Phenomenological Movement. A contemporary of Husserl, Pfänder was one of the original editors of Husserl's *Jahrbuch,* his main interest being the phenomenology of willing and motivation. In 1900, the same year as the publication of Husserl's *Logical Investigations* and Sigmund Freud's *The Interpretation of Dreams*, Pfander's *The Phenomenology of Willing* (1900/1967) was published. In titling work *The Phenomenology of Willing,* rather than *The Phenomenology of the Will,* Pfänder demonstrates his interest in the lived act of willing and not merely theoretical constructs, be they philosophical or psychological. He distinguishes willing from what he refers to as "striving," which includes wishing, hoping, longing, desiring, fearing, despising, and so on (p. 3). Pfänder goes to great lengths to make this distinction, laying out these phenomena in explicit detail. For the purposes of this study the term striving is signifies an object, situation, or event, which calls out to be recognized and attended to. Within the field of human consciousness, something arouses or impels a person to respond. In terms reminiscent of Husserl's use of noesis/noema, Pfänder points out the "centrifugal"/"centripetal" movement in place in the striving phenomenon (p. 17). He is quick to point out that in striving, the striving itself is "blind"; in other words, it originates outside of the person and is not engaged with the individual's own self in any way, as such (p. 17).

Willing, in the proper sense, is distinct from striving in two ways. While there is an interplay that is parallel to the centrifugal/centripetal motion of striving, willing is distinguished from striving by "the belief that what is striven for can be brought about by one's own doing and secondly, that the range of this striving extends to the conditions of its realization, including one's own doing. But what converts such striving into willing in the proper sense is that the ego sides with such striving" (p. 3). One is subject to strivings as they come upon one, "attacking" the ego. They *happen* to a person. Willing, on the other hand, begins with the ego. An act of willing "includes the immediate consciousness of self (p. 22). Pfänder sums this up by saying,

> The act of willing is, therefore, a *practical act of proposing filled with a certain intent of the will* which issues from the ego-center and, penetrating to the ego itself, induces in it a certain future behavior. It is an act of **self-determination** [boldface added] in the sense that the ego is both the subject and object of the act. (p. 23,)

Here it is now possible see the will as the act in which one, confronted by some circumstance, event, or issue, engages the confronting issue with reference (albeit pre-thematically) to oneself and to one's life projects. Pfänder goes on to describe how acts of willing are grounded by motive, and not caused by strivings. He says, "Motives do not cause anything; they supply grounds" (p. 38). Motives, for Pfänder, are the meaningful basis on which the directive of the ego's willing is founded. It may be that these motives provide a complete and confident basis, or they may amount to an insufficient and incomplete basis. This basis becomes a catalyst as it is used as a support, by the ego, for the act of willing. In an act of willing, the demand of the situation is acknowledged. It is also incorporated and used as the basis of the willing act.

These last few points are especially salient to the analysis of the appropriation of the prospect of taking medicine. Here it begins to arise that willing involves most centrally one's sense of oneself, the pre-thematic "who" of who one is. Willing involves the incorporation of meaningful grounds that become the very basis for the willing act. Is the taking of medication an act of willing? Can the prospect of *refusing* medication be put in the same light? Can the way in which a person receiving a prescription for psychoactive medication incorporates this prospect be understood in light of motives? In other words, by approaching the prospect of taking medication as an act of will, it becomes evident that there must be *grounds* for that act. What are the meaningful bases on which this appropriation is lived out? Again, these bases, these motivations, are not to be seen as causes. Willing is free in the sense that one sees the confronting situation, is aware of its demands, and responds to these demands on some meaningful basis. This response is not predetermined, nor is it caused by the demands or by the motives. Rather, this response is made in the situation on the meaningful grounds at which one arrives within the limits of the actual state of affairs.

Another phenomenologist who has contributed greatly to examining the phenomenon of willing is Paul Ricoeur. One of his earliest works is *La Philosophie de la Volonte*, or *The Philosophy of the Will*. Ricoeur's interest in the will has found its way into many, if not all, of his successive works. One of the most direct and concise formulations of his thinking on this subject is a paper he presented in May of 1964 in Lexington, Kentucky. The paper, titled “Philosophy of Will and Action” begins with a historical-philosophical reflection on human willing. He eventually arrives at a phenomenological reflection, and his views fall in league with Pfänder’s, whom he invokes several times. Ricoeur also raises the issue of freedom, of the act of will as grounded by motivation, not causal determinism. Indeed, he says, “Our needs, our desires are not simply irresistible forces that can be measured and treated as physical magnitudes; they are also significations, evaluations, which are capable of entering a field of motivation and of being confronted there with other values….” (p. 24). He even uses the words “support” and “base” to talk about motives. Going further, he talks about motive not only as *meaning*, but also as *force*. It seems that he is saying that the meaning grounds of an act of willing are also the “energy, a power” (p. 22) that fuels the act of willing. Finally, acts of willing, grounded by motives, “decide the meaning of [the] motives… [and bind] the particular decisions of will to the whole of the personality” (p. 23).

For Ricoeur, just as for Pfänder, acts of willing are always situated in the context of the projects of one’s life. Ricoeur points out the self-implication essential to the act of willing. One finds oneself in “a world in which there is something ‘to be done by me’” (p. 18). Taking up this position, one takes up a position with respect to oneself. “I commit myself and I bind myself…. In determining something, I determine myself. Thus I myself figure in the project as the one to whom the action can be imputed…. [T]his action [then] represents me in the world" (pp. 18-19). In this way one establishes oneself as the agent of the action, the one to whom the action is imputed. Ricoeur's work corroborates Pfänder's, and prompts again the questions of if and how the initial issue of the prospect of taking medication can be understood in relation to the field of willing. Can it be asserted that the prospect of taking medication is in fact an issue of the will? If so, how and on what grounds? Surely, Pfänder and Ricoeur show how the act of willing proper is essentially self-determining and meaningfully grounded.

Without the use of any such notions or constructs as "ego-center" or "force," Heidegger approaches what is typically referred to as "drives" or "will." He does not isolate willing, wishing, urges, drives and so on as isolated "mental" phenomena (and certainly not causal phenomena) detached from the world (the referential totality/context of Dasein) in their origins. Rather, within the situatedness of one's facticity and concernful dealings with the world, one is motivated by the "for the sake of which" in a given situation to a given possibility. Heidegger states,

> The determining factor is not an urge or a drive, driving me or urging me from behind, but something standing before me, a task I am involved in, something I am charged with… for which [I] have *resolved [myself]*, in the sense of having-opened [myself] for it. (2001, p.173)

More simply stated, our relatedness to the world in and through our engagements with the projects of our lives provide motivations; they call us, they move us to comport ourselves in and toward the world in the particular ways depending on the given situations we encounter. To continue, "Willing belongs to freedom, to being-free for a claim to which I respond. Then claim is the motive for willing. I only will [something] when I am engaged in a motive, when I *appropriate* [italics added] it as such, when I accept it" (Heidegger, 2001, p.218-219).

In a similar fashion, Medard Boss approaches the subject of will. Like Heidegger, he opposes any sort of understanding of will as a construct but rather within the framework of a Daseinsanalytical understanding of the human being. Some of this framework has already been articulated above. In sum, the Daseinsanalytical perspective understands the human being as the kind of being for whom its own being is at issue. In this, the human kind of being is a being-in-the-world. This means that human beings find themselves "there" in the contexts of the projects and concerns around them, the *world* that is their relatedness to these contexts. Thus Da-sein (there-being) is a being-with-others as others are a part of our referential totality. Dasein is also a being-towards in that it is already always engaged somehow with the projects of its world. The human kind of being is such that meanings are not inherently pre-given, but emerge in Dasein's encounter with its world. Dasein is not only a Mitwelt, as mentioned earlier, but also an Umwelt, a world of concrete surroundings where the happenings of our lives take place. Most important to the discussion here, the human kind of being is such that it ***is*** its engagements with the world. It is *in its encounter* with the factical referential totality of its world-relatedness that Dasein exists.

Boss understands motivation as a meaningful, worldly (or more precisely, "worlded") phenomenon. Opposed to a viewpoint that reduces motivation to a causal force, Boss instead mandates an understanding of motivation as a reason that moves one to act, choose, or refrain from action, decide, consider, or nurture a feeling, or behave in some particular way. Furthermore, “[m]otives, as well as that towards which motives are directed, are determined by an impending task that has been recognized and accepted. To inquire into the motives of a person is to inquire into the particular concernful dealings and projects of that person. It is to inquire into that person’ world. Examining the reasons that beckon one to some kind of action or other is to look at the very engagements that give being to this person *as* Dasein. “Every human action is motivated on account of something recognized by the person in question, and this recognition is grounded in the person’s being engaged by some phenomenon that addresses him” (Boss, 1994, p. 150).

The issue of motivation provides yet another lens through which it might be possible to interpret or recognize the results of the research data. In terms of the phenomenon of this study, it could be suggested that the issue of motivation, i.e. the motivation to accept or refuse a prescription for medication, will center on the particular meaningful projects and engagements of a person’s life. One would expect to see this experience include concerns relative to the relationships with the others in patients’ lives, the goals of their lives (be they large or small, long term or short), the understandings patients have of oneself, the values they have acquired/ established in the world-with-others, and so on.

Selected Literature on Depressive Disorders

The highly specialized situation of confronting the prospect of taking medicine for psychological complaints emerges out of a difficulty or inability to participate in a person’s situation, and the subsequent actions that the person has taken (i.e. seeking the help of a professional). This difficulty or inability is a constriction of motivation as discussed above. It is not a complete loss of motivation; the person has taken action in seeking help. It is a failure of, in Heidegger's terms, the claim of one's world or of answering that claim. Mental disorders can be understood as a state of blockage of this claim. Nowhere is this better illustrated in the panoply of mental disorders than it is by the phenomenon of depression. For this reason, some relevant literature on depressive disorders is included to help illuminate the decision to focus this study solely on the experience of patients suffering with depressive disorders.

Whether depression is caused by imbalances of neurotransmitters in the brain, or some genetic predisposition to a certain metabolism, or social and environmental influences that a person has learned or internalized, or the dynamics of forces that fall outside the access of awareness is not what is of import here. Rather than attempt a distillation of the huge array of theoretical and clinical information, it will suffice for the purposes of this study to discuss and establish an understanding of depressive disorders that is germane to the phenomenon we are investigating. Recognizing that, the literature review on depression contains a brief overview of the various current approaches to depressive disorders, followed by a more in-depth discussion of the literature that approaches depressive disorders in a way that sheds light on how these disorders are lived and experienced. What is important here is the question of how depression is lived. The themes of meaning, being-with-others socially and interpersonally, willing and motivation and are elucidated for the benefit of understanding medication-taking in the light of depression, and vice versa.

The most prevalent, most popular understanding of depressive disorders at this moment in western culture emerges out of the biological perspective. From this approach, depressive disorders are understood as having their origin in neurochemical imbalances in the brain. These imbalances may arise from a hereditary, genetic predisposition or through physiological dysfunction or some combination of the two. As the etiology of depressive disorders is understood, in this approach, to be found in deficits or excesses of various neurotransmitters, the treatment of choice for those who practice from this understanding is the use of antidepressant medication. For those whose disorders are severe, electroconvulsive therapy is also a treatment method used by practitioners of this approach.

Alternately, cognitive theory proposes that depressive disorders are the result of a negative "cognitive interpretation of oneself that reflects self-blame, self-criticism, and exaggerated ideas of duty and responsibility. Such beliefs are often exaggerated and irrational and are interpreted in a catastrophic manner" (Sue, Sue and Sue, 2003, p.360). From this perspective, those with depressive disorders are essentially suffering from a disturbance of thought patterns and of cognitive interpretations of themselves and of the world around them. In this approach, it is faulty schemas of thinking that yield the experience of depressive feelings. Accordingly, treatment, according to this theory, involves the identification of the faulty schemas, the examination of each negative thought/belief, and the replacement of the negative thoughts with realistic, positive, and affirming schemas.

Behavioral theorists posit an explanation of the etiology of depressive disorders involving the reduction or loss of reinforcement. From the behavioral perspective, depression is "a product of inadequate or insufficient reinforcers in a person's life, leading to a reduced frequency of behavior that previously was positively reinforced" (Sue et al., 2003, p.358). A period of reduced activity may ensue and this may draw reinforcement from others in the form of sympathy, encouraging the person to sink further down into inactivity. The preferred treatment of depressive disorders by practitioners of a behaviorally based psychology is behavioral therapy (which is often done in conjunction with cognitive therapy). This involves rigorous tracking by the patient of his or her activities, rating each for a level of reinforcement or "pleasantness." The tracking encourages heightened awareness of what activities bring positive reinforcement as well as patterns of behavior present in instances of negative consequences for the patient, which then may be reduced or avoided.

The psychodynamic approach to depressive disorders emerges from the theories of Sigmund Freud (and those who followed and developed his theories thereafter). They center on the concepts of anger and separation. Depressive disorders are understood to originate when one suffers the loss of another, either literally (i.e. death, separation, etc.) or symbolically (i.e. rejection, withdrawal, etc.). According to this approach, depressed people are fixated in the first stage of development, the oral stage, and are thus fixated to a position of dependency. The failure of others to support this dependency brings forth depressive feelings. Also, a person may suffer a depressive disorder when anger emerges as a response to the loss of another. A person feels deserted, becomes resentful of the one who has gone, and then feels guilty about his or her anger and resentment. While the practice of traditional psychoanalysis has become less frequent, the treatment of choice for this perspective (and the many derivative incarnations that now exist) is some form of interpersonal therapy. Very often this is done in conjunction with psychopharmacotherapy as well.

There is, as well, an approach to depressive disorders that would best be described as “sociocultural” in orientation. This approach emphasizes differences of prevalence and of symptomatologies between given societies, between the genders, and across many given cultures. Depressive disorders are understood etiologically here as a result of stressors and lack of resources that make a patient’s life unstable. In addition to incorporating therapies from any of the aforementioned perspectives, the sociocultural approach treats depressive disorders by helping the patient to secure adequate social supports and resources.

While the approach to depression as an essentially biochemical disorder is the current overarching preference of psychiatry and psychology, it is not the case that all psychologists (and even psychiatrists) understand or treat it primarily as such. Two works in particular are of importance in illustrating this point. These works provide valuable insights that inform both psychological understanding in general and this study in particular.

The first of these two is the work of Boss (1994). He approaches human phenomena within the framework of a Daseinsanalytical understanding of the human being. This includes his approach and understanding of depressive disorder. For Boss, a depressive being-in-the-world is attuned to the world in a constricted manner. Specifically, as Dasein is its openness to possibilities, a person who is depressively attuned to the world has a narrowed down responsiveness to what addresses that person from the surrounding world (p. 219). Furthermore, depressed persons encounter themselves as "nothing but emptiness, inferiority, worthlessness, and culpability" (Boss, 1994, p. 219). As a result, such persons cannot, do not relate to their world in ways that are their own. Boss says, "…for them, time has stopped…. This consigns them to an emptiness that is beneath human dignity, for human being can happen only in its time, carrying to fulfillment the inborn possibilities for relating to whatever addresses it " (p. 219).

"Existentially, the [depressive patient] has come to a standstill; he is related to neither the future nor to the present," but rather the bleakness of a blurred state of emptiness that holds no promise of dissipating (Boss, 1963, p. 210). And yet, people who suffer thus are not oblivious to the inherent orientation of human being toward the future. It is simply the case that they cannot answer the call of the future and cannot receptively respond to the surrounding world of relationships, projects and concernful dealings. As this persists, depressively disordered people become, as Boss says, "indebted to… their unfulfilled inborn possibilities for existing authentically" (1994, p. 220).

Boss is not primarily concerned with the pathogenesis of depressive disorders. For him this question is secondary to the question of (and understanding of) the phenomenon as a lived mode of human existence. This can only be accomplished through a

Daseinsanalytic approach to human being. Writing long before the advent of the multi-billion dollar psychopharmaceutical industry, Boss points out that

> Even if it were demonstrated that certain [depressives] exhibit metabolic dysfunctions or toxicity during their periods of depression, this would still not explain their illness as the human existential phenomenon that it is, and even if future discoveries produced a completely reliable pharmaceutical therapy, we would not thereby have a real understanding of the phenomenon itself. Beyond the fact that it is difficult to know whether physical evidence…is simply a consequence of behavioral disturbances, the true nature of [depression] can only be understood in terms of the loss of freedom over existential traits. (Boss, 1994, p. 221)

Boss makes the same point about “endogenous” versus “reactive” depressions, saying that etiologies that do not approach the human being in its openness (or foreclosure) toward its possibilities are insufficient to explain or understand the phenomenon as the particularly human phenomenon that it is.

Boss is also keenly aware that as human phenomena, possibilities such as a depressive way of being-in-the-world exist in and emerge out of particular times and places in human history. With regard to the phenomenon of depressive disorders, Boss has this to say:

> The tendency today is increasingly toward depressive illnesses…. Even among nonhospitalized psychoneurotically disturbed people, most who seek help today are people horribly depressed by the meaninglessness and tedium of their lives…. Suffering as they do, these people try to drown out their desperation through addiction to work, pleasure, or drugs. When this fails, the depressive attunement of boredom and meaninglessness that prevails in this age shows clearly, and we see dramatically the impairment of perceptive openness which boredom is. (Boss, 1994, p. 223)

It is in the attunement of boredom that one becomes confronted with the world as a world where everything means almost nothing and hope is out of reach. The past, the present and the future all merge into an unstable, un-world that is open only to the possibilities of doom and death. Thus in our highly industrialized, highly medicalized society, "we avoid depression… as we avoid perhaps nothing else… a symptom to be treated, an illness to be cured" (Romanyshyn, 1989, p. 226). Depression goes against the very essence of a culture that centers itself on material acquisition and progress. "Depression is profoundly anti-progress" in a society where "the pursuit of happiness has become a frenzied hunt married to a success measured more often than not in material possessions, in dead things" (Romanyshyn, 1989, p. 226-7).

In addition to Boss' contribution to approaching and understanding depressive disorders, a particularly interesting viewpoint on depression comes from Keen (1984). Emerging out of a narrative psychology perspective, Keen seeks to do away with the typical understanding of depression as a symptom or set of symptoms.

> In fact, depression may be the paramount nonsymptom. *Symptoms* are ways of coping; *depression* neither tries to cope, nor succeeds…. *Symptoms* are life struggling, however maladaptively, to survive; *depression* is a ceasing of the struggle and the beginning of death. In its purest form, depression is giving up. (Keen, 1984, p. 803)

In the experience of depression, time slows to a standstill, the world appears empty, devoid of life or promise, and other people become as things, objects that cannot be reached or are able to reach through the veil of depression.

Keen's treatment of the phenomenon of depression elucidates and echoes what is perhaps one of the most graceful and poetic English language expressions of the modern, western experience of depression as it is lived and found in the voice of Shakespeare's Hamlet, who muses:

> I have of late, but wherefore I know not, lost all of my mirth, foregone all custom of exercises: and indeed it goes so heavily with my disposition, that this goodly

> frame, the earth seems to me a sterile promontory, this most excellent canopy the air, look you, this brave o'erhanging firmament, this majestical roof fretted with golden fire, why it appeareth nothing to me but a foul and pestilent congregation of vapors.… What a piece of work is a man… the beauty of the world; the paragon of animals; and yet to me, what is this quintessence of dust? (Shakespeare, 1985, p. 884)

Depression is a hopelessness, a saying of "I can't" that is a paralysis, a giving up on life. Keen delineates two variations on depression's "I can't": an "I won't" which is anger and an "I shouldn't" which is guilt. These kinds of agitated depression are less hopeless than depression in its purer form (Keen, 1984, p.804). In describing a fourth variation, he distinguishes a depression and loss of touch with life that goes undetected because "I perform [a] magnificent ruse by indulging myself in a thousand distractions that life makes available to me—mass media, tranquilizing drugs, alcohol, or an all-consuming work-role" (Keen, 1984, p. 805). Dependency follows these distractions and they become necessary to keep the person from facing what would otherwise be overwhelming emptiness. It is likely that such a person is not even immediately aware of this emptiness and depression.

Though Keen points out that one resolves and emerges from each of these different variations of depression in different ways, he also notes that each emergence involves the "common necessity of facing and surviving that utmost of human horrors—death in life, being alive and conscious without a script, myth, or storyline that provides meaning, life without reason, death without death's sleep" (Keen, 1984, p. 805). Thus unable to see or find meaning in life, one encounters, in sadness, mourning and despair, the essential lack that all humans bear and according to some, fill with the meanings they find in the worlds of their own lives, experiences, relationships, concerns and projects.

Depression also has the characteristic of a “self-deception that attempts to protect us from sadness” (Keen, 1984, p. 806). In depression, one often embraces fantasies that prevent us, by various means, from confronting the loss that one seeks to avoid facing. These fantasies take root deeply and strongly. Emerging from depression is difficult, then, as one must overcome this self-deception in order to confront and transcend (by mourning and/or acceptance) the emptiness/loss/void that covers over ones entire existence. In this confrontation with emptiness, a person does not do away with the loss or lack, but rather re-creates or re-dis-covers self, opening up to the future.

> My present life, which leads from the past into the future, matters when it is a part of a historical unfolding within which I can place myself in an integral part. Having a job, being a parent, engaging in crafts, for example, can supply such a story. In depression, these ordinary aspects of life have been… rendered meaningless by the death themes of depression: the stoppage of time, the emptiness of space and the reification of people. The reestablishment of a future, the refurnishing of space with significance and vitality, and the repersonification of others are all implicated in reinventing myself and emerging from depression. (Keen, 1984, p. 808)

While Keen goes on to describe in detail the long and difficult process of re-dis-covery, enough has been said to understand that depression is entirely appropriate to this investigation. Grasping depression as a nonsymptom and a phenomenon of giving up on life in the despair of emptiness is to grasp depression as a constricted, narrowed down and reduced existence. Each dimension (time, space, others, etc) of this kind of existence manifests this constriction. In sum, depression, as has now been unfolded, appears to be a perfect vehicle for the examination of the phenomenon investigated in this study.

As this review of literature draws to a close, it is pertinent to discuss the matter of what is, with reference to the phenomenon under investigation, the "psychological import" of this topic; namely, how people participate in the meaning of their own situations, as project-ed, as experiencing, as participants living out their concernful relations to the contexts of their lives. Central to the interpretation of the body of literature reviewed and likewise central here is the issue of willing. It is willing lies at the core of this psychological import. It will also be seen that the dimensions of being-with (i.e. the doctor-patient relationship, the experience of stigma, etc.) of belief and of dynamics of power are, in fact, essential elements of the phenomenon. The highly specialized situation of confronting the prospect of taking medicine for psychological complaints bears particular significance here insofar as it is, in this situation, *precisely* a person's difficulty or inability to participate in his/her own situation, along with actions that he/she has taken (i.e. seeking the help of a professional) that is at issue.

In summation, the literature review has rendered the development of the major themes of the phenomenon of this investigation as it is understood so far. The review indicates that this study is needed to provide what does not, at this time, exist: a thorough investigation and explication of the lived structure of appropriating the prospect of taking medication for a depressive disorder. The existing literature is, for the most part, not sensitive to the need or importance of such a study.

That medications occupy a significant place in our culture and in psychology in particular is beyond debate. Because the typical approach to this phenomenon, that others most often take, is focused more on the calculable particulars of certain manifestations of this phenomenon, there is a risk that a comprehensive understanding of it in its fullness of meaning will be covered over. That alone is enough to justify this study. It is also a good indication of why the particular methodology that has been proposed is employed. This methodology is intended to approach this phenomenon from a human science perspective that is rigorous and thorough without being reductive, one that will allow the multiplicity of meanings to emerge from thoughtful consideration and inquiry. In the end, the present study renders a unique and important contribution to the field of psychology in general and to the specific areas of identity, will, and the experience of medication-taking in particular.

Methodology

Theoretical Understandings

As has been established, the purpose of this study is to examine the phenomenon of appropriating the prospect of taking medication *as it is lived meaningfully* by people with regard to *the contexts of everyday life*. Focus is placed on the "lived experience, on how we read, enact, and understand our life-involvements" (von Eckartsberg, 1986, p. 1). For this reason, this study is a work whose approach is existential-phenomenological in nature. As such, prior to considering particular processes techniques, attention must be given to the approach. The need and reasons for this consideration have been well documented (Giorgi, 1985, Wertz, 1985, von Eckartsberg, 1986, Moustakas, 1994, etc.), and are tantamount to understanding the human being as precisely that being for whom existence itself is shot through with meaning and cradled in contexts. These contexts arise out of facticity, the everyday life of human being (Dasein) and they include the contexts of one's projects, one's interpersonal relationships, and also the cultural, societal and historical contexts that frame a person's life. It is precisely these contexts that constitute the referential totality of the human being, (i.e. "the world."). Thus understood, human beings are always in the position of finding and making meaning in all engagements with their worlds. Researchers who understand the human being this way, then, are "concerned with the potential meaning, inherent and dormant in all the single situations one has to face in and throughout his or her life" (Frankl, 1984).

In this existential-phenomenological approach, the subject matter is not reduced, constricted, predeterminately defined or distilled in any way, but rather is allowed to stand out in its own right and show itself in its multiformity of meanings as they present themselves to the researcher. "Objects are to be taken as they show themselves in themselves, i.e. just as they are encountered by *a definite manner of looking toward them and seeing them*… on the basis of a being-oriented, an already-being-familiar with these beings" (Heidegger, 1999, p. 58-9) as they stand forth in everyday life. Importantly, it must be noted that the researcher, too, is subject to being in the position of having to find and determine meanings in a given situation. Therefore, phenomenologically oriented researchers acknowledge their work as interpretive (i.e. hermeneutic) as well as descriptive. These researchers do not stand outside of the situation "objectively," but are part of the work itself, actively uncovering the meanings embedded in the data.

> Everything depends upon our understanding being guided from out of the indefinite and vague but still intelligible content of the indication onto the right *path of looking*. Successfully getting onto this path can and must be aided by a precautionary measure which takes the form of rejecting certain positions of

> looking which are dominant in the situation of research at the particular time, which *seem* relevant, and which thus of themselves crowd in upon us. (Heidegger, 1999, p. 62)

As active participants in the research, it is up to the researchers to be aware of their own preconceived understandings of phenomena as impacting both the data and subsequent analysis. In the course of this research these initial understandings, discussed at the outset of this study, will not simply be cast away, but will be understood as the researcher's access point to the phenomenon. They will appear directly in a later dialogue with the evidence from the data gathered.

Methodological Procedures

As an empirical phenomenological study of "appropriating the prospect of taking medications for psychological complaints," concrete descriptions of lived experience that illuminate this phenomenon were gathered and investigated for inherent structural meaning. Data were gathered in the form of written protocols and followed up by interviews between the researcher and the individual participants. The collected data were examined via an analysis and methodology based on that which was outlined by Giorgi (1985) and furthered by Wertz (1985). Analysis involved examining each protocol and interview, and attempting to glean its data thematically, yielding a thematic structure for each participant's experience and a generalized structure derived from the experiences of all participants.

This methodology is not so much of a definitive set of exact procedures as it is a thoroughly articulated and involved set of attitudes and approaches to encountering the data. To be sure, there are techniques that are suggested, but the flexibility of this approach rests in its openness to letting the phenomenon, in its uniqueness, be an indicator of how best to unfold it in its many layers of significance. “Information about what is present for the making-present can only be given by the making-present itself. We must be instructed by it where to look in order to find what the content of [the phenomenon] is” (Heidegger, 2001, p.68). In this way, the research attempts to adapt itself to the phenomenon it investigates, allowing it to open in its own fullness of meaning, rather than a procrustean approach that forces the phenomenon to fit into pre-existing definitions that are not subject to review or even questioning, thereby truncating the vitality and full meaning of the subject of inquiry.

The process employed in this research project seeks to explicate the general structure of the participant’s lived phenomenon by way of individual or situated structures generated from the raw data of individual protocols. The raw data serve as the basis from which emerges a narrative, a “story… the foundation of human everyday meaning making” (von Eckartsberg, 1986, p. 201). As the interpretation of these stories unfolds, the endeavor to be aware of and dialogue with one’s presuppositions is helped by the collaborative nature of this methodology. Interviews allowed for the opportunity for a participant’s clarification of how the researcher grasped.

It is important to note what Wertz calls “the basic stance or attitude of psychological reflection” (1985, p. 204). By this he means the processes where the researcher encounters the data, considers it in its complexity, looks at it with his own presuppositions in check, gives focus to layers of meaning and so on. This stance can be articulated another way. "*Phenomenology* is… a *how of research* which makes the objects in question present in intuition and discusses them only to the extent that they are there in such intuition" (Heidegger, 1999, p.57).

How was this inquiry made? In a discussion on how phenomenology opens up and illuminates the path of ontological inquiry, Heidegger (1999) says, "What is necessary is to bring this phenomenon authentically into view… in such a way that Dasein itself… discloses itself with regard to definite characteristics of its being" (p. 61). To be sure, the character of this study is not ontological in nature (i.e. it is not inquiring along the path of the meaning of being). It is rather an ontic inquiry into the characteristics of a particular human phenomenon. Moreover, it is an inquiry into a phenomenon that is lived out in the cultural, historical milieu of the participants of this study. Nevertheless, this inquiry, parallel to Heidegger's remarks above, required that it bring the phenomenon of confronting the prospect of taking medication into view in such a way that the phenomenon revealed itself in relation to the characteristics of its being. In other words, as the focus of this investigation emerged out of everyday life experience, it reveals something itself and also about everyday life itself, about the facticity of Dasein as lived by the individuals who participated in this study. The human world in the sense described above was encountered in the experiences of the participants. This study sought to clarify "the as-what and how of its [this inquiry's phenomenon of study] being-encountered [which] lie in what will be designated as significance…. [Significance is] a how of being" (Heidegger, 1999, p. 66). As the significance of a phenomenon emerges, the world is encountered as "*what we are concerned about and attend to*" (Heidegger, 1999, p. 66). The *significance* of confronting the possibility of taking medication for psychological complaints was given clarity. Said another way, almost everyone who enquired as to the subject of this dissertation understood rather quickly what was being talked about. This topic is a part of the everyday world shared by all those who belong to this time and culture. It is understood and relevant as such. Yet that seemed to be where general understanding ended and the inquiry herein began. What does the situation of being asked to take psychological medications mean? What is its *significance* and how is it lived by particular individuals of this era and culture who are confronted by this very possibility?

The themes and contexts emerge while looking at the phenomenon, and this looking took the character of being occupied with or a “tarrying” (Heidegger, 1999, p. 67) alongside it to bear witness to the themes of the phenomenon, the meanings of the phenomenon as they stood forth. Finally, “we need to be cautioned against a widespread error which consists in taking a so-called ‘experience’ in the sense of an isolated act, an artificial extract” (Heidegger, 1999, p. 67). In other words, as themes emerged in the looking, it had to continually be remembered that these themes were lived within the network of contexts and concernful relatedness to the world. They emerged in a shared world, a world-with-others. “The everydayness of Dasein has its Dasein there for itself and seeks it on the path heeding of what others say about it, what its pursuits look like to others, how *the others in advance come to appearance within its pursuits*” (Heidegger, 1999, p. 72). The phenomenon in question emerged out of facticity. However, this is not to say that receiving a prescription is something that is *necessarily* familiar to or a part of everyday life for all those of a given era and common cultural background.

Certainly, it appears that an increasing number of people are taking psychoactive medications. Further, psychological medication itself appears to occupy more and more a part of our cultural consciousness. References to medications at all levels and contexts, from humor to insult to philosophy to economics, are quite common. But even if confronting the prospect of taking psychoactive medication was not encountered in the familiarity of the everyday it still remains a phenomenon for interpretation that, as such, yields clarity on particular, socio-historical Dasein itself. Again,

> even there where the disclosedness of what is being encountered—the in-order-to, the for-whom, etc.—is not encountered in the Familiarity of the everyday… where something strange presses into the world closest to us and we happen across it, the character of the disclosedness nonetheless announces itself precisely there in our explaining the thing in question from certain points of view as we tarry at it for a while—the question "what is it?" explicates itself into a "What is it for? What are we supposed to do with it? Who is it for? What is it supposed to be? Who made it?" (Heidegger, 1999, p. 72)

These are the attitudes and understandings that shaped the approach of this study, particularly its methodology. This methodology provided theoretically and procedurally appropriate grounding for this project precisely because it aimed to unfold a phenomenon as lived by individuals within the context of their own lifeworlds. This is exactly the contribution this work offers regarding the phenomenon of appropriating the prospect of taking medication.

Selection and Protection of Research Participants

In keeping with the parameters of this study's approach and methodology a set of research participants was determined. Specifically, individuals chosen must have had already, prior to the study, been given a diagnosis, as determined by the DSM-IV, for a depressive disorder of some kind. Individuals with other diagnoses and those who were diagnosed or given prescriptions as minors were excluded. Participants were eligible only if they had received a prescription for medication as a form of treatment for their depressive disorder. Furthermore, it was necessary that participants' protocols reflect their first experience of receiving such a prescription. While both male and female participants were solicited, only females responded.

Individuals chosen as research participants for this study had to meet the following criteria: 1) they were currently receiving psychotherapeutic care of some kind, or had easy access to a therapist or psychiatrist, and 2) were able to participate comfortably in all phases of the research, including interacting with the researcher and being recorded on tape. Every effort was made to choose individuals who could participate without risk of severe emotional distress. Therefore, individuals were not chosen who had had recent episodes of suicidality or hospitalization for an episode of major depression. Because this research is descriptive and qualitative in nature, rather than simply numerical and quantitative, the sample size need only be large enough to field protocols that do, in fact, reflect the phenomenon of this investigation. This can be reasonably accomplished with no more than ten solicited protocols. Of these, the three that most clearly reflected the focus of this study are utilized.

To safeguard a situation that contained the possibility of touching on sensitive or difficult personal subject matter, all necessary accommodations were made to assure the safety of the research participants. Solicitation using posted flyers or advertisements was not utilized for several reasons. First of all, eliminating this kind of solicitation removed concerns of the validity and/or accuracy of the potential participant's self-report of his or her diagnosis, history and also his or her singular assessment of ability to participate in the study. Colleagues and associates of colleagues who see people in a therapeutic capacity referred participants. Therapists were instructed to refer only those potential participants who are most able to make judgments about their own participation. This was beneficial as it afforded greater certainty regarding the diagnosis of the potential participant, as well as an opinion, additional to that of the potential participant, on his or her ability to participate comfortably in the study. The therapists who referred potential participants were thus able to preliminarily screen out those who might be vulnerable in some way, or endangered in any way, by participation in the study. In order for the referring therapists to have all of the necessary information on the nature of the study and its procedures, the researcher issued a formal communication to the therapists involved, as well as the informational materials (found in Appendix D below).

Acquiring participants through referral in this way presented its own issues, particularly a keen awareness of the possibility for participants to feel pressured by referring therapists. Formal communication issued to a therapist directly expressed this issue, asking that the therapist not only refrain from any sort of pressure on a potential participant, but to actually, explicitly inform potential participants that they were under no obligations to participate in the study. Also, therapists were asked to communicate to potential study participants that this would in no way jeopardize their involvement in therapy or their compliance with a medication regimen, should one exist.

It is important to note that participant solicitation in this manner is preferable in this situation because it provided, beforehand, measures to protect participants (within the pre-existing therapeutic relationship) in the event of discomfort or negative reaction on the participants' part.

Participants were given informational materials, which were reviewed with the researcher, on the nature and purpose of the study itself and also of the precautions that taken to safeguard confidentiality and participant safety. Further, participants received a consent form to sign, which reiterated all of the above-mentioned specific concerns. These precautions were carried out in strict accord with the guidelines given by the Graduate Handbook of the Psychology Department as well as the Institutional Review Board of Duquesne University.

Formulation of the Research Question and Acquisition of Research Data

Thorough consideration has been given to the phenomenon as a meaningful and contextualized experience. Through pilot research (Mangine, 1996), possibilities were considered as to a question that would best point to and access the phenomenon under investigation. This study uncovered the importance of how participants' initial impressions regarding their relationships to the therapy are affected; how the process of reappraisal is affected by the introduction of the suggestion of taking medication. It became clear that asking about situations of unsuccessful medicine compliance could also be beneficial as it also shed light on the phenomenon. “How did you come to receive the prescription?” “How was the prescription presented to you?” “How did you respond to it? What did you think of it? How did you feel about it?” These were seen to be necessary questions. Ultimately, the following question was developed and stands, as follows, in its final form as it was presented to the research participants:

> **I am interested in how people think and feel about taking medication for psychological problems or complaints.**
>
> Please describe, in as much detail as possible, your experience of how you came to take medication for psychological complaints. Please include a description of: a.) what lead up to your seeing the person who gave you the prescription; b.) how he/she presented the prescription to you; c.) your thoughts and feelings at the moment you received the prescription as well as your thoughts and feelings before and after being given the prescription.

This question, printed out as it appears here, was given to each research participant. Each participant responded to the question at their own pace in an environment of their choosing. Most took the question home and answered it there. Answers were made in writing or were typed. If a participant wanted to handwrite her answer or could not type the answer out, type transcription was offered. After the initial responses were received and transcribed, a follow-up interview was conducted with each participant. During the interview, the transcribed response was reviewed line-by-line with the participant. Thus, initially unclear words and phrases were given clarity, and condensed or ambiguous expressions and meaning were given expansion. These interviews were audio taped and transcribed. The transcriptions of the initial responses were edited together with the transcriptions of the interviews to comprise the raw data for each participant.

Analysis of Research Data

Data were analyzed in the manner of Giorgi's (1985) research methodology. Data given by participants were rendered into textual form and then broken down into single units of meaning. These meaning units were then synthesized into a situated structure and finally rendered into a general structure in order to convey psychological meaning. However, the general structure was specifically languaged to disclose the phenomenon of the appropriation of the possibility of taking medication in light of its *significance*, the way in which the world is encountered and that to which one attends and about which one is concerned as one lives out this experience. The significance referred to here is the lived significance for the particular individuals who participated in this study.

A unit of meaning refers to a moment of distinct significance in the participants' descriptive account of their experience. Often in the synthesizing of the situated structure, these units are reorganized to reflect the lived order of events. The language used to render the meaning units into an organized gestalt was as faithful to the participants' original language as possible.

The situated structure entails, according to Wertz (1983), "various possible activities of psychological reflection" (p. 206). The kind of reflection required in this case was interested in "…the subject's participation in the network of immanent significations which make up his lived reality" (p. 207). Using an approach toward participants' accounts that “tarried alongside” each participant’s experience via their description, it was possible to move beyond the manifest expressions of meaning in the text to arrive at the deeper meaning and ground of the experience as lived. Each account was re-languaged in more explicitly psychological terms to highlight research reflections that arose. This is understood by Wertz (1983) to be an “original speaking” of the participant’s participation in the meaning of the situation (p. 210). This speaking, while perhaps mundane, is nevertheless revelatory of the lived meaning of the situation. Thus, the language itself that was used was an issue of consideration. As the meanings and themes arose and reappeared from participant to participant, inquiries were made as to the context of vague areas in the descriptions. Possible configurations of the phenomenon were explored through the use of imaginative variation. These methods were crucial to the entire process of drawing the meanings forth from the phenomenon in question and are found in all stages of this process (Wertz, 1983).

Assembling the data in this way culminated in a general structure. The general structure is a synthesis, articulated in general psychological language, of participants’ lived meanings disclosed in the situated structures, which were, in turn, derived from the protocols as they were organized into units of meaning. The stance of the researcher was one of abiding reflection on and reference back to the original texts supplied by participants. In the formation of a general structure, it was imperative to articulate the phenomenon in an explicitly psychological manner while remaining as close to the original lived experience of the participants as possible. This particular general structure does not lay claim to a generalized structure for all people across cultural and temporal boundaries, nor does it purport to generalize a complete or requisite structure for all members of a given era or a given culture. The general structure derived herein is interested only in identifying factors that have made possible the specific experiences of the individuals who participated in this study. In so doing, this inquiry seeks to further the field of psychological understanding in terms of how this phenomenon may be lived and what conditions may give ground to this experience.

Research Participant Profiles

Jillian is a 31-year-old, unmarried Caucasian female who lives with her 2-_ year old daughter in a townhouse in a suburban neighborhood. She is a college graduate with a degree in political science. She is, at this time, unemployed and considering going to graduate school for elementary education. She continues to have contact with the father of her daughter, though he is an irregular presence in their lives. Jillian grew up as an only child. Until she went to college, she lived locally with her family who is, by Jillian's account, situated in the upper socio-economic class. She considers herself to be non-affiliated with any particular religious tradition, though she considers herself to be a spiritual person.

Felicity is a 39-year-old Caucasian female who lives with her youngest son in their home in the suburbs. She is separated from her second husband and is pursuing a divorce at this time. Felicity's second husband moved out of their house at the beginning of January 2003. Her two older sons have been living with their biological father (Felicity's first husband) since last summer. Felicity agreed to this arrangement partly in light of the troubles that she anticipated with her second husband in the past six months. She sees her oldest sons every weekend. Felicity is employed in a local hospital as a registered nurse and is currently pursuing her certification to be a school nurse.

Amy is a 31-year-old Caucasian female who was born and raised in Hamburg, Germany. She is a college graduate. She met her husband in California in 1995. She became pregnant with their first child. They moved to Germany, where her daughter was born. They married and remained in Germany for two more years, during which time they also had a son. Amy's daughter is now 6 years, 10 months old and her son is now 5 years, 9 months old. All four of them returned to the United States when Amy was 28 years old. Both of Amy's children attend school. Amy's husband is a self-employed tradesman, while she works full time as a staffing director at an agency that provides comprehensive services (i.e. child care, tutoring, support groups, counseling, and parenting skills classes) to low-income single parents who are full-time students. Amy and her husband remain married at this time and continue in their struggle to work through their difficulties as they try to keep their family intact.

Results

General Structure

The phenomenon of appropriating the prospect of medication taking emerges out of an initial mode of being-in-the-world where a person is engaged in the relationships of oneself to one's world. This initial state of being-in-the-world is of a particular character. The character of this being-in-the-world is of *having been disrupted* in its engagements with its projects and in the contexts of its meaningful relations to the world. This state may take the form of a long history of difficulties or may be a series of recent concurrent events. The crucial aspect is the disruption that is experienced as culminating or reaching a peak. This disruption serves as the backdrop, the context on which the experience of appropriating the prospect of medication takes place.

This disruption has the character of making an impact in all of the domains of the person's lifeworld. Thus, one's interpersonal relationships, one's projects, one's experience of one's own body are disturbed. For these individuals, the flow of their particular lives has been disrupted in such a way that they can no longer meet the demands of, and fulfill the relationships to and within their own lives. The decision to take some kind of action to remedy one's situation is based on the failure or inadequacy of one's habitual modes of coping, problem-solving, and managing conflicts or crises. The individual's usual ways of coping are experienced as no longer viable.

In the course of searching for a solution, the person feels unable to alleviate his or her suffering. The individual begins to feel overwhelmed and compromised in his or her life's roles and projects. Visibility to others also becomes an issue. Other people stand out most especially in their capacity to view the person as being out of control, as being one who is suffering and also as unable to conceal or censor that suffering from others. As the individual becomes less and less able to alleviate the disruption of his or her life, the situation worsens. Faced with the inability to repair, or cope with, the situation single-handedly, the person begins to neglect the self, lose self-esteem, and/or become saddened.

Eventually a feeling of desperation emerges wherein the person desires change, improvement, restoration of the original state prior to the suffering. This desperation is also an experience of being overwhelmed. It is a feeling of being unable to stem the tide of suffering. One desires to survive and reclaim one's life, with all of its relations and projects. The individual seeks resolution and to restore a sense of self-agency and the ability to navigate life independently again.

The decision to visit a doctor ushers in the experience of doing something in the service of self-help. Deciding to make and actually making an appointment brings about a sense of relief, an increase in confidence and sense of self-agency in those participants who had some initial sense that the nature of their concerns was psychological. When the person did not experience the presenting problems as possibly being of a psychological nature, there was no such increase (or previous decrease) in self-confidence.

The decision to see the chosen doctor is a considered decision. In this study, two participants chose their doctor based on the trust of the person who had referred them. For one participant, the decision was made in order to minimize effort in getting to the doctor and to maximize anonymity. For each of these participants, the experience of seeing the doctor included an assessment of the doctor's presence. While all three experienced a positive presence, this was not the deciding factor in choosing to accept or refuse the medication. It was, however, something that all three participants noted with varying degrees of emphasis.

As the opportunity to take medication was introduced, it emerged to all participants as a "giving in" or an admission of incapability to resolve one's problems independently. The medication can hold the promise of helping, but it does so only as it "takes over" where a person is no longer, or no further, able to help him or herself. The willingness to "give in" or admit the limits of self-agency is a choice based in the priority of the values threatened by the original suffering. Furthermore, for these research participants, associations to personal historical reference influenced this choice. A person may thus choose to take the medication in favor of preserving the values that are held dear. Likewise, a person may refuse medication for *the same reason*.

After weighing whether or not to accept the suggestion to take medication, an individual comes to terms with the matter within the framework of how he or she assesses the medication's ability to alleviate some or all of the present suffering. If this is assessed to be likely, then the person can hope and/or anticipate that suffering will decrease. Medications come to have a place in the person's field of possibilities as a viable way to address suffering. If the medication holds no promise or is too great of a compromise of values, the medication will be refused and other methods of address will be sought to alleviate suffering. In either case, the prospect of medication has had the effect of confronting the person with what is most important. A person accepts or rejects medication resolutely.

Illustrated General Structure

In what follows, the general structure above is rendered again and illustrated with excerpts from the protocols and protocol interviews that reflect its various points.

Emerging out of an initial mode of being-in-the-world where one is engaged in the relationships of oneself to one's world, the phenomenon of appropriating the prospect of medication taking emerges in an initial state of being-in-the-world that is of a particular character. The character of this being-in-the-world is of *having been disrupted* in its engagements with its projects and in the contexts of its meaningful relations to the world. This state may take the form of a long history of difficulties or may be a series of recent concurrent events.

> Jillian: I have had a series of events over the past 3 years that led to my taking prescription medication for depression. First, I was in a car accident… then I caught my boyfriend of 3 years cheating on me… my father had quintuple bypass surgery at the age of 52. 4 months after my fathers' surgery, I got pregnant by my boyfriend (whom I was not even dating at the time, for we had broken up due to the infidelity). Next, at 30 weeks pregnant, I was in [another] car accident…. After my pregnancy… my long time best friend from 8 years of age was killed in a car accident. Needless to say, I experienced a very busy 3 years.

> Felicity: I always had a very stressful and crisis-oriented life, from about the time that I was nine years old to the present. I now, in retrospect, believe that I also suffered from depression of varying degrees from that time on.

> Amy: In the spring of this year I had on several occasions physical "things" happen to me that scared me…. My husband and I weren't getting along at all,

> constantly fighting, and I was considering moving out of our home with our two kids. Also I was working a nearly full time schedule…. I spent several nights a week catching up on my paperwork and reports. I didn't sleep enough, had stress at work, at home, kids that needed me to be stable and a husband that was not only not supportive but contradicted a lot of my efforts.

The significant factor is the disruption is experienced as culminating or reaching a peak. This disruption serves as the backdrop, the context on which the experience of appropriating the prospect of medication takes place.

> Jillian: I… had the distinct feeling that I could not control myself…. [M]y fear [was] so overwhelming that it really caused a problem.

> Felicity: My level of depression and anxiety became very overwhelming during that time; I was crying almost daily; I could not concentrate at work, and my anxiety level was very high.

> Amy: I am trained in professionally dealing with stress, but this was too much. I knew I was burning the candle at both ends but hadn't realized that I couldn't handle it anymore the way I had been able to the years before.
>
> Amy: It went past the point that I could deal with it.

This disruption has the character of making an impact in all of the domains of the person's lifeworld. Thus, one's interpersonal relationships, one's projects, one's experience of one's own body are disturbed. For these participants, the flow of their particular lives have been disrupted in such a way that they can no longer meet the demands and fulfill the relationships to and within of their own lives.

> Jillian: I found myself flying off the handle at my co-workers, friends and family for the smallest of things…. I was also extremely sad. I was very quick to cry and felt an overwhelming responsibility to the child inside of me…. My weight and my emotions were out of control and I knew it…. I would have a racing heart, constricting feeling in my neck, a sense that my blood pressure was up and I would begin to get clammy and sweaty. I also was experiencing a lot of dizziness and lightheadness…. I started to lose interest in friendships with anyone other than family or Toni…. I became super critical of our group of friends – even the ones I liked…. I lost interest in any cleaning, housework, cooking, working outside the home, having my own interests or hobbies…. I was short fused, rude, impulsive and generally didn't like people talking to me. My daily routine was pretty slovenly…. [O]ur friends that they were beginning to avoid Scott and stopping inviting us places, basically because people didn't want to have to deal with me anymore…. I cried an awful lot, was pretty temperamental and really didn't function well…. It was awful… to see what I had become. I just didn't like what I was.

> Felicity: I wasn't able to function as a contributing human being to society at all. I was just so wrapped up in those feelings…. I lost fifty pounds in a month. I was eating pears, drinking coffee, and smoking cigarettes, and that was it…. I would

> be so insecure, I would be sitting in a room full of people just frozen, sweaty palms and all…. [I needed to be] eating more, not crying all the time, moving on with my life, being able to be more patient with my children, be strong enough to face the task of raising those kids on my own.

> Amy: In the spring of this year I had on several occasions physical “things” happen to me that scared me. One time my tongue started tingling and became partially numb. I also felt like I couldn’t talk. Another time my right arm felt “detached”. I was looking at it and wasn’t aware of it. It was very strange. I became scared because my paternal grandmother’s side of the family suffered from strokes. [Also m]y husband and I weren’t getting along at all, constantly fighting, and I was considering moving out of our home with our two kids. Also I was working a nearly full time schedule in a human services agency, dealing with families and individuals with all kinds of difficult backgrounds…. I spent several nights a week catching up on my paperwork and reports. I didn’t sleep enough, had stress at work, at home, kids that needed me to be stable and a husband that was not only not supportive but contradicted a lot of my efforts.

The decision to take some kind of action to remedy one’s situation is based on the failure or inadequacy of one’s habitual modes of coping, problem-solving, and managing conflicts or crises. The individual’s usual ways of coping are experienced as no longer viable.

> Jillian: It was then that it became clear that I was not going to snap back to normal…. All I knew to do to try to make things better for myself was to try to outwardly act happy and somehow, I thought maybe I would really start to feel happy. That didn't work.
>
> Jillian: I just tried to fake it until it would become natural. So I would be happy. I figured I could strong-arm myself; kind of pull myself up by my bootstraps and say, "Enough of this." It didn't work…. everything else about me either got worse simply remained the same…. But I didn't know how to fix it; I couldn't fix it.

> Felicity: I was eating pears, drinking coffee, and smoking cigarettes, and that was it.

> Amy: There were other things, like fun events, nights off where I was hanging out with my friends. Or even here, after we moved here, and I had a friend here, I could take the kids over there, and we were just hanging out. I just left a lot, avoided a lot of complications…. I couldn't handle it anymore the way I had been able to the years before.

Feelings of inability to alleviate one's own suffering, of being overwhelmed and of being compromised in one's roles and projects emerge as one searches for a solution to one's problems.

> Jillian: I felt like I couldn't fix it on my own. I was powerless to…get myself under control again. I would try to be nice, and I couldn't.

> Felicity: The feelings of anxiety and depression were just over-consuming… to the point where [I] couldn’t function.

> Amy: I knew I was burning the candle at both ends.
>
> Amy: It went past the point that I could deal with it.

For two of these participants, one’s visibility to others also becomes an issue. One sees others most especially in their capacity to view one as being out of control, as being one who is suffering and also as one who is unable to conceal or censor that suffering from others.

> Jillian: I would go so far as to pretend that I was in our bedroom sleeping if I knew that Scott had invited friends over to the house.

> Felicity: An acquaintance said to me, that really didn’t know my life history, just someone I worked with, said to me, “You look like me before Paxil.” She knew me to say, “Hey how you doing?” and we worked very well together, we worked in close proximity. But she knew nothing about my life, and she knew nothing about what I was going through. [I thought,] “Oh my god, is it that apparent? It must be bad.” The depression, the anxiety, the illness, [was] so apparent that someone who doesn’t really know me can see right through me, can see it…. I thought to myself, “This girl doesn’t even know me. She doesn’t even know what

> I'm going through and she can pick up that I need help." It must be bad; it must be something that needs to be addressed.

As one becomes less and less able to alleviate the disruption of one's life, one's situation worsens and one begins to neglect the self, lose self-esteem, and/or become sad because one cannot fix the situation on one's own.

> Jillian: If I showered 3 times a week I was lucky. And shaving the legs? Didn't know that was supposed to be done in American society. This was all accompanied by panic attacks and the whole fear of driving thing with still being fat on top of it all…. I could see myself… more clearly and did not like what I saw.

> Felicity: I went from here [a place of positive self-esteem] back down [to a position of negative self-esteem]…. I was very, very insecure. I was so afraid of Walt leaving me…. My husband being abusive. I always thought, if I was prettier, if I was better, if I did this or I did that.

> Amy: I was very sad.
>
> Amy: …the parts that hurt over being, or giving into that completely and being sad and not getting out of bed anymore.

Eventually a feeling of desperation emerges wherein the person desires change, improvement, restoration of the original state that was prior to the suffering.

> Jillian: I just didn’t like what I was. I used to be a very happy, very tolerant person, and I wasn’t that way anymore…. I felt desperate and willing to try anything.

> Felicity: I was at a point in my life where I was actually very happy, very centered, had a lot of peace. I was at a point where I was feeling pretty good about myself, and then Walt came into the picture. I thought I was losing my mind and I was desperate to feel better.

> Amy: I was thinking, if I’m really that tight then that’s why I’m having these symptoms, I’m really going to have to start making some changes…. I thought, all right, I’m probably not suffering from strokes here; I’m very tight, very tense. It was easy to say that was the case and that I have to do something.

This desperation is also an experience of being overwhelmed. It is a feeling of being unable to stem the tide of one’s suffering.

Jillian: My emotions were out of control and I knew it.

Jillian: It became clear that I was not going to snap back to normal…. I felt desperate.

Felicity: I felt like I just wanted to be in my room alone all day.

> Amy: I couldn't handle my life's stresses in my life and needed to take good care of myself…. I didn't think I was going to be able to continue with the job I had the way I was having it.

One desires to survive and reclaim one's life, with all of its relations and projects. One seeks resolution. The individual seeks resolution and to restore is one's own self-agency or ability to navigate one's own life again.

> Jillian: I didn't like the reality of going back to work and dealing with adults. Because I couldn't control what everyone said and did…. I wanted to run the show, be completely in control.

> Felicity: Well… It was the physical things, you know… the tightness in the chest, the tightness in the muscles… um… my hands were always shaking… I had racing thoughts… negative racing thoughts.[D: Did your being a mother and being a worker, being employed as a nurse and so on have any relation to "getting better"? F: Yes.] The physical things were so consuming that it was difficult for me to do any of those things.

> Amy: I took that [the doctor's concern's] very seriously…I had kind of started thinking in that direction [that the problems were not of a physical origin and] like having to make some changes in the way I was doing things.

The decision to visit a doctor ushers in the experience of doing something in the service of helping oneself.

> Jillian: The other part [of her feelings about her first psychiatric appointment] was actually gaining a little bit of self confidence about feeling that I'm finally trying to take care of responsibilities and trying to get myself in line so that I could function at a higher level.
>
> Felicity: I couldn't wait to get in and see her. When I made the appointment, I think I had to wait two weeks. And it was the longest two weeks, because I thought I was losing my mind and I was desperate to feel better.
>
> Amy: [She does not experience this in any way other than the expectation that something is physically wrong with her and she is going to see someone with knowledge and diagnostic skill to give her the information] , I've started seeing doctors as mechanics. When you go, they will tell you a way to get out of it, but that doesn't necessarily mean that's the answer.

Deciding to make and actually making an appointment brings about a sense of relief, an increase in confidence and sense of self-agency in those participants who had some initial sense that the nature of their concerns was psychological. When the person did not experience the presenting problems as possibly being of a psychological nature, there was no such increase (or previous decrease) in self-confidence, but rather a reconsideration of how to solve the problem.

> Jillian: I couldn’t wait for my first appointment. I felt like even making two phone calls had sent me on the right path and that there would be a solution coming soon. I felt like that first appointment, I would be all better. I would be in treatment, and all better, and no problem, as soon as I got there. I had placed a high expectation of what would happen.

> Felicity: I knew when I made the appointment I was going to get medication. It never occurred to me in the past to go and seek it. But from the time I made the appointment, I couldn’t wait until it came.

> Amy: [For Amy there is no sense of relief, but only a sense of the doctor confirming her suspicions that she has no physical disorder, but is suffering from bodily manifestations of stresses and conflicts] D: As you go through the first visit into the two weeks when the original prescription for muscle relaxers starts to decrease the symptoms you’re having and you start to, as you say, “change your thinking” that things are going to be maybe leaving the physical and into the realm of the psychological or the interpersonal. A: Right. The emotional stress I hadn’t put into perspective before.

The decision to see the chosen doctor is a considered decision. In this study, two participants chose their doctor based on the trust of the person who referred them.

> Felicity: I got the name, and I did it. I was just so eager to get better, to feel better…. My counselor at that time recommended a psychiatrist; I made the appointment and went.
>
> D: Based upon the recommendation of your counselor? F: Yes. I trusted her completely.

> Amy: My neighbors recommended her to me. I had a different doctor who did a work physical for me, and I was not impressed. I was not impressed at all. And I know they [my neighbors] have all kinds of situations with allergies and a bunch of stuff that they have to see doctors regularly. And I had a good experience with their recommendation before.

For one participant, the decision was made in order to minimize effort in getting to the doctor and to maximize anonymity.

> Jillian: I made them read me a list of names so that I wouldn't recognize anybody, because I knew so many people in the area. I needed to be sure it wasn't a name I would recognize.

For each of these participants, the experience of seeing the doctor included an assessment of the doctor's presence. While all three experienced a positive presence, this was not the deciding factor in choosing to accept or refuse the medication. It was, however, something that all three participants noted with varying degrees of emphasis.

> Jillian: I felt complete relief and trust in the doc. It was like, um, I had finally found the guy who was going to know the answers to what combination of medications are going to be right. It was like I had walked into an office and met with a walking, talking PDR…He would be smart enough to know the answer. And he did!

> Felicity: She had a concerned look on her face, like empathy. She talked to me sympathetically about what I was going through. She wasn't intimidating

> Amy: I felt very comfortable with the way she told me the information. She wasn't intruding at all. She was very genuine and I believed everything she said. She was so very nice; I would have never felt negative about her…. [D: You did take the prescription from her?] A: I think it was mostly because I was doing her a favor…. She's just doing her job.

As the opportunity to take medication was introduced, it emerged to all participants as a "giving in" or an admission of incapability to resolve one's problems independently. The medication can hold the promise of helping, but it does so only as it "takes over" where a person is no longer, or no further, able to help him or herself.

> Jillian: I was so beaten down that I gave up. It was a giving in, more than a proactive decision. I guess with this kind of stuff with a problem of the mind, you

> should be able to help yourself. And not have to turn to somebody else to help you in that way. So that's why I see it as more of a giving in to have to turn to outside yourself to fix your problem. So really, I decided to let myself know it was OK to turn to help.

> Felicity: I just remember thinking, "Finally, I'm going to get some help."

> Amy: I immediately said there was no way I would take that. She then changed the name and told me about the benefits of becoming more emotionally stable and being able to make it through a hard time better. She said it wouldn't be for a long time, just to get me on my feet again. She seemed very pharmaceutically strong. She did not insinuate or hint at anything else I could be doing. She was basically pointing out that what she thinks I need.

The willingness to "give in" or admit the limits of self-agency is a choice based in the priority of the values threatened by the original suffering.

> Jillian: I could see myself more clearly and did not like what I saw, nor did I know how to change myself…. To fix [my] problem…I decided to let myself know it was OK to turn to help.

Felicity: I thought to myself, “This girl doesn’t even know me. She doesn’t even know what I’m going through and she can pick up that ***I need help***.” It must be bad; it must be something that needs to be addressed.

Amy: When I got the prescription, I knew I wouldn’t take it. When there is something wrong in my body, I believe I have to make changes in my life. Because my body has problems, the purpose of that is to tell me I have to do something differently. To use a chemical and to continue on cannot be the right answer.

Furthermore, for these research participants, this choice was influenced by associations to personal historical reference.

Jillian: It was the same way I felt about taking medication. It was like I wanted to be able to take a pill and have my headache go away…. Once I had the medication, I was hoping it would just be an instant cure-all…. The prescription drugs out there. The legal drugs. What’s going to be the best fix for me? Any time I switched medications after seeking treatment, I was always so open to it because it was like this big game. What’s the best drug, what’s the best combination of drugs that’s going to fix me?

Felicity: I’m in the medical profession; I know that pills help.

Amy: I'm like, come on already, I work with people who take this.

Amy: It was interesting that she prescribed me the exact same name that my client was taking. Where if she had prescribed me Prozac, I would have probably thought of Lady Di and paparazzi, or whatever.

Amy: This is the example of one of my best friends. She is not very happy with her relationship, and she blames it on PMS. She's been taking the medicine and she's been taking it for months, says that's helping her maintain her relationship. And I just think if you're that grumpy you have to do something.

A person may thus choose to take the medication in favor of preserving values that are held dear. Likewise, a person may refuse medication for *the same reason*.

Jillian: There was an option that I chose not to take, and that's self-medicating through drugs and alcohol. Which I very well could have done. ***Had it not been for Emily, had I not been a parent***, that's probably the route I would have gone. I would have just started drinking again. Scott smoked pot every day; there was pot in my house every day of the year. I would have started smoking pot again. I would have started seeking what I needed that way.

Jillian: Scott and I talked about the fact that I cried an awful lot, was pretty temperamental and really didn't function well. So, I asked him to bring me home meds. I felt desperate and willing to try anything – so I started on Paxil.

Felicity: [I needed to be] eating more, not crying all the time, moving on with my life, being able to be more patient with my children, be strong enough to face the task of raising those kids on my own. [D: Did your being a mother and being a worker, being employed as a nurse and so on have any relation to "getting better"? F: Yes.] The physical [symptoms/problems] were so consuming that it was difficult for me to do any of those things.

Amy: I'm not going to take this myself. How am I going to do my job thinking I can tell people what to do or I can direct them in the right direction if I'm taking the same medicine they're taking?

Amy: It felt very real, but it felt very real like, "What am I doing here? This doctor's not going to tell me what to do."

Amy: I need to be in control and if I can't be, I need to remove myself from the situation that causes me trouble.

Amy: But that's not [the case that] when you get sad you need to take medicine.

Amy: The deciding question is can I be a parent to my children, or am I just going to be a crying, sobbing person who can't get out of bed.

After weighing whether or not to accept the suggestion to take medication, a person comes to terms with the matter within the framework of how one assesses the medication's ability to alleviate some or all of the present suffering.

Jillian: The prescription drugs out there. The legal drugs. What's going to be the best fix for me? Any time I switched medications after seeking treatment, I was

> always so open to it because it was like this big game. What's the best drug, what's the best combination of drugs that's going to fix me?

> Felicity: Again, I was thinking I was finally going to get something that was going to make me feel better. I can only parallel it to going to a doctor with a bacterial infection. You know you're going to get an antibiotic and it's going to make you feel better.

> Amy: She [the doctor] was so very nice; I would have never felt negative about her. I was very firm. I would have never gone that way, and I will never go that way…. There is a possibility. I have seen friends go through the actual divorce, and…um… where things have been bad, and they have separated, things were getting much better, and then they were confronted with situations, and things get really, really bad. I think that possibly that might play a role. I was thinking, "I might have to get through something really, really tough"…. I can't see myself ever getting there, but who knows? I don't want it to go that far.

If this is assessed to be likely, then the person can hope and/or anticipate that suffering will decrease. Medications come to have a place in the person's field of possibilities as a viable way to address their suffering.

> Jillian: I felt complete relief and trust in the doc. It was like, um, I had finally found the guy who was going to know the answers to what combination of medications are going to be right. It was like I had walked into an office and met

> with a walking, talking PDR…He would be smart enough to know the answer. And he did!

> Felicity: My counselor at that time recommenced a psychiatrist; I made the appointment and went. She prescribed the Effexor and I felt an overwhelming sense of relief.

If the medication holds no promise or is too great of a compromise of values, the medication will be refused and other methods of address will be sought to alleviate suffering.

> Amy: Keeping my senses together I can only do when I know what is right. I will never need substances for that. I do believe in healthy nutrition and sleep and exercise.
>
> Amy: It put the emphasis on, "I have to do something to do that [stay healthy]." Healthy nutrition, sleep and exercise…. I've learned other relaxation and muscle techniques.

In either case, the prospect of medication has had the effect of confronting the person with what is most important. A person accepts or rejects medication resolutely.

> Jillian: It's now more important to function well than to have pride that [I'm not needing outside help and] I am not functioning well.

> Felicity: The anxiety was gone almost instantly. It was a godsend! I was able to start thinking clearly and looking at my life with more clarity. Everything started

> to fall into perspective. It was like a whole new world opened up for me. Over the last three years I have become a lot stronger as a person. I have been able to set limits with my husband and stick by them; my self-esteem has grown; I have been able to further my education and make the high honor roll. [Now] I live my life.

> Amy: That's what I did…I took better care of myself, did what I know to be right for myself… I also talked with my closest friends. I realized I wasn't crazy.
>
> Amy: The way I've been reacting to things, I've not gotten to my life to the point where I don't think there's something I can do. As long as I can think that way, I'm not thinking of myself as depressed…. When you get sad and depressed, you might have to make sure you get more fun into your life… on top of the other stuff.
>
> Amy: It [receiving the prescription] was a big turning point realizing that there was a real situation that I could do something about. I could handle it. I've not gotten anywhere in my life where I've thought, "I can't handle this." I've had situations where I think, "I don't want to handle this." Instead of saying "I can't" and trying to, I would say, I don't want to, I will not do this.

Discussion

Summary and Discussion of Findings

Thus far, the goals of this investigation have been stated as well as the opinions and presuppositions that formed its goals. Expectations regarding the investigation's outcomes and findings have been examined. In this section, each of the findings of the study is considered in relation to initial expectations and also to the review of literature. How these findings converged with (or diverged from) initial expectations and the literature is also discussed. Finally, this section relates the general implications of each of the findings of this study.

At the beginning, this investigation set out to shed light on the experience of appropriating the prospect of taking medication as lived by the individual facing this possibility. Furthermore, it was suggested that the research would show a direct relationship between that experience and the individual's meaningful relations and engagement with her or his world. The data revealed that the prospect of taking medication emerges out of a particular kind of lived experience in relation to one's world. This state of being is a state of *disruption* with regard to one's projects and one's relationships to one's world. In other words, it is only after one finds oneself attempting to carry on with one's life and unable to carry on or unable to do so adequately that the possibility of being faced with the prospect of taking medications can come about.

Quite simply, there is first a state of distress. Particularly, for these participants, each of whom later came to confront the possibility of taking medication, the common theme in the nature of this distress was one of having been cut off from or constricted in engaging with the meaningful relationships and projects of their lives. They were unable to do the things they liked or wanted; they were unable to take up the roles their lives contained. They were unable to be the parents, spouses, lovers, employees, etc. that made up part of the meaningful contexts of their lives.

This finding is certainly convergent with the literature on will and volition. These roles referred to above are what Heidegger would call the “for the sake of which” that motivate one in any situation. They are the grounds on which the constriction of these participants’ lives occurs. They are in the flow, as Daschbach has referred, of their lives, called forward by the “for the sake of which” of their lives until this flow is blocked or slowed. They have become unfree to respond to the claims of their lives. Notably, this does not have the effect of eliminating these “claims” themselves, but fuels the efforts to regain that flow.

It should be noted that the particular roles from which these participants found themselves blocked were, like all such understandings of self, culturally and historically informed. Simply put, the expectations that go with the particular roles to which these participants were called were well formed by the ideals of society. When Sampson discusses the ideal of the self-contained self, he is pointing out the cultural tendency to marginalize those who cannot or do not carry themselves in accord with this ideal. This ideal minimizes the essential relatedness to others that is a part of being human.

The ideal of the self-contained self propagates a demand on the individuals of a society that they remain in control of their thoughts and emotions quite firmly; it demands strict boundaries between oneself and others. Framed in this way, the participants of this study, as they found themselves unable to continue to engage in their relationships and projects, came to fall short of this ideal of the individualized self. Their state of being in this regard was enframed as pathology. It was simply a given that, failing to progress through their lives entirely on their own, they must have needed "help." As the literature suggested this, so does the data support it.

The implications of this finding are far-reaching. To begin with, it calls mental health professionals to seriously reconsider operative understandings of human beings and plays of power that shape and direct such understandings as they are situated in given places in a society, culture and in history. Further, this finding implies the need for the voices of those who become constructed as "serviceable others" by those who maintain social power and do exemplify the ideal of the individualized self, to be heard. For now, it is as if those who are unable or unwilling to try to fit the idealized individual self are swept under the carpet of a medicalized culture. The voice of the dominant self echoes in the voice of modern medicine. Again, the literature suggested this and the data supported it. Scambler and Britten elucidate this in saying, "When a doctor, wittingly or otherwise, dominates or controls an encounter with a patient this typically has the effect of absorbing and dissolving the patient's self-understanding…." (2001, p. 55) The voice of the patient, the serviceable other, is drowned out by the voice of the doctor, a benchmark of the idealized self in a privileged, isolated position of authority, imbued with power and reward by the same society that would see power remain in the hands of those who seek to further propagate the ideal of the individualized self. The psychiatrist, so concerned with patient *functionality* fits easily into this position. It is not how the patient is living and relating to his or her life, but how well they are functioning that is the primary concern.

Accordingly, this ideal was in place for the research subjects as well. Though there were no explicitly negative interactions between the participants and their respective doctors, each participant's encounter was well enframed by the dynamic of power and authority. The participant who refused to take medications took the prescription from the doctor knowing she would not take. But perhaps rather than confront the doctor's authority directly, she politely thanked the doctor and threw the prescription away after she left the doctor's office. In each encounter, it was the doctor's version of reality that predominated, at least while the encounter lasted. It was also the case that each doctor provided answers to each participant's complaint that came in the form of explanation and knowledge. As Foucault (1997) remarked earlier, "the truth function intensifies around the physician…[and his] power enables him to produce the reality of mental illness…" (p. 44).

Closely related to the first finding is the pervasiveness in the disruption that impacted these participants' lives. By the time they were confronted with the prospect of taking medications, they were losing ground on many, if not all, fronts. Several dimensions of their lives had been compromised and there was a sense with each participant that this compromise would only worsen. Most significantly, this points out that one's relationships with others are seriously impinged or constricted. Again, the literature seemed to suggest this. Boss noted earlier that the character of living in the world with others can come to have the quality of an interrelatedness that is less than what human relationships in their fullness can be. For these participants, there was a loss of being able to be among and relate with others.

Furthermore, each participant also experienced a change in the way she bodied herself forth in her ways of relating to the people and projects of her world. Physical concerns emerged for each as they became overwhelmed by the all-pervasive constriction of their ability to engage their worlds. They experienced physical symptoms (i.e. racing heart, clammy hands, dramatic increase in smoking, severe changes in diet, numbness, and so on) when they encountered other people. There was nothing to directly foreshadow this in the literature, but it came as no surprise. As humans are embodied beings, it stands to reason that as the constriction grew in the life of each participant, it came to color the way participants bodied themselves forth in the now-constricted quality of their attempts to engage life. The implications here are that the constriction is in fact pervasive, manifesting in all facets of the participant's life including interpersonal relationships, physicality, and meaningful projects and engagements.

Another finding of this study involves the emergence of a self-awareness wherein the participant realized that she was unable, through her own actions, to sufficiently alleviate the disruption that had blocked the flow of her life. Each participant tried to use means or methods that were historically native to them, familiar ways of coping, problem solving and so on. All of these were experienced as no longer viable. Clearly, these participants were trying to *regain control* over their lives. This tendency is in accord with the literature on the idealized self. As before, the works of Keen and Sampson stand forth as particularly relevant. In this case, however, it is not so much the matter of an actively dominating voice of the ideal individualized self, but rather the passive control that this voice has gained as it has suffused itself into the very fiber of this culture and has thus become internalized to some degree by the members of this society. Simply put, each participant's first efforts were to regain control because that was what they are supposed to do, according to the firmly rooted, dominant ideal. In this regard, again, this finding converges with the literature reviewed.

In exploring willing and motivation, the grounds of the actions of each participant became apparent in their initial attempts to regain control of their lives and resume the previously unimpeded flow of their engagements with the projects of their lives. What began to emerge here is the self-determining nature of the will. It is not so much a question of *what* these participants were trying to get back to but really a question of *whom*. This became evident in these participants as they found themselves unable to reclaim their lives, their former selves almost, as their access to the dimensions of their lives became ever narrower. Each participant mentioned aspects of losing the sense of who they had been; things that had been so much a part of their lives, activities and attributes by which they identified themselves, were disappearing as they found themselves unable to stem the tide of their symptoms. Thus the data are, in this regard, convergent with the literature. The implications here are that the initial proposition, that this phenomenon is situated both within the fields of willing and of identity, is in fact an appropriate proposition to make. Before the phenomenon had even been fully explicated, the presence of these fields began to emerge in the data.

As the participants became aware of their inability to change the course of their situations, they began to experience *themselves* as inadequate and unable. Their lack of control was noticed by others. They were unable to control, conceal or censor their own suffering, thus it became available for others to know. These participants begin to feel conspicuously visible to others as such, and they felt exposed as being less than complete persons. Again, in terms of willing and motivation, this is a significant thread as it presents the idea that both began to be affected simultaneously.

The research data, then, supported and exemplified the literature on the social construction of others in three areas. First of all, it is completely within the purview of the notion of the idealized, individualized self that one should have total control over one’s suffering. One should, according to this model, be able to contain suffering and continue on with the work of one’s daily life. The individualized self would not suffer the compromise of function simply because of a “personal crisis.” According to this ideal, one should handle those matters alone, and unless one is weak or ill, one does. A person failing to contain such suffering, allowing others to witness it and allowing one’s function to be compromised, becomes, in Sampson’s terms, constructed by the individualized self as a serviceable other. Such responses differ from those of the idealized self and this “difference, when construed as a deficit, serves to validate that very distortion” which levels down human relatedness to weakness and illness (Sipiora, 1997, p.14).

Secondly, this finding converges with the literature on the interpersonal dimension of the phenomenon. The literature suggests the idea of the familiar everyday being overtaken by the strange and thus disturbing one’s world. Each participant echoed that notion as they experienced others and particularly their own visibility to others as being vulnerable, weak, less than fully able, less than fully human. Absorbed in the concerns common to all (and the ideologies currently in power), one becomes a stranger in one's own life as one loses touch with the things of significance of one's life and lives in an uncanny state of unfamiliarity with one's surroundings.

Thirdly, the aspect of visibility, of being seen by others in a particular way or context is resonant with Makal's research on stigmatization. For these participants, relations with others were lived out from that disturbed, absorbed, unfamiliar, and uncanny place. In short, relations with others became difficult and eventually undesirable or even impossible. The implication of this finding's convergence with the literature is that the participants' difficulties began to compound as their situation remained unresolved and they became burdened not only with the original distress, but also with a compromise in social standing as they became seen and known as out of control.

This third finding follows directly from the second one. As the situation became increasingly compounded, each participant experienced an emerging sense of desperation in which she sought a restoration of her original state prior to initial distress. A feeling of being overwhelmed was also prominent at this point. Aside from wanting to restore the original flow of life, each participant also wanted to restore her own ability to manage and navigate her own life. It was as if, at that point, each one said, "That's it! I've got to do something before it gets any worse and all is lost." Certainly this dimension of restoring self-efficacy is supported by the literature, especially the literature on medication taking and on willing and motivation. Conrad's work illustrates this point, as does Hyland's. They both, as do other psychological theorists, connect the desire for self-efficacy to the willingness to consider medication when it is suggested.

Again, the literature supports this finding's connection between motivation and the phenomenon. Clearly, the reasons that beckon one toward some kind action are in fact the very things that give a particular person her life as distinctly hers. For each participant, access to those life projects, relationships, values and so on had, at that point, become not only blocked but also significantly threatened. Each participant came to understand herself through these things. As they are threatened, each participant experienced a threat to her identity. Relationships and engagements with one's world provide this calling of motivation; what one is called *to* is oneself. The response to the call of motivation is a person's appropriation of the call's claiming. These participants and this particular literature illustrate that in desiring resolution of their constricted world-relatedness, each participant was hearing the call of a motive. Each participant found herself beckoned to her self as she knew it before her life was constricted.

Being beckoned to action and acting are not the same thing. The next finding illustrates the particular component of the phenomenon wherein these participants found themselves doing something in the service of helping themselves when they went to see a doctor. Relief came to each participant after they arranged to meet with a doctor. For the two participants who had at least a provisional sense that their complaints might be psychological (and not physical) in nature, the emerging sense of relief included some alleviation of their desperation. This was evident in the form of increased confidence and an improved sense of self-agency; a small reversal of their complaints beginning before ever seeing a doctor or receiving the suggestion of medication. For the participant who did not believe her problems were psychological (but rather were physical in origin or at least manifestation) there was no change in self-confidence.

This finding opened up many new facets of the phenomenon. To be sure, the data of these participants is consonant with the literature, especially the literature on willing and action. Beyond this, however, there are several significant considerations to make here, not the least of which was the divergence of one participant ("Amy") from the general pattern maintained by the other two participants. More than the other two participants, Amy was aware of psychological treatments and therapeutic processes. Secondly, she was convinced from the outset that her symptoms were physical in nature. Even though she acknowledged that the stresses and conflicts in her life had become overwhelming and likely were appearing as physical manifestations, she maintained that she could handle or treat them through physical means (i.e. relaxation techniques, etc.).

Interestingly, each participant took action when they seemed to be confronted first by inability to resolve problems alone and then by desperate desire to reclaim their lives. It was as if there were an ebb and flow, an alternation between the strength of the feelings of being overwhelmed or cut off from one's life, and the ardent desire to return to the life that existed before troubles emerged. The two forces seem to be at odds, each one holding sway for a time until a resolution is made. That resolution seems to be found in taking action of some kind.

The literature and this finding resonate in the dimension of where the data pertain to action in the face of one's own desperation. One finds oneself in a position "in which there is something 'to be done by me'…. I commit myself and I bind myself…. In determining something, I determine myself" (Ricouer, 1964, p.18). More clearly than before, the component of identity in this phenomenon stands forth as a definite and important facet of this experience. Even so, it is not yet fully articulated in this phenomenon. Nevertheless, the convergence between this (and the previous) finding and the literature implies that the phenomenon is firmly rooted in issues of identity, will and motivation.

This facet of the conflict between the inability to resolve one's problems alone and the desire to reclaim one's life also illustrates what was suggested in the literature on expectation. The "ebb and flow" referred to above, echoes Daschbach's (1986) statement that the person in this situation is vacillating "between … wishing, wanting, imagining and fearing, while trying to continually appraise how they and their valued life projects are faring with respect to the future(s) they perceive themselves as being-on-the-way-towards" (p. v). Furthermore, in Amy's comment, "If I'm really that tight, then that's why I'm having these symptoms, I'm really going to have to start making some changes… I thought, all right, I'm probably not suffering from strokes here; I'm very tight, very tense. It was easy to say that was the case and I have to do something," one can directly see the manifestation of Keen's statement, "In all cultures… ideas about the origin of depression, delusions, anxieties, and antipathies are part of the cultural stock of knowledge" (Keen, 1998, p. 128).

Centering on the encounter that each participant had in meeting with a doctor, the data show that this decision is a considered decision. Participants chose their particular doctor deliberately. For two of the participants, the decision was based on trust: trust in the person who referred them. For the remaining participant, her decision was made on the basis of the location of the psychiatrist in order to minimize travel and maximize anonymity. Each participant made an assessment of the doctor's presence and bearing. While all three found their respective doctors to be positive in this regard, this factor alone was not enough to serve as the basis for choosing to accept or refuse the suggestion of medication that was to follow. Yet all three participants remarked upon this taking note of the doctor.

With respect to the literature on the doctor-patient relationship, this finding is interestingly situated. First of all, the literature that gives its focus to medication taking as "compliance" fails to account for the participants' noting that the doctor's presence, while important, was not the deciding factor in accepting or refusing medications. Those theorists who fail to recognize that the medications have some meaning to the patient fall short in this regard. Furthermore, Nevins's (1990) understanding that the possibility of taking medications may hold negative significances for the patient is evident in the data of Amy, who refused medication. Notably, the data for each participant is congruous with Waitzkin (1991) as he points out that "lived social contexts" (p.7) are an attendant part of what the patients bring when they bring themselves to a doctor and are significant to the reasons that they went in the first place. Patients respond to how these contexts are handled, whether they are explicitly aware of them as such or not. All three participants responded to their respective doctors positively (regardless of their position on taking medications) because these doctors did not marginalize their lived social contexts. The implications here are that the doctor-patient relationship is a factor in this phenomenon, though not perhaps the most important or powerful consideration for a person confronting the possibility of taking medications for a psychological complaint.

The next two findings are absolutely at the heart of the phenomenon. The first is the suggestion of medication; the introduction of the possibility for taking arose as an explicit consideration. To all three participants, it stood forth as a kind of admission of defeat or final acknowledgement of inability to independently bring about resolution of their presenting complaints. For each participant, medications were a kind of giving-in or surrender. The participants gave consideration to taking the medication. It may have stood forth as potentially helpful, but only as it might assume control in the very place where the participant was previously unable to take control. In the moment of considering the medications as a viable choice, each participant reviewed her priority of values, both in terms of how they were threatened by the state of distress and how they might be affected by the choice regarding use the medication.

Secondly, associations to medications as encountered previously in their lives (either on their own or in their knowledge of others' encounters) influenced all participants in their choices regarding medication for themselves. In one participant's case, previous experiences were with illegal narcotics and illegally obtained pharmaceuticals. Thus the consideration of whether to accept or reject the prospect of taking medication was made with reference to one's values, experiences and associations. This important finding in the data is indeed consonant with much of the literature reviewed. The actual consideration of the medication as it is presented, along with the findings regarding the medication as surrender, illuminates the phenomenon at its core. Therefore, reflection on this literature is particularly significant.

With regard to the literature on the meaning of medication, there is convergence on two themes. First of all, Conrad's assertion that stigma is a factor in choosing whether or not to take the medication was confirmed by the data. All three participants regarded the prospect, at least in part, as a giving-in and a surrendering of control where they themselves had failed. That sense of failure, coupled with existing feelings of being seen by others, not the least of whom was the prescribing doctor, as ill, weak, sick, abnormal, etc., serve to illustrate this concern as it was described in the literature and lived by these participants.

Secondly, for two of the participants, the medications came to symbolize hope and held promise for the restoration of their lives prior to their distress, or at least a significant alleviation of their current distress. Montagne (1991) asserts that medication taking is a phenomenon of primarily social significations "with defined interactions between self, others and society…" (p. 143). Again, the data prove this assertion to have some credibility. In this way, the data actually bear out the literature. By viewing medication taking as a possibility for returning to one's former lived existence, the participants actually defined their experience in terms of defined interactions.

Regarding the doctor-patient relationship, the data did not always parallel the literature. This is true mainly where the literature focused on the authority of the doctor as the basis of compliance. These writers fail to account for the meaning that each patient establishes for himself or herself regarding medication taking. Certainly, arguments for a more collaborative approach are congruous with what the data has already borne out: that the doctor's presence is an important, contributory factor, though perhaps not the most decisive one. Without doubt, Keen's argument that both doctor and patient are operating in the contexts of various roles is supported by the data, at least as far as the patient is concerned. (Researching the opposing experience, *offering* someone a prescription, would indeed be an interesting complement to this investigation.) This idea is reiterated by Waitzkin and also by Scambler & Britten. Additionally, Scambler & Britten explore the issue of trust in the doctor-patient relationship. This, of course, was present in the participants' decision to choose a doctor. It is also a part of the decision as one considers the viability of medication as a choice. All three participants mentioned the doctor's presence and perceivable competence as they considered taking medication.

The literature on the social, interpersonal dimension of taking medication found support in the data. The questions regarding how a person lives out relations with others in the experience of confronting the possibilities of taking medication are addressed by this finding. It was in the valuative prioritizing that took place for these participants as they considered the suggested prospect of taking medication that their relations with the important others in their lives stood forth as a high priority for consideration. In the moment of having to think about what was most important, these participants gave thought to their children, their spouses/lovers, etc.

Literature on expectation shed light on a facet of this phenomenon, namely, the question Daschbach's participant asks, which is, "If this medication holds any real promise for me, what will be required of me in giving myself over to it or trusting in it?"

These participants echo this theme as they considered taking medications and how they might be allowing those medications to “take over” where their efforts fell short. In this same vein, the data reveals that the particular moment of the phenomenon when a person is considering taking the medication or not, does support what the literature on motivation calls the “for the sake of which.” This “for the sake of which” is in essence, a question that asks “for the sake of which important elements, values, relationships of my life will I make the choice to accept (or refuse) this medication?” This is the call of motive. In deciding and responding to this call the participant determined something for herself. In determining this “something,” she determined herself in the action of her choice. In responding to this call, these participants appropriated the claim of the call of their own motives and their own identities.

Interestingly, while these three participants each had previous exposure to the general use by others of medication (i.e. through work or knowledge of others), none of them indicated that the cultural pervasiveness of psychopharmaceuticals was a top priority in the decision to accept or refuse the medication. However, all three participants mentioned their experiences, indicating that further research into the matter might have uncovered more significant material. It does, however, speak to the impact of this cultural pervasiveness that each subject mentioned their social knowledge without any prompting and included it in their protocols.

The findings that relate to the social, interpersonal dimension of taking medication resonate with the literature on dialogic psychology in a convergent way. Sampson and Keen discuss the suppressing forces of the ideal of self-contained individualism and the relation of dependency to power. These themes are certainly in place as the participants considered medications. This moment involved a consideration of values, insofar as these values were culturally, historically informed and were thus in place for each of these participants as they lived through this experience. The implications of this are twofold. First, more consideration needs to be given by those who prescribe medication to the dynamics of power and the ideals that are in place when prescribing medication. Secondly, there are alternative understandings and conceptual frameworks through which doctors and health practitioners may come to a deeper capacity to recognize those in their care as unique others, engaged in the meaningful pursuit of the relationships and projects of their lives.

Closely related to these social and interpersonal dimensions of the findings, are the aspects of the results that illuminate the assessing and deciding that are at the center of the culminating moment of the experience of confronting the prospect of taking medication. As the participants gave consideration to the viability of medication as a choice for them to accept or reject, the participants also made an assessment of the medication’s perceived ability to bring about the resolution that they desired. If the participant perceived the medications as being able and likely to help, she decided to accept the medication and began to feel hopeful, anticipating that suffering would decrease. Medications came to have a place in that participant’s field of possibilities as a viable way to address the disruption that has constricted her life and caused her suffering. The participant who assessed the medications as holding no promise and also as too great of a compromise to her values refused the medication and began to attempt to address the distress through other methods. All three participants, at this point, found themselves confronted most directly by what matters most to each of them. The participants each made their decision whether to accept or refuse medication resolutely.

Findings on the assessing and deciding during the experience of confronting the prospect of taking medication converged with several different areas of the literature review. The literature on expectation and belief unfolds the phenomenon of continuing re-evaluation as a person becomes confronted with what promise therapy holds vis-à-vis one's own initial expectations. Likewise, the participants in this study were confronted with having to re-evaluate what they perceived the medications to be offering relative to their reasons for and expectations of seeking help in the first place. Also related to precisely this facet of the phenomenon is the way in which the doctor presents (or fails to fully present) the medication to the patient. Here, the literature on the doctor-patient relationship is again both supported and illustrated. Clearly, one is likely to consider the medication as more of a possibility for oneself if one trusts the person prescribing it. While it has been noted that Amy did not take the medication despite her positive experience of the doctor, even she did actually take the written prescription from the hand of the doctor, only later to dispose of it. What is implied clearly in the data is that the presentation of the medication serves to constitute, alongside the patient's already existing attitudes, part of the framework of the meaning of the medication that is used to determine the medication's perceived efficacy and thus the promise or value that it holds for the patient in restoring life to what it was prior to being overwhelmed by the current distress.

Regarding this assessment of the medication's ability to restore control back to the person who takes medication, several of the topics of literature are germane here. First, in relation to regaining control over one's life, this assessment of the medication is a judgment made on how the medications will help the person to reclaim ability to contain emotions, to resume a significant level of individual function in the workplace and to conduct relationships with others with self-control and without dependence upon others. In short, this assessment is directed at restoring the person to the status of the individualized self that Sampson and the dialogic psychologists describe. The person wants to rejoin the masses of the everyday. They want to be "normal" again. What has remained largely unspoken, at the clinical and the theoretical levels, is that the absorption of this everyday normality, which is so informed by the ideal of the individualized self, is the very ground out of which much of the suffering of patients such as the participants in this study have endured. This is precisely what is implicated by this part of the literature relative to this last finding.

Another facet of this assessment is not only the medication's perceived power to restore "normality" but also to remove the stigma of the suffering. As these participants struggled with their respective complaints, this suffering was compounded by their visibility to others as vulnerable and suffering people. As such, they endured the stigma of the gaze of the others that signified a failure to live up to the ideal of the individualized self and were instead constructed by the other as a "serviceable other." They experienced themselves as being, or in danger of being, less than fully human, less than a complete person because of their suffering. Makal's research is of particular import here. As the participants assessed the value of the medication, that assessment was informed, in part, by the participants' perspective, wittingly or otherwise, as stigmatized, as a serviceable other. The data imply that those who prescribe medications should be aware of the lived context out of which emerges the person who has come for their help. In so doing, it will be possible to appropriately contextualize the medication to fit into the person's own context. But above and beyond mere compliance, what is implicated here is the need for practitioners to reconsider (or perhaps, to consider for the first time!) their own part in the propagation of the ideal of the individualized self. In doing so, they could begin to effect a change in the dominance of this suppressive ideal and make room for other visions and frameworks of understanding (and subsequently of treating) people.

Beyond an assessment of the medications' perceived level of ability to restore control to the participants over their lives, the medication is also assessed for its value or promise in being able to restore the person to the flow of their active engagements of their own worlds. In simpler terms, the participants asked themselves if the medication could help return them to the lives they were living and the selves that they knew themselves to be before the onset of their difficulties. Could the medication, in all likelihood, help these people resume their former identities and take back up the roles and responsibilities of their lives prior to being disrupted by their complaints?

As before, the literature on willing, motivation and identity is more than pertinent to this facet of the phenomenon. The assessment is entirely connected to acts of choosing, in which case, one determines something for oneself and thus determines oneself as well. Interestingly, this is applicable to the participant who refused medication as well as the two participants who accepted it. For each of these participants, the medication was considered in terms of the contexts of the person's values, including their sense of determination to return to the life with which they had lost contact. Also included in these values were the significances of the projects and relationships of their respective lives. For the two participants who accepted medication, the medication was ultimately assessed as being a means by which they could attain again the flow of their lives toward the meaningful roles that they understood as their own. For the person who refused medication, the medication was not assessed as holding the promise of such help. If anything, it held the threat of altering the participant and dis-abling her from returning to the former flow of her life. In all three cases, the decision to take the medication was made against the backdrop of the participants' identity as it was defined by their motives and the contexts of their respective lives.

Having completed this assessment, each participant enacted her choice resolutely. This enacting is an act of willing. "Willing belongs to freedom, to being free for a claim to which I respond. The claim is the motive for willing. I only will when I am engaged in a motive, when I appropriate it as such, when I accept it" (Heidegger, 2001, pp. 218-219). Furthermore, it can now be said that this is true about medication taking even when the prospect is appropriated—when it is accepted as an unacceptable prospect. This final convergence of data with literature comes to verify what was put forward at the outset of this study, namely that the act of appropriating the prospect of taking medications for a psychological complaint (specifically a depressive type of complaint) is a phenomenon that is lived as a confrontation with one's sense of being-able, one's sense of self-efficacy.

The act of appropriating the prospect of taking medication is also lived as a confrontation with the threat of losing one's relations to one's world as they have historically stood and been informed by the dynamics of power and social/cultural influence. As these relations give ground to who one understands oneself to be, this phenomenon is lived a confrontation with one's own sense of who one is. This phenomenon is an experience of the lived human meaning of identity and self-understanding. It is lived out by individuals within the contexts of their lives as an ongoing evaluation of the meaning of medication relative not only to its possible restorative power, but also to existing understanding of themselves, of others (particularly of the other who prescribes the medication) and of contexts of meanings that is their world. This includes thoughts and understandings about medication that are culturally, socially, historically informed. As such, the meaning of medication is assessed and co-determined in the face of all of these considerations and understandings.

Limitations of this Study

At the outset of this study, it was stated that in selecting participants, consideration would be given to the ratio of participants, male to female, accordingly with the ratio found in the general population. There was, in fact, one male respondent, but his protocol was received too late to be included in the data. It was certainly surprising that all of the respondents except one were female. Thus, the fact that all of the protocols for this research were given by female respondents constitutes one of its limitations. First of all, it may simply be the case that there were no male participants available to take part. This is not very likely, though, as the opportunity to participate was extended equally to male and female potential participants. Secondly, it may be that potential male participants were unwilling to participate. The imbalance of female participants over male participants may be indicative of a greater pattern that is commonly seen in the field of psychology and in psychotherapy in particular: specifically, that women are far more likely to seek treatment for a psychological disorder than men. It is commonly thought that this is so because of the different cultural expectations of men and of women. In a society dominated by the notion of the individualized self that has been previously discussed herein, men have much less latitude than women to admit vulnerability and to be in need of the help of another. Therefore, as there are significantly more women willing to relegate themselves to treatment, it is no great leap in logic to say that more women than men might have been willing to participate in a study that would extend awareness of their difficulties and diagnosis to yet another person. This possibility is consistent not only with the turnout, so to speak, for participation in this study, but it may also be in keeping with the known trend that women are more commonly diagnosed with depressive disorders. Lastly, the imbalance of females to males participating in this study may be due to precisely this imbalance that exists in the general population: that there are more women than men with depressive disorder diagnoses. The imbalance in female over male participants may simply mirror this greater trend.

In any event, the lack of male participants is a shortcoming to which this research is subject. It limits the scope of the conclusions that can be drawn from the results. Specifically, can one surmise that that the impact of the medication-taking prospect on one's sense of volition, self-efficacy or identity is the same for men as it is for women? Does having to face the possibility of taking medication for a psychological complaint stand as a possibility that is different for a man than for a woman? It would seem, based on what was previously discussed regarding the different roles that men and women have in our society, that for men the prospect would likely be at least somewhat different. Speculatively, there might be an additional dimension of this prospect that males experience as a threat to identity ***as*** a male (perhaps due to all of the expectations of the society demanding that men be more in control of their emotions). There may be other dimensions that cannot here be guessed or anticipated. There may be dimensions of the female participants' experiences that would be absent from the experiences of men. Likewise, there may be dimensions of male participants' experiences that would be absent from the experiences of women. This research cannot be said to represent the male experience of appropriating the prospect of taking medications for psychological complaints. Only future research can help to address and answer these questions and fill in the blanks, so to speak, of the present study.

Another limitation of this study is the fact that, for purposes of focus and keeping the scope of the study manageable, only participants with a depressive disorder were considered. While depressive disorder diagnoses are by far the most common, there are other equally significant diagnoses that should be considered and explored. The results of this study illustrate the lived experience of three participants whose lives were veiled or clouded in a depressive way of being-in-the-world. The particular attunement of this kind of being-in-the-world colors the entire scope of the individual's relationships to the projects of life. As the meaning of any situation, including the appropriation of the prospect of taking medication, is established between persons and their world and is colored by the particular attunement of those persons, the specific quality of that attunement will affect the particular meanings of the situation as it happens.

In other words, a depressively oriented person will engage the world depressively and will engage the prospect of taking medications from that particular vantage point. A person anxiously attuned to the world will co-constitute the meaning of medication taking anxiously. A person manically attuned to the world will do likewise, and so on. This study has only elucidated the phenomenon of medication taking as a person approaches it from a particular vantage point, namely the vantage point of a depressive being-in-the-world. How this particular vantage point shapes the structure of the phenomenon as a lived experience will be better understood when this phenomenon is explored from vantage points other than and in comparison to the one chosen for this particular study. Until that occurs, the results of this study remain limited in this regard. Also, the issue of disorder orientation is significant in relation to the physical concerns that emerged for each of the participants. Were these physical concerns, which seemed quite similar among them, indicative of their particular depressive orientation? This study falls short in fully addressing this problem. This issue remains for future research considerations.

In addition to considerations of participant populations and concerns about parallels with other phenomena, it would be prudent to give careful consideration to the methodology in place for the analysis of data. This study, like most empirical-phenomenological investigations, utilized meaning unit analysis, situated structures and a general structure to unfold and illustrate the phenomenon of interest. This approach was found suitable for the purposes of this study, but in no way does this approach exhaust the methodological possibilities for other research on this phenomenon. As a piece of phenomenological research, this study's approach seems to lean toward individualistic orientations and person-centered approaches to understanding the phenomenon. As it examines the participants' individual experiences, it gives priority to the individual. What may at times seem to have secondary status is the social dimension of the phenomenon, not just in terms of the way a participant may feel relative to the immediate others in their surroundings, but also as they all participate in the socially and historically defined roles and values of the culture in which they live. This element was not neglected by this study, but the orientation of the methodology may have given it a place second or subordinate to the individual experience of each of the participants. Of course, this methodology understands that the social, the cultural and the individual level of meaning exist concurrently and are equiprimordial in the formation of meaning in a given situation. The results are socially, culturally, historically and individually situated. However, the limited thematization of the social, cultural and historical dimensions of the results arises from the character and scope of the empirical-phenomenological methodology here employed.

Implications and Suggestions for Future Research

First of all, this study was consonant on several important points with the studies mentioned in the literature review geared toward non-depression populations (i.e. asthma, epilepsy, etc.). Each of the participants' experiences contained issues of: self-efficacy/ self-reliance; the import of the doctor-patient relationship; and beliefs about their own diagnosis. It leaves one wondering whether other situations of medication taking would also show similar results. How, for example, do people respond to the prospect of taking medications for an anxiety disorder or for schizophrenia? Furthermore, it would be beneficial to research medication taking not only in the face of other disorders but also other situations: people who have taken medication before (and have had side effects!); people who take medications reluctantly; people who take non-psychological medications; people who are pressured or compelled to take medications; minors who take medications; and people who use narcotics as medications. Studies geared to these populations and situations would help to reveal the phenomenon of appropriating the prospect of taking medication in greater depth and detail.

Another suggestion for further research is indicated in the previous section that discusses the limitations of the study. The lack of male protocols in the data presents a significant shortcoming of this study that could easily be taken up by further research by ensuring the inclusion of male participants. It would also be interesting and helpful in developing a fuller understanding of the phenomenon of this study to include in future research considerations of the place of a participant's age on the phenomenon in question here. Insofar as the results of this study pointed to a component of compromise or threat to one's identity, the question of where in one's lifespan development one happens to be seems important. Is medication taking for a 22-year-old male the same as it might be for a 55-year-old male? Future research could address this question easily and shed even more light upon the overall phenomenon of medication taking.

As the literature suggested and the data showed, the relationship between the prescriber and the patient is of some significance in the phenomenon under investigation here. The quality of this relationship informs the way in which the prospect of taking medication is appropriated, though this in itself is not necessarily a determinant here. One of the issues that became of interest to this researcher during this investigation was how a person makes the decision to choose a psychologist, psychiatrist or therapist. Are the same preliminary structures that were in place for the participants of this study also in place for a person who is presented with the choice to continue or discontinue meeting with a mental health professional? Again, at first glance, there seem to be some similarities. As before, only future research will tell.

The dynamics of power were subtle in the experiences of these participants. A more thorough analysis of the social, cultural and historical dimensions of the results of this study could be profitably made in terms of Foucault's project so well articulated in *Birth of the Clinic* (1975) that is "concerned… with determining the conditions of possibility of medical experience in modern times" (p. xix). Foucault's understanding of power would likely shed interesting and revealing light on the results already gleaned by this study. Similarly, it would be beneficial to conduct further and more detailed research on how the experience of confronting the prospect of taking medications for a psychological complaint is affected by the overwhelming pervasiveness of medications in the present time and culture. Given the great magnitude of this pervasiveness, the relationship between this social reality and the phenomenon studied herein is of serious significance and deserves further attention.

Lastly, the study explored the phenomenon of taking medication at the suggestion of a health professional. As such, this suggestion is framed as a “therapeutic intervention.” The question then arises: what about other “interventions”? Future research in this area would seem well to include a study on the prospect of being given the suggestion to begin individual therapy. The same would be true for group therapy. What about interventions other than types of “talk therapy”? What would one find, relative to the results of this study, if one were to investigate the experience of being given the suggestion to receive electroconvulsive therapy? How does a person appropriate the prospect of receiving the suggestion of biofeedback as a way to address his or her psychological complaints? Once again, future research can bear these questions out to answers that will broaden the general understanding of how a person receives and accepts/rejects help for psychological complaints.

Conclusions

This study set out to illustrate the experience of appropriating the prospect of taking medication for psychological complaints, specifically for complaints that would be classified as with the spectrum of depressive disorders. The results of this study demonstrate that in confronting the possibility of taking medication, one is confronted with questions of one’s own sense of being-able and one’s own sense of who one is and how one is faring relative to the projects of one’s life. As such, the confrontation with the prospect of taking medication brings one to a choice. One assesses if one sees restorative hope in the taking of medication. One asks oneself if the medication holds the promise of helping one be who one understands oneself to be, however this may be culturally, historically informed. One also assesses what is most important relative to the relationships and meaningful projects of one’s life. On these bases, one resolves to accept or reject the medication.

This study suggested that the decision to take medication was situated in the fields of will and volition. It further suggested that this phenomenon was bound up with an individual’s sense of identity. Lastly, it was postulated that this phenomenon was a social phenomenon in the twofold sense of: the doctor-patient relationship; and the socially, culturally, historically influenced meanings that a person would live out when confronting the prospect of taking medication. All of these were found to be present in the experiences of the research participants. Issues of power and social construction were subtly present in their experiences as well.

These are the constituent facets of this phenomenon. What about the phenomenon as an articulated whole? This study was initiated through interest in a particular moment: the moment that a person first confronts the prospect of taking medication as a possibility for himself or herself as a way of addressing a psychological problem. The results of attempting to draw out the lived meanings of that moment into an organized understanding have rendered the results reviewed herein. But perhaps the most significant understanding that can be gained form this work is that this moment of confronting the prospect is by no means an isolated moment. This moment is rather the culmination of the whole experience. The original blockage of the flow of one's life, the motives and values that prompt one to seek help, the pre-existing cultural, societal and historical awareness of medication, the meaning it has to a particular individual, the doctor-patient experience, and so on are all "part of the moment" that is the apex of this phenomenon. All of the threads of meaning that are constituent elements of the experience of confronting the prospect of taking medications (within the parameters that were set at the outset of this study) are woven into this culminating moment.

Those who prescribe medications would do well to consider the findings of this study if they wish to understand and influence their patients' acceptances and refusals of their advice. It would serve such care providers to understand not only that they are, even before they encounter the individual patient, involved in a power relationship with those to whom they would give their care and expertise, but also that those they encounter as patients come to them with their own particular histories, traditions, values, motivations, understandings of their presenting problems, attitudes and experiences, all of which ground their ultimate decision to accept or refuse medication.

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Appendix A: Data and Analysis ("Jillian")

Protocol 1: "Jillian"

I have had a series of events over the past 3 years that led to my taking prescription medication for depression. First, I was in a car accident in which I sustained a serious, life-changing back injury, then I caught my boyfriend of 3 years cheating on me. Two weeks after I caught my boyfriend cheating, my father had quintuple bypass surgery at the age of 52. 4 months after my fathers' surgery, I got pregnant by my boyfriend (whom I was not even dating at the time, for we had broken up due to the infidelity). Next, at 30 weeks pregnant, I was in a car accident where the car rolled off a road and landed upside down in a ditch. When the car came to a stop, I was suspended by my belly. My feet or knees could not touch the ground. I was in shock, so I was lucky enough not to know I had a broken nose, sprained shoulder and was in labor. I was taken to the hospital and labor was stopped. I carried my daughter 6 more weeks, giving birth to her at 36 weeks pregnant. After my pregnancy, the day my daughter turned 38 weeks old, my long time best friend from 8 years of age was killed in a car accident. She was a newly wed, and full term pregnant. The baby was taken c-section, but his head was crushed.

Needless to say, I experienced a very busy 3 years. During my pregnancy, even before the car accident, I was overly emotional. I was very touchy and sensitive. I could not take teasing of any kind and needed to have everything my way. I found myself flying off the handle at my co-workers, friends and family for the smallest of things but had the distinct feeling that I could not control myself. I was also extremely sad. I was very quick to cry and felt an overwhelming responsibility to the child inside of me. I felt like I should have stopped my life completely so that I could do nothing but be pregnant – giving all of my attention to nutrition, rest, reading, etc. Also during the pregnancy I sustained an injury to my round ligament (the ligament that holds the uterus in place). This injury caused me to walk at an excruciatingly slow pace with extreme pain (sort of an over-exaggerated pregnant lady waddle). I also gained 62 pounds while pregnant thereby shooting my self-esteem to the bottom of the pit, for I had never been that heavy before. My weight and my emotions were out of control and I knew it. I became fearful of unusual things. For example, I refused to be in the house alone. I would come home from work before my boyfriend and if he was not home, I would either sit on the front porch until he arrived or drive around for a while. Typically, I would call home before I left work to be sure that I would not arrive to an empty house. I also hated being the passenger in a car, but had to tolerate it because most of the time I was too uncomfortable to drive. After the pregnancy, I have always driven unless extenuating circumstances arise.

Towards the end of the pregnancy, Scott and I were both crossing our fingers that what I had been experiencing would simply go away. We were hoping I was just an overly emotional pregnant lady with the raging hormones. After having Emily, the initial 6 weeks or so are pretty blurry to me, however I remember I was very emotional, but usually not angry or short. Mostly a joyful weepiness. I would be sad and happy all at the same time. Driving now with a newborn was particularly difficult. If I was not the driver, I became so obnoxious that most of the time Scott would pull the car over and we would change seats so I could drive. Now I could see that little face I had been protecting. Her life instantly became more important than mine, and I would trust it to no one. To this day, people other than Scott or myself have driven Emily less than 10 times. I took Em with me to meet a friend in State College for the day when she was about 4 months old. The car ride there was fine, however on the way home I was crying hysterically; full of fear that I was going to crash the car because it was dark and raining and I was having difficulty seeing on Route 22. I pulled over about 6 times, and actually tried to talk Scott into coming to Murraysville to pick us up. He refused.

Panic attacks began somewhere in the summer of 2000. Usually I would have a racing heart, constricting feeling in my neck, a sense that my blood pressure was up and I would begin to get clammy and sweaty. I also was experiencing a lot of dizziness and lightheadness, to the point that Scott and I were testing my sugar levels multiple times a day worried about diabetes. I started to lose interest in friendships with anyone other than family or Toni. I would go so far as to pretend that I was in our bedroom sleeping if I knew that Scott had invited friends over to the house. I became super critical of our group of friends – even the ones I liked I was finding major flaws with and reasons not to spend time or talk with them.

I completely turned myself to Emily and lived by her schedule. I would sleep when she did – for much longer than the few weeks after birth. I lost interest in any cleaning, housework, cooking, working outside the home, having my own interests or hobbies. I simply wanted to take care of Em and in an ideal world, have a maid take care of the house and cooking while Scott would financially support me. Reality bites. But, I could not bring myself to do chores on a regular basis.

Then, after 18 weeks of maternity leave (which I loved because I could isolate myself all day and hide at night), I had to return to work. It was then that it became clear that I was not going to snap back to normal. My behavior was the same as it had been. I was short fused, rude, impulsive and generally didn't like people talking to me. I wanted to run the show, be completely in control.

My daily routine was pretty slovenly. I developed a system that I would wake in the morning, usually not shower, take Em to daycare then go straight to work. Emily, however, was always perfectly clean, tidy, and organized. After work, I would pick up Em from daycare, take care of her until her bedtime (which until she turned 2 was 7:30 – 8 p.m.) and then go to bed directly after putting her down. If I showered 3 times a week I was lucky. And shaving the legs? Didn't know that was supposed to be done in American society. This was all accompanied by panic attacks and the whole fear of driving thing with still being fat on top of it all. Oh, and I had been being so rude to all of our friends that they were beginning to avoid Scott and stopping inviting us places, basically because people didn't want to have to deal with me anymore.

My first introduction to medication was illegally. Scott's father is a primary care doctor and Scott worked for him. Scott and I talked about the fact that I cried an awful lot, was pretty temperamental and really didn't function well. So, I asked him to bring me home meds. I felt desperate and willing to try anything – so I started on Paxil. I couldn't get enough of it. I kept increasing my dosages on my own. Scott's dad knew nothing of me being on the medication – even though he was my pcp. I stayed on the Paxil from about September of 2000 to May or June 2001. Once I had the medication, I was hoping it would just be an instant cure-all. Literally like taking an aspirin and having your headache go away. I was hoping Paxil would just fix all my problems. It didn't. It helped me be slightly more aware of my situation, but did not help me solve any problems – So I actually think that I became more depressed because I could see myself more clearly and did not like what I saw, nor did I know how to change myself. This was about how I felt from September of 2000 to December of 2000. All I knew to do to try to make things better for myself was to try to outwardly act happy and somehow, I thought maybe I would really start to feel happy. That didn't work. It takes too much energy to put on a happy show when I felt the way I did, so most of the time I was just miserable. Then the bomb dropped.

Jacky was killed December 27, 2000. I must have cried for 8 weeks straight. There were times I couldn't even hold Emily. I couldn't even take care of her because I kept thinking that Jacky should be doing the same thing with Maximus – that she should be alive instead of me. I still wonder if the Grim Reaper didn't miss me the day Jacky's mom and I were in the accident and hit Jacky instead. The connections Jacky and I have together are so strong that it's almost mystical. Jacky would visit Em at our house in Mt. Lebanon after she died; however she would never come in Em's room. She always stayed in the hallway or stood in the doorway. The only exception was when she scratched my pinkie finger in the master bedroom before she was cremated. Now that Em and I live in the house I grew up in, Jacky goes in all the rooms because she knows the house and is more comfortable there.

As I continued in early 2001 to be just lost about Jacky's death, everything else about me either got worse simply remained the same. I did not seek professional help until May of 2001. Until this time, I had been self medicating through the samples Scott would bring home. I knew nothing of how quickly to increase dosages, or what would happen if I missed doses. As a result, sometimes a week would go by without my taking the meds and I would eventually lose it and have a breakdown.

When I decided to seek help, I knew I needed a psychiatrist so I could have medication. I also knew that I did not want to get involved with a therapist or counselor and then have to see someone different for medication prescriptions and monitoring. I called my healthcare provider and asked for the number of psychiatrists in my zip code; since I also knew I wouldn't go if I had to drive more than 10 minutes in the car. I couldn't wait for my first appointment. I felt like even making two phone calls had sent me on the right path and that there would be a solution coming soon.

Ultimately diagnosed with depression, bipolar, ADHD and with panic attacks, I was relieved to be working with someone who could manage my meds. I felt complete relief and trust in the doc. I wonder about my diagnoses, whether they are accurate or not, but I have complete trust in the med management. It has been since May of 2001 that I have been seeing my doc, and I dread the day that I run out of my meds. I have side effects if I run out of a med or miss more than 2 doses in a row. My meds have been stable now for about 9 months, but up until then, we went through a trial and error process that was enlightening – never frustrating. If I felt a med wasn’t doing well or I didn’t feel good on something, or could feel the effects wearing off I would just let him know and we would adjust. It took time, but I have confidence in the medications. I am losing confidence in the doc as a therapist, but he seems to be able to take what I say and convert the information into useful medication management. He says I will always be on meds. That it’s a lifelong thing for me. That’s ok with me. It would be nice not to have to take anything, but I would rather do it than suffer.

Protocol Interview: “Jillian”

D: “I have had a series of events over the past 3 years that led to my taking prescription medication for depression. First, I was in a car accident in which I sustained a serious, life-changing back injury, then I caught my boyfriend of 3 years cheating on me. Two weeks after I caught my boyfriend cheating, my father had quintuple bypass surgery at the age of 52. Four months after my fathers’ surgery, I got pregnant by my boyfriend (whom I was not even dating at the time, for we had broken up due to the infidelity). Next, at 30 weeks pregnant, I was in a car accident where the car rolled off a road and landed upside down in a ditch. When the car came to a stop, I was suspended by my belly. My feet or knees could not touch the ground. I was in shock, so I was lucky enough not to know I had a broken nose, sprained shoulder and was in labor. I was taken to the hospital and labor was stopped. I carried my daughter 6 more weeks, giving birth to her at 36 weeks pregnant. After my pregnancy, the day my daughter turned 38 weeks old, my long time best friend from 8 years of age was killed in a car accident. She was a newly wed, and full term pregnant. The baby was taken c-section, but his head was crushed.
Needless to say, I experienced a very busy 3 years.”

J: “Very busy three years” was from March of ‘97 to December 2000. So many things happened, I was more emotional in that period than my normal state would be. Even before the pregnancy.

D: “During my pregnancy, even before the car accident, I was overly emotional. I was very touchy and sensitive.”

J: that second paragraph is talking about…Normally in a pregnancy, you’re more emotional anyway. Just because of the hormones. But I was EXTREMELY.

D: There are a couple themes here to being overly emotional. The first is being touchy and sensitive – do they mean the same thing?

J: Yeah.

D: “I could not take teasing of any kind” – which is more of that?

J: Yeah.

D: “I found myself flying off the handle”, that seems to be part of it, but is it a little different. Flying off the handling meaning…

J: Having a very short temper, a short, um,

D: And the feeling of out of control?

J: Yeah, I would start to sort of spout off and tell somebody off. Where normally – reacting to someone, where instead of saying, “You know what, that really hurt my feelings, I don’t appreciate being spoken to that way” – Instead of being able to say that in a normal way, I would just lose it. Just tear into that person, “How dare you this, and how dare you that.” And “Don’t you ever speak to me like that or else.”

D: You say also “extremely sad”.

J: I could not take teasing of any kind and needed to have everything my way. I found myself flying off the handle at my co-workers, friends and family for the smallest of things but had the distinct feeling that I could not control myself.

D: “I was also extremely sad.” The sentences that follow, “I was very quick to cry and felt an overwhelming responsibility to the child inside of me.” Are those continuing the idea of being sad?

J: Yeah.

D: Did anything else have to do with feeling extremely sad?

J: Scott cheating on me.

D: So was there disappointment and hurt as well as sadness?

J: Yeah.

D: Now this feeling of “overwhelming responsibility”, feeling overwhelmed –

J: No. I was never overwhelmed by the pregnancy.

D: What is this feeling of “overwhelming responsibility to the child”?

J: I’m trying to say that for the first time in my life I had to be accountable. To be accountable for my actions and my thoughts. I was starting to look at my past, at my college years and my high school year, and I would think, “Oh, jeez, the sum of what is me is going to produce a child.” Being scared for that baby.

D: Especially given the fact it was just you at this point?

J: No! I forgot to tell you that. As soon as I got pregnant he and I got back together. I’m looking at my past, and thinking, “This isn’t a person who is responsible enough to be a parent.” To live up to these high moral standard I have.

D: Meaning him?

J: No, meaning me! I was scared I wasn't going live up to my own expectations.

I felt like I should have stopped my life completely so that I could do nothing but be pregnant – giving all of my attention to nutrition, rest, reading, etc.

D: "Also during the pregnancy I sustained an injury to my round ligament (the ligament that holds the uterus in place). This injury caused me to walk at an excruciatingly slow pace with extreme pain (sort of an over-exaggerated pregnant lady waddle)." How did that injury happen? Was that part of the car accident?

J: No, I was teaching tennis at a…we were doing a school program; I was teaching kindergarteners how to play. And I pushed in a set of bleachers by myself.

D: "I also gained 62 pounds while pregnant thereby shooting my self-esteem to the bottom of the pit, for I had never been that heavy before."

J: Except for now. [laughs]

D: "My weight and my emotions were out of control and I knew it. I became fearful of unusual things. For example, I refused to be in the house alone. I would come home from work before my boyfriend and if he was not home, I would either sit on the front porch until he arrived or drive around for a while. Typically, I would call home before I left work to be sure that I would not arrive to an empty house. I also hated being the passenger in a car, but had to tolerate it because most of the time I was too uncomfortable to drive. After the pregnancy, I have always driven unless extenuating circumstances arise."

J: The battle between driving and not driving was a big battle…I still don't [want anyone else to drive]. I was so physically uncomfortable during the pregnancy [child interruption] – It was too physically uncomfortable to drive, but too fearful not to be the one driving.

D: Because you had already been in several accidents, and the feeling of control…

J: Even now I can't be a passenger in a car.

D: So this is all preliminary. "Towards the end of the pregnancy, Scott and I were both crossing our fingers that what I had been experiencing would simply go away." In other words, "what I had been experiencing" means all of these symptoms that follow from crying, etc. That's what that means?

J: Yes.

D: “We were hoping I was just an overly emotional pregnant lady with the raging hormones.” So there’s some expectation here that all this stuff is accountable because of the fact that you’re pregnant, and your body is changing and maybe all those body changes is part of what’s going on for you in terms of all these things we just talked about beforehand.

J: Right. We were hoping that once the hormones went back to normal, that I would go back to normal.

D: “After having Emily, the initial 6 weeks or so are pretty blurry to me, however I remember I was very emotional, but usually not angry or short.” So some of it went away?

J: Actually what happened was I was just so utterly in love with this new child. That I couldn’t get angry at anything.

D: But were you still easily evoked? In other words, being emotional?

J: Yes.

D: “Mostly a joyful weepiness. I would be sad and happy all at the same time.” I understand the happy part, but help me understand the sad part.

J: I’d cry for hours about Jacky. That was my girlfriend’s death. It also brings in the sadness that any parent would undergo burying their child. I think we’re meant to bury our parents, not our children.

D: Burying her and her child, for you, was like burying your own?

J: Yeah.

D: “Driving now with a newborn was particularly difficult. If I was not the driver, I became so obnoxious that most of the time Scott would pull the car over and we would change seats so I could drive.” What do you mean by “so obnoxious”?

J: Staring at all the cars, pointing at things, stomping on the imaginary brake with my feet. Nit-picking…to the driver.

D: “Now I could see that little face I had been protecting. Her life instantly became more important than mine, and I would trust it to no one.” Where you this way, obnoxious, when Emily was not in the car?

J: Yes.

D: But particularly when she was in the car, driving became even more heightened?

J: Yes.

D: “To this day, people other than Scott or myself have driven Emily less than 10 times. I took Em with me to meet a friend in State College for the day when she was about 4 months old. The car ride there was fine, however on the way home I was crying hysterically; full of fear that I was going to crash the car because it was dark and raining and I was having difficulty seeing on Route 22. I pulled over about 6 times, and actually tried to talk Scott into coming to Murraysville to pick us up. He refused.”

J: This last story, at the end of page three…is the first time I can remember a panic attack and my fear being so overwhelming that it really caused a problem. More so than being 10 minutes away from home.

D: Panic attacks began somewhere in the summer of 2000. Usually I would have a racing heart, constricting feeling in my neck, a sense that my blood pressure was up and I would begin to get clammy and sweaty. I also was experiencing a lot of dizziness and lightheadness, to the point that Scott and I were testing my sugar levels multiple times a day worried about diabetes.

D: Are you diabetic?

J: No. I still get lightheaded like that, too. I don’t know why.

D: “I started to lose interest in friendships with anyone other than family or Toni.” Toni is?

J: My only other living girlfriend. I didn’t explain that. I’ve known Toni since I was two. Growing up I had two very good friends: Jacky, from the age of eight, and Toni, from the age of two. Still friends with Toni.

D: “I would go so far as to pretend that I was in our bedroom sleeping if I knew that Scott had invited friends over to the house. I became super critical of our group of friends – even the ones I liked I was finding major flaws with and reasons not to spend time or talk with them.”

J: To avoid contact with people. I was also doing this because I was very mean. I started to become mean toward people. I didn’t just lose interest in them, but I sort of lost the ability to hold onto the social graces…that you have in friendships. I would hide.

D: “I completely turned myself to Emily and lived by her schedule. I would sleep when she did – for much longer than the few weeks after birth. I lost interest in any cleaning, housework, cooking, working outside the home, having my own interests or hobbies. I simply wanted to take care of Em and in an ideal world, have a maid take care of the house and cooking while Scott would financially support me." In an ideal world….

J: Yeah, in an ideal world, I'd have a maid cooking and cleaning, and Scott going out and earning the money. All I had to do was take care of the baby.

D: "Reality bites" Could you say a little more about that?

J: Yeah, we don't live in a fantasy land. I have to earn money; I had to go back to work. I couldn't be a stay at home mom. I didn't want to face any of the real things.

D: The real things, these things that you're talking about?

J: Money.

"But, I could not bring myself to do chores on a regular basis."

"Then, after 18 weeks of maternity leave (which I loved because I could isolate myself all day and hide at night), I had to return to work."

D: "It was then that it became clear that I was not going to snap back to normal. My behavior was the same as it had been. I was short-fused, rude, impulsive and generally didn't like people talking to me. I wanted to run the show, be completely in control." Can you say a little more about wanting to run the show, be completely in control?

J: When all you have to do is worry about taking care of yourself and a newborn, I was in charge of my life and Emily's life. I didn't like the reality of going back to work and dealing with adults. Because I couldn't control what everyone said and did. When my boss would tell me about my work, I would tell my boss off. I'd tell supermarket clerks off. They were little high school kids talking to their friends, I'd tell them off. Right there in the checkout line. "You know honey you're not paid to talk to your friends. Do that at home. You're paid to take my money." I'd look at their friends, I'd say, "Get out of here." I was nasty.

D: "My daily routine was pretty slovenly. I developed a system that I would wake in the morning, usually not shower, take Em to daycare then go straight to work. Emily, however, was always perfectly clean, tidy, and organized. After work, I would pick up Em from daycare, take care of her until her bedtime (which until she turned 2 was 7:30 – 8 p.m.) and then go to bed directly after putting her down. If I showered 3 times a week I was lucky. And shaving the legs? Didn't know that was supposed to be done in American society." …hmm, American society… "This was all accompanied by panic attacks and the whole fear of driving thing with still being fat on top of it all." Another American society expectation?

J: I think so. But from the ending, it's bigger than that. The fatness thing? I dated Scott when we were 15 and 16 years old. Even back then, he had this really extreme…sensitivity to fat people. Hates fat people. Wouldn't let me eat in high school. I remember going over his place, being there for 5-6 hours. He'd give me a handful of crackers. I was actually at my lightest weight ever when I was with him the first time. Then when I was with him the second time, after college, this go around, you see it in the pages. Before I got pregnant, I remember him making bets with me, that I couldn't go to aerobics every day for a month. He would bet me $100 against a month's worth of aerobics, so I would lose weight. Every day. And I did it. I won the $100. I used to walk back and forth to work when I lived in Bridgeville. It was 5.2 miles each way. It would take me two hours. Not only do I think there's this cultural thing that girls are told they should be like models and be ultra skinny and be in great shape. But I had this boyfriend who, he himself can't gain weight. He could sit down and eat gallons of ice cream and pizza all day, and will not gain weight. Me, I have naturally bigger bones, and naturally muscular – I'm built the way I'm built. But then he would push me to be even skinnier. I think as a result, now that we're not together, I'm fatter than I've ever been. [Laughs]

D: What do you make of that?

J: I'm sick of being told what to eat. So I'm going to eat as much as I want to eat; I'm going to get as fat as I want to get. And now I hate it; it sucks.

D: It sounds like it has to come back around for you. It was for him before.

D: "Oh, and I had been being so rude to all of our friends that they were beginning to avoid Scott and stopping inviting us places, basically because people didn't want to have to deal with me anymore." That was another part of the problem? Because all of this stuff up until now is part of your answer to the very first part of the question, "what lead up to you taking medication.?"

J: Oh, yeah. People didn't want to deal with me. My mother didn't want to deal with me, people at work didn't want to deal with me. My father was avoiding me.

D: To what extent was that problematic for you?

J: Big.

D: You noticed others trying to avoid you?

J: Yeah.

D: And besides what other people were trying to do, avoid you, what about you in your own right?

J: I'd get angry at them. According to my mother, I have a great ability to place blame on others and to take responsibility off myself and put it on other people, and say, "Well I'm going to be mad at Sandra because she's being me to me."

D: According to your mother, but what about according to you?

J: According to me, I have the right to do what I want to do. If I want to walk around being bitchy, goddamn it, I'm going to do it. And if you want to react to me, and not be around me, fine. But understand that I'm a bitch and I'm going to be mad at you for it. And that's how it was.

D: "My first introduction to medication was illegally. Scott's father is a primary care doctor and Scott worked for him. Scott and I talked about the fact that I cried an awful lot, was pretty temperamental and really didn't function well. So, I asked him to bring me home meds. I felt desperate and willing to try anything – so I started on Paxil." Tell me about feeling desperate.

J: I felt like I couldn't fix it on my own. I was powerless to…get myself under control again. I would try to be nice, and I couldn't.

D: In other words, to get your emotional level where it was before the first incident on our page one?

J: Before he cheated on me.

D: "I couldn't get enough of it. I kept increasing my dosages on my own." Can you say more about that?

J: It was like I thought if I took more, it would work better. And it didn't.

D: Is that related to, "Once I had the medication, I was hoping it would just be an instant cure-all. Literally like taking an aspirin and having your headache go away. I was hoping Paxil would just fix all my problems"?

J: Yes. Like having it be ten in the morning and taking your medication and wanting to go right back to bed again until you could wake up and take some more…It leveled me out a little bit, my emotion level.

D: "Scott's dad knew nothing of me being on the medication – even though he was my pcp. I stayed on the Paxil from about September of 2000 to May or June 2001. Once I had the medication, I was hoping it would just be an instant cure-all. Literally like taking an aspirin and having your headache go away. I was hoping Paxil would just fix all my problems. It didn't. It helped me be slightly more aware of my situation, but did not help me solve any problems"

J: It helped me cry less.

D: It [Paxil] lessened the crying spells. "It helped me be slightly more aware of my situation, but did not help me solve any problems."

J: I could see things more clearly, but I couldn't fix them.

D: Was it because you were crying less and were less subject to the symptoms, that you were seeing things more clearly?

J: It reduced the symptoms a little bit.

D: "– So I actually think that I became more depressed because I could see myself more clearly and did not like what I saw, nor did I know how to change myself." Could you say more about "I didn't like what I saw"?

J: It was almost like I was watching from a third person perspective. You know, seeing myself from the outside in. It was awful. To see what I had become, that I had become so temperamental and dislikeable and grumpy. I just didn't like what I was. I used to be a very happy, very tolerant person, and I wasn't that way anymore. But I didn't know how to fix it, I couldn't fix it.

D: You didn't know what to do differently?

J: Nope.

D: "This was about how I felt from September of 2000 to December of 2000. All I knew to do to try to make things better for myself was to try to outwardly act happy" – Can you say more about acting happy?

J: Like the old, "Fake it till you make it." I just tried to fake it until it would become natural. So I would be happy. I figured I could strong-arm myself; kind of pull myself up by my bootstraps and say, "Enough of this." It didn't work.

D: I that what you're saying here with "and somehow, I thought maybe I would really start to feel happy. That didn't work. It takes too much energy to put on a happy show when I felt the way I did, so most of the time I was just miserable. Then the bomb dropped." Now I have a question, were you in the car with her?

J: No, no, her husband was driving.

D: Because I was unclear…

J: I compared her car accident to mine. Where she was really…I guess I should tell you about this. She was like a perfect person. She was good-hearted and extremely religious and faithful. Never did anything wild or bad; she kind of toed the line. She was a good kid growing up, and she was a good adult. I mean, 28-years-old, she was still going on church youth retreats. She was just a phenomenal person. I, on the other hand, from the age of twelve was a disaster. I did everything wrong and made all kinds of stupid mistakes. She was just a wonderful person all around. I kept wondering, how could God take away such a good person? Rather than me. He had the chance to take me, but didn't. He took a really good person instead. I wonder.

Jacky was killed December 27, 2000. I must have cried for 8 weeks straight. There were times I couldn't even hold Emily. I couldn't even take care of her because I kept thinking that Jacky should be doing the same thing with Maximus – that she should be alive instead of me. I still wonder if the Grim Reaper didn't miss me the day Jacky's mom and I were in the accident and hit Jacky instead. The connections Jacky and I have together are so strong that it's almost mystical. Jacky would visit Em at our house in Mt. Lebanon after she died; however she would never come in Em's room. She always stayed in the hallway or stood in the doorway. The only exception was when she scratched my pinkie finger in the master bedroom before she was cremated. Now that Em and I live in the house I grew up in, Jacky goes in all the rooms because she knows the house and is more comfortable there.

D: "As I continued in early 2001 to be just lost about Jacky's death, everything else about me either got worse simply remained the same." At this time, you were still taking the medication outside of a prescription, and they weren't working, but you continued to take them anyway. Why?

J: Because of the reaction of what would happen if I didn't take them. They weren't making things better, but if I didn't take them things would be even worse. They were working at some minimal level. At that point, it came down to me being able to express my feelings and my needs, as far as communication with Scott. If I stopped taking medication, it almost felt as if I got so wrapped up in what was going on in my mind that I would forget to speak to other humans. Eventually I would just blow up. Almost had that assumption that he could read my mind this whole time, like he knew what I was thinking. But why did he make all these mistakes? Why didn't he follow my directions? I would get wrapped up in my own thoughts. Basically staying on medication at that point would just help me remember to speak to him.

D: "I did not seek professional help until May of 2001. Until this time, I had been self medicating through the samples Scott would bring home. I knew nothing of how quickly to increase dosages, or what would happen if I missed doses. As a result, sometimes a week would go by without my taking the meds and I would eventually lose it and have a breakdown."

"When I decided to seek help, I knew I needed a psychiatrist so I could have medication." Those first six words of that last sentence there, can you talk about "decided"?

J: I was so beaten down that I gave up. It was a giving in, more than a proactive decision. I guess with this kind of stuff with a problem of the mind, you should be able to help yourself. And not have to turn to somebody else to help you in that way. So that's why I see it as more of a giving in to have to turn to outside yourself to fix your problem. So really, I decided to let myself know it was OK to turn to help.

D: So in other words in giving up, you were giving up on…

J: Fixing me myself.

D: And that connects to "I knew I needed a psychiatrist so I could have medication."

J: That's just knowing the difference between a psychologist and a psychiatrist. One can prescribe meds, the other can't.

D: "I also knew that I did not want to get involved with a therapist or counselor and then have to see someone different for medication prescriptions and monitoring." Can you speak a little more on that, please?

J: Yeah, I don't like having to explain my story to more than one person. I don't want to have to go through that repetitive nature. So I figured I would go to a psychiatrist for everything, for talk therapy and medication.

D: "I called my healthcare provider and asked for the number of psychiatrists in my zip code; since I also knew I wouldn't go if I had to drive more than 10 minutes in the car." This is all the process of finding a psychiatrist. Actually those three lines kind of talk about the thing that you did to go about finding a particular psychiatrist. Part of your decision was informed by your concern about driving?

J: If I had to put too much effort into it, I wouldn't do it. Even if it meant help for myself. I would have the motivation to drag myself out of bed for help if I had to sit in traffic. Incidentally, I made them read me a list of names so that I wouldn't recognize anybody, because I knew so many people in the area. I needed to be sure it wasn't a name I would recognize. But in the end, it turns out, I did know him; I just never knew his last name. I knew him from AA. So all my efforts to find someone I didn't know – I had known him…1990 was the first time I met him.

D: “I couldn’t wait for my first appointment. I felt like even making two phone calls had sent me on the right path and that there would be a solution coming soon.”

J: It was the same way I felt about taking medication. It was like I wanted to be able to take a pill and have my headache go away. I felt like that first appointment, I would be all better. I would in treatment, and all better, and no problem, as soon as I got there. I had placed a high expectation of what would happen. Part of it was that; the other part was actually gaining a little bit of self confidence about feeling that I’m finally trying to take care of responsibilities and trying to get myself in line. So that I could function at a higher level.

D: So compared with what you expressed a couple of paragraphs earlier about not knowing what to do to help yourself, how to change yourself. This seems to be the opposite of that; this is a positive action you’re taking for yourself. Is there any more to that or does that sum it up?

J: Right. No, it’s almost like I wanted the doctor to do the work, and not me. He would fix me instead of me fixing me.

D: Which is what you had given up on when you decided to seek help?

J: Right. I couldn’t fix me; I needed somebody else to fix me.

D: “Ultimately diagnosed with depression, bipolar, ADHD and with panic attacks, I was relieved to be working with someone who could manage my meds.” That is the sentence that has to do with the second part of the research question. Can you tell me about how he presented the prescription to you?

J: It was more…Instead of him presenting for the very first time, “I think you need medication”…Obviously I was already on medication.

D: And you had told him this.

J: Yes. I had told him I was getting these medications illegally. And that…it wasn’t working. What I was doing to try to improve my situation wasn’t cuttin’ it. There was never a time where I had to face the reality, that hitting a brick wall of, “Oh, jeez, now you need medication.” That didn’t happen with him. It was more me explaining what had gone on. Basically everything that I’ve written here, that you and I are discussing, I explained all of this stuff. I said, “This is what’s been happening, this is how I’m doing” and he kind of took all that information and processed it and said, “Well, the medications you’re on are not doing the job. We need to find a different medication for you to do this.” What’s funny is even in talk therapy with him, we never really worked on problem solving or coping skills or anything like that. He would talk about medication. How was I sleeping, was I crying less, was I less temperamental and less irritable? He would manage my medication based on how I would feel.

D: OK, I think that captures Part B pretty well. I want to go now to Part C, which is "Please include a description of your thoughts and feelings at the moment you received the prescription." I think we have some of that already in terms of, when we talk about the illegal meds. In other words you said --

J: Oh, here, oh my gosh I just forgot [remembered?] about this. I *liked* the idea of having the medication illegally, through just having samples without a prescription. I preferred that, rather than having a chart with my name on it and a list of prescribed medications, and pharmacy having me on record because in the back of my mind somewhere I didn't ever want it to be on paper that I was having psychological difficulties.

D: So there's a concern for anonymity with this?

J: Yep.

D: And you had that with Scott's father's drugs because only you and Scott and his father maybe – I don't even know if his father did know.

J: No, he never did know.

D: So it's just you and the person who at that moment in your life was the most intimate with you and knew the most about you anyway, knew about the drugs. So you had virtual anonymity.

J: Yes. I didn't ever want it to show…I didn't ever want to have to answer a question on a job description, "Have I ever received psychological treatment." I always wanted to be able to say, "No." I can't say that anymore.

D: Let's talk for a second about the first "legal" moment. Was there a change for you, a change in that once you consented to decide to go see a psychiatrist in the first place…that concern for anonymity was gone?

J: No, the concern wasn't gone, I just had to realize that I couldn't remain anonymous forever.

D: Is there any difference at all in the concern for anonymity between going to a psychiatrist and getting medications from a psychiatrist?

J: They're the same.

D: Let's go back just for a second to the "illegal" moment, the first time you got drugs from Scott. "I felt desperate and willing to try anything, so I started Paxil." I want to focus on, "so I started on Paxil." Can you tell me about what your thoughts and feelings were at that moment…You asked him to bring them? This [idea]came from you?

J: I think if he suggested it, it was always in a sly kind of off-handed remark, "You know, you need fixed, you need drugs". He would normally tease me in a real negative way about it, say, "You need help."

D: But that was at the level of teasing and of not serious?

J: He meant it, but he would make me feel bad about it. He did mean what he was saying. But I knew that he would give them to me. When I did ask for them, I had to ask because I knew I couldn't sneak pills from him, I just couldn't start taking his.

D: Oh, was he taking pills?

J: Oh, yeah, he was on Paxil. I knew I couldn't just sneak it from him, because he would find out and I didn't want to do it behind his back. I had to ask him to get me a supply on my own. But I also knew he was [willing] [going] to say yes because he had made all these offhand remarks in the past.

D: I'm interested in is how you first entertained the possibility of meds in such a way that it became a possibility for you of taking medication. Are you telling me that that's how it began: your situation, and your exposure to Scott, who was taking it, and who would occasionally, even if it was in jest, say, "You need to take these" Or "You need to take medication." At some point where you go from recognizing that that is said with a hint of sincerity, but still in jest, to making it or having it be for you a real possibility.

J: Yeah, there's a left out part…There was an option that I chose not to take, and that's self-medicating through drugs and alcohol. Which I very well could have done. Had it not been for Emily, had I not been a parent, that's probably the route I would have gone. I would have just started drinking again. Scott smoked pot every day, there was pot in my house every day of the year. I would have started smoking pot again. I would have started seeking what I needed that way.

D: When you say again, you had previous experiences where you were…

J: Numbing myself to the world? Yes.

D: can you speak to that for just minute, the history of that?

J: Oh. I started at age 12.

D: Drinking?

J: Yeah, oh, yeah. Started drinking Jack Daniel's out of the bottle at age twelve. I would do a shot before school, before I'd get on the school bus in seventh grade. Started doing drugs in high school…Pot, mainly, but my favorite was mushrooms. Did not like acid, had a bad experience with that, ended up catatonic in a mental hospital because they didn't have a detox ward. They took me to the hospital then. At one point in my life, the drinking was so bad at age 16 I had a blood alcohol level of .35 and went into a coma.

D: When did you get…you started AA?

J: Yeah, my parents sent me to rehab right after I graduated from high school. I was 18 and they sent me…July of '90, I spent a full 30-days in …living there – in patient treatment. That's actually is where I met Suzanne; she was a therapist the place I went. I was 18 then. I was sober for 4 years, all through college. Thank god for that because I don't think I'd ever have a degree had I gone to State College and tried to drink at all the bars and go to…try to get a degree at the same time. It was my last year in school, '94-'95 when I started to drink again. Absolutely, my tolerance level was not the same…From '95 to 1999 drank five-six days a week, every night, out till two in the morning, closing bars, smoking pot. In '96 I had started doing coke [cocaine] and crack and loved it. Downright loved it. But started dating Scott right then, and he didn't approve of that. So luckily I wasn't in too far, that I just dropped it. I made the decision that he was more important than that and quit doing that. I enjoy drugs and sober.

D: How long have you been clean & sober now?

J: Well, I don't even consider it that. I don't…I drink occasionally. I can have a beer; I don't have a desire for it. I don't have…I don't care about it. Quite frankly I don't like that out-of-control feeling anymore.

D: How long has it been since you used alcohol or drugs excessively?

J: When I got pregnant. As soon as I got pregnant, I mean literally. When I took a pregnancy test, I quit smoking cigarettes – I was a pack a day smoker. I quit drinking; I wouldn't drink caffeine, including chocolate. I wouldn't even eat chocolate cake for fear it would have caffeine in it. The pregnancy turned me around, I turned my attitudes around; it turned around my desire to be out in my twenties and party. I could care less if I ever walk into a bar again. I mean the idea of being a parent hit me so strong that the desire to do any of that stuff is just completely gone. And it stayed away, which is amazing.

D: Thank you, I think that's just exactly what we need for understanding the background.

J: I would have though, had it not been for being a parent, I would have – instead of seeking treatment – I most likely would have just started partying. I would have found my niche and some combination of pot, pain pills and alcohol to make me function. I would have gone on like that. Knowing I was a parent, the importance of my role in Emily's life was too strong to do anything like that. So I knew it wasn't even a choice. It was a decision I had made when I got pregnant. So the idea of doing it that way, the old way, wasn't even a choice. It just…I didn't even think of it. I knew I had to go a legitimate way, and I also knew in a sly-handed way I could get these really good drugs. I could get the Paxil and the Zoloft and Wellbutrin. I could get legal drugs illegally.

D: So your thoughts and feelings about taking the medication just before you got it illegally… "I felt desperate and willing to try anything." I am understanding those as the feelings before. And then afterwards –

J: Knowing that that "anything" – excuse me, but – understanding that anything does not include drink, drugs and alcohol.

D: And the feelings you had after, you've already started to talk about. You were hopeful it would be a cure-all and that it would fix everything. But then afterwards you became more depressed. But did that change your feelings about it, because it didn't change what you were doing with the drugs. You continued them because they had a reducing effect on some of the symptoms. But did your thoughts or feelings about taking the medication change after that first experience?

J: I became more curious. It's almost kind of strange. It's like diving into the realm of prescription antidepressants and tranquilizers.

D: You became more curious about…?

J: The prescription drugs out there. The legal drugs. What's going to be the best fix for me? Any time I switched medications after seeking treatment, I was always so open to it because it was like this big game. What's the best drug, what's the best combination of drugs that's going to fix me?

D: Let's switch gears a little bit and go to the meetings with the psychiatrist. You talked about how he presented them to you. And we talked about the feelings before, too…Let's talk about your thoughts and feelings after this meeting with the doctor, in other words, after the doctor said, "Let's find the best drugs for you." Is that where we pick up: "I felt complete relief and trust in the doc"?

J: Yeah. It was like, um, I had finally found the guy who was going to know the answers to what combination of medications are going to be right.

D: That was the relief and trust?

J: Yeah, it was like I had walked into an office and met with a walking, talking PDR…He would be smart enough to know the answer. And he did! However, if I go off them, the side effects are terrible!

D: OK… "I wonder about my diagnoses, whether they are accurate or not, but I have complete trust in the med management." So in terms of the doctor as a medication manager, you trust him. But in terms of a diagnostician, in terms of knowing what's wrong with you… or what's essentially wrong? Whether he's actually hitting the nail on the head as to what's wrong in your situation, that's a different matter?

J: Some [garbled] medications can control the peripheral things. The actually diagnosis – if you picture that as a target, if you picture me as the target, my actual diagnosis being the bull's-eye. I doubt that he knows what the bull's-eye is. But he can keep the rest of the target round with these peripheral medications that are going to… let me function better. But I don't know if the diagnosis is correct or not.

D: "It has been since May of 2001 that I have been seeing my doc, and I dread the day that I run out of my meds. I have side effects if I run out of a med or miss more than 2 doses in a row. My meds have been stable now for about 9 months, but up until then, we went through a trial and error process that was enlightening – never frustrating. If I felt a med wasn't doing well or I didn't feel good on something, or could feel the effects wearing off I would just let him know and we would adjust. It took time, but I have confidence in the medications. I am losing confidence in the doc as a therapist, but he seems to be able to take what I say and convert the information into useful medication management. He says I will always be on meds. That it's a lifelong thing for me. That's ok with me.

D: "It would be nice not to have to take anything, but I would rather do it than suffer." Could you say more about this, please?

J: It would mean that I would be normal. I have these diagnoses. I have to take these meds. I don't consider myself normal.

D: "…but I would rather do it than suffer."

J: Yeah… It goes back to the point about not wanting to seek outside help. But It's now more important to function well than to have pride that [I'm not needing outside help and] I am not functioning well.

D: OK. Thank you very much.

Meaning Units: “Jillian”

1. S.’s experience of receiving a prescription emerges out of a series of traumatic events that deeply disrupt the live of the S. on many different fronts and leave her emotionally vulnerable, overly sensitive and reactive as well as irritable and easily agitated.
2. S. experiences a strong sense of accountability vis-à-vis the child she is carrying. Specifically, S. is afraid that she will not be up to the task of being fully responsible for the coming baby, especially given that she has been particularly irresponsible in the past.
3. As S. gains a significant amount of pregnancy weight, her self-image and self-esteem drop significantly and she loses control of her emotions.
4. S. begins to become unstable emotionally and irrationally fearful and is aware of herself as such.
5. S. hopes that this instability is only associated wither pregnancy and that after she gives birth, the changes that pregnancy has brought about to her body will disappear and all of the emotionality and sensitivity with them.
6. After giving birth to her daughter, S. continues to be emotionally sensitive, but less angry and aggressive, owing to the happiness of having a newborn. She finds herself simultaneously joyful (over her daughter) and in mourning (over her friend’s death).

7. S. develops a difficulty with driving/riding in cars that is only enhanced by the presence of her newborn in the car. Her anger and aggressiveness return when she is in a car.
8. As time passes, S. experiences panic attacks, dizziness and lightheadedness and becomes concerned that she might be diabetic.
9. S. experiences a loss of interest in maintaining relationships including all but the closet of her friendships, to the point where has begins to actively avoid people at all.
10. At the same time, S. begins to focus all of her energy and care on her newborn daughter. S. loses interest in maintaining any of her responsibilities, interests, hobbies or roles in her household.
11. S. is confronted with financially needs that necessitate her return to work . S. does not want to face these concerns. At this time, S. realizes that she has not made any significant improvement since she gave birth and that the chances of her suffering going away on its own was very unlikely.
12. S. experiences almost everything about herself and around her, except her daughter, as being out of her control. She begins to neglect the daily hygiene of her body as well as its nutritional care.
13. S. gains weight, which has a particular significance to her in relation to her boyfriend. S. perceived him as trying to control what and how much she ate and thereby make her thinner than she would otherwise be. Reacting against this, S. eats recklessly and gains weight, about which she herself is unhappy.

14. S. behavior towards others effective alienates her from most of her friends and family. S. perceives others as not wanting to have contact with her. S. experiences anger and resentment towards most others. S. maintains a stance of defiance towards these others.
15. S. begins to feel desperate to control her crying, temper and lack of sufficient functioning.
16. S. experiences her boyfriend frequently makes remarks (first in jest, then more seriously) that she should take medication to control these things. She and boyfriend eventually discuss her taking medication in the form of samples stolen by S.'s boyfriend from his father, who is a physician. S. would have easy access to this kind of illegal medication. S.'s feeling of desperation lends itself to a willingness to take medications and to take them illegally on top of that.
17. S.'s makes a conscious choice not to resort to what has historically been for her the best way of coping with suffering: alcohol and drugs. For S., this was no longer a viable option because she identified herself as a parent. She refrains completely from any drinking (or illegal narcotics) at this time on the basis of her parenthood.
18. S. becomes curious, in an almost game-like manner, about the use and action of medications. For S. they seem to take the quality of a substitute for alcohol and drugs. S. views medications as similar to "legal drugs.'
19. The idea of illegally obtaining the meds appeals to S. for it offer her the opportunity of anonymity, both from anyone who might treat her, and from being

known in the future as someone who had received psychiatric treatment (e.g. having to admit treatment in a future job application)

20. Hoping to find them a quick cure-all, S. takes medication in a sporadic, unmonitored fashion and experiences some effects that level her emotions out somewhat, thus giving her a bit more clarity on her own situation.
21. This newfound clarity serves to worsen S.'s emotional state as she does not like what she can now more clearly see of her life..S. experiences depressive feelings and increased dislike for herself.
22. S. experiences some amount of painful distance from herself as she remembers herself to be.
23. S. feels powerless not knowing what to do to reclaim the desireable historical self that she sees as absent now.
24. S. tries to act happy in an effort make herself truly happy. This is unsuccessful.
25. S. continues medication taking because of the decompensatory results when she doesn't. All of her other efforts had been unsuccessful.
26. S. feels defeated and inclined to give up on trying to make her life better or happier. S. feels that help from another in this type of situation is a giving up on her own ability to get herself out of the depression she is in. S. decides to see a psychiatrist.
27. S. rejects the prospect of getting a therapist in addition to a psychiatrist due to a desire to keep as many people as possible unaware of her difficulties, nor does S. want to repeat her story to both the therapist and the psychiatrist.

28. S. finds and makes an appointment with a psychiatrist. Part of S.'s decision is informed by proximity so as to reduce driving time. This reveals S.'s continuing struggle of motivation to help herself; if the psychiatrist was more than ten minutes away, S. would not have committed to going.
29. Part of S.'s decision process in choosing a psychiatrist is anonymity, owing to her desire for as few people to know about her problems as possible.
30. After making the appointment, S. immediately feels positive sense of self-help. S. anticipates visit with psychiatrist will be a cure-all in the same way she earlier perceived the medications.
31. S. also experiences a feeling of increased self-confidence and self-recognition in her efforts to improve her life.
32. S. has a slight shift in attitude about seeking help: in contrast to her previous grasp of getting help seen strictly as failure, S. now also sees help can provide what she can't bring about on her own. S. then experiences relief.
33. The decision to meet with a psychiatrist continues to be a source of concern for being known as being in treatment, but S. decides for it anyway in favor of getting help.
34. S. explains her medication use to the psychiatrist, and after listening to her, he offers his evaluation and suggests that they collaborate on finding medications that will help improve S.'s situation.
35. S. notices that psychiatrist gives all of his attention to medication, even in moments where S. is expecting dialogue of psychological significance. S. comes

to see psychiatrist as a medication manager. S. feels trust and relief in seeing the psychiatrist this way.

36. Though S. comes to value psychiatrist as a medication manager, his lack of attention to S. therapeutically has brought forth, in S., a lack of confidence in him. S. doubts that psychiatrist actually knows/understands the nature of her problems. The value he retains for S. is his ability to supply and manage medications.
37. S. is amenable to taking medications in the long term now, even lifelong. Nevertheless, S. sees her needs for medications associated with her being not normal. Being able to function, though, remains a greater priority for S. than being seen as normal.

Situated Structure: "Jillian"

The Preparatory Circumstances: Disturbance Across Life-Domains

J.'s experience of receiving a prescription emerges out of a series of traumatic events that deeply disrupts her life on virtually every level of her existence and leave her emotionally vulnerable, overly sensitive and reactive as well as irritable and easily agitated. In addition, J. experiences a strong sense of accountability vis-à-vis the child with whom she is pregnant. Specifically, J. is afraid that she will not be up to the task of being fully responsible mother for the coming baby, especially given that she has been particularly irresponsible with her on life in the past. As J. gains a significant amount of pregnancy weight, her self-image and self-esteem drop significantly and she loses control of her emotions. J. begins to become aware of herself as being unstable emotionally and irrationally fearful. Thus, the disruption of J.'s life is manifest in her relationships to and with others (i.e. her cheating boyfriend, her ill father, the death of her best friend, others, whom she finds so irritating, etc). It is manifest in her experience of moving toward the future (i.e. fearing the responsibilities of motherhood, the uncertainty of her relationship with her daughter's father, etc.). It is manifest in the ways she bodies forth her life (i.e. the radical physical changes of pregnancy, the bodily disabilities left over from two car accidents, etc.). Finally, this disruption is manifest in the way J. experiences herself (i.e. by virtue of her instability and irritability, as alien to the self she has historically understood herself to be, her drop in self-esteem, etc.).

J. associates at least some of this to being pregnant and begins to hope that after she gives birth, the changes that pregnancy has brought about to her body will disappear and all of the emotionality and sensitivity with them. After giving birth to her daughter, J. continues to be emotionally sensitive, but less angry and aggressive, owing to the happiness of having a newborn. She finds herself simultaneously joyful (over her daughter) and in mourning (over her friend’s death). J. develops a difficulty with driving/riding in cars that is only enhanced by the presence of her newborn in the car. Her anger and aggressiveness, that had not been present since delivering her daughter, return when she is traveling in a car. As time passes, J. experiences panic attacks, dizziness and lightheadedness and becomes concerned that she might be diabetic. J. experiences a loss of interest in maintaining relationships including all but the closet of her friendships, to the point where has begins to actively avoid people at all. At the same time, J. begins to focus all of her energy and care on her newborn daughter. J. loses interest in maintaining any of her responsibilities, interests, hobbies or roles in her household. J. is confronted with financially needs that necessitate her return to work . J. does not want to face these concerns. At this time, J. realizes that she has not made any significant improvement since she gave birth and that the chances of her suffering going away on its own was very unlikely. As before, the disruption of J.’s life manifests in her being-with-others (i.e. as she begins to grow reclusive and isolated), her bodying-forth (i.e. her newfound symptoms of dizziness, lightheadedness, etc.), her temporality (i.e. she fearfully anticipates being diabetic, being in a car accident; she anticipates the childbirth will bring about the end of her emotional labiality, etc.) and her projectedness toward the projects of her life (i.e. she loses interest in all of her responsibilities except her infant daughter’s care, her diminishing care for maintaining the relationships with friends, etc,).

J. experiences almost everything about herself and around her, except her daughter, as being out of her control. She begins to neglect the daily hygiene of her body as well as its nutritional care. J. gains weight, which has a particular significance to her in relation to her boyfriend. J. has perceived him as trying to control what and how much she ate to try to make her thinner than she would otherwise be. Reacting against this, J. eats recklessly and gains weight, about which she herself is unhappy. Her behavior towards others effectively alienates her from most of her friends and family. J. perceives others as not wanting to have contact with her. She experiences anger and resentment towards most others and maintains a stance of defiance towards these others. Again, J.'s difficulties continue to manifest (and worsen) across the domains of her life, socially physically, temporally, and in relation to her self and her own sense of control in her life. This last issue of control comes strongly to the fore at this point.

J. begins to feel desperate to control her crying, temper and lack of sufficient functioning. She endures her boyfriend's frequent remarks (first in jest, then more seriously) that she should take medication to control these things. She and boyfriend eventually discuss her taking medication in the form of samples stolen by him from his father, who is a physician. Having easy access to this kind of illegal medication and coupled with her feeling of desperation to experience a positive change in her life, J. discovers a willingness to take medications and to take them illegally on top of that.

Part of this decision to try medication is based on the rejection of what J. knows has historically been for her the best way of coping with suffering: alcohol and drugs. For her, this is no longer a viable option because she now identifies herself as a parent. She refrains completely from any drinking (or illegal narcotics) at this time on the basis of her parenthood. J. becomes curious, in an almost game-like manner, about the use and action of medications. For her, they seem to take the quality of a substitute for alcohol and drugs. J. views medications as similar to “legal drugs.” The idea of illegally obtaining the meds appeals to J. for it offers her the opportunity of anonymity, both from anyone who might treat her, and from being known in the future as someone who had received psychiatric treatment (e.g. having to admit treatment in a future job application).

Again, J.’s difficulties show themselves in the facets of her existence: temporally, she anticipates the possibility of a future in which she is identified as having been a psychiatric patient; socially she finds appealing the possibility to get medications without being known to a doctor. Also she endures a contentious relationship with her boyfriend. Physically, J. continues to suffer through crying spells and has a curiosity about drug interactions with her body. With regard to her relation to herself and her relatedness to the projects of her life, J.’s sense of control is at a very low point. She feels out of control in most situations. One thing she retains control over is her ability to refrain from drugs. Her lack of ability to make any other positive changes in her life leave her feeling out of control, desperate.

Hoping to find them a quick cure-all, J. takes medication in a sporadic, unmonitored fashion and experiences some effects that level her emotions out somewhat, thus giving her a bit more clarity on her own situation. This newfound clarity serves to worsen her emotional state, as she does not like what she can now more clearly see of her life. She is lifted out of the fog that has masked her suffering for so long. Instead of alleviating this suffering, it brings her into direct contact with it in an unpleasant way. Subsequently, she experiences depressive feelings and increased dislike for herself. J. now experiences some amount of painful distance from herself as she remembers herself to be. Again, J.'s suffering manifests in the temporal dimension of her life as she encounters herself in the present as different than as she had been earlier in her life. The past is a painful reminder of what her life has become. The medications are not rendering the effects she has hoped for. She is disappointed. At this latest failure, she feels powerless not knowing what to do to reclaim the desirable historical self that she sees as absent now. She even tries to simply act happy in an effort make herself truly happy, carrying herself in front of other in a disingenuous fashion. This effort is unsuccessful. J. continues taking the medication because of the decompensatory results when she doesn't. All of her other efforts are unsuccessful.

J. feels defeated and inclined to give up on trying to make her life better or happier. Though she feels that help from another in this type of situation is tantamount to giving up on her own ability to get herself out of the depression she is in, she decides to see a psychiatrist. J. rejects the prospect of getting a therapist in addition to a psychiatrist due to a desire to keep as many people as possible unaware of her difficulties, nor does she want to repeat her story to both the therapist and the psychiatrist.

The Decision as a Turning Point

Initially guided by desperation, J. finds and makes an appointment with a psychiatrist. Part of her decision is informed by proximity so as to reduce driving time to the psychiatrist's office. This is revelatory of her continuing struggle with motivation to help herself (i.e. if the psychiatrist was more than ten minutes away, she would not have committed to going) and to be engaged with the existing projects of her life. Part of J.'s decision process in choosing a psychiatrist is anonymity (i.e. a doctor in her area that doesn't know her or her family), owing to her desire for as few people to know about her problems as possible. She does not wish to be seen as abnormal or unable to conduct her own life, in short, out of control. After making the appointment, J. immediately feels a positive sense of self-help. She anticipates the visit with psychiatrist will be a cure-all in the same way she earlier perceived the medications would be. J. also experiences a feeling of increased self-confidence and self-recognition in her efforts to improve her life.

J. also experiences a slight shift in attitude about seeking help: in contrast to her previous grasp of getting help seen strictly and solely as failure, J. now also sees that help can provide what she can't bring about on her own. Following this, she experiences relief. What provided the grounds for this shift? It appears that there are several factors.

First of all, the level of *desperation* that J. experiences serves as a realization that her situation is severe. The breakdown and constriction in the domains of her life is something to which she bears witness: relations with others (significant and otherwise), relation to the prospects of her life (i.e. motherhood, etc.); her relation to a future that holds promise for nothing but increased suffering, a past that is only a painful reminder of what no longer is, and a present that is becoming increasingly isolated, narrow and unbearable.

Secondly, the discontinued viability of J.'s habitual mode of handling suffering has a hand in her turn to seeing help-seeking anew. It is precisely because she has identified herself as a mother and feels responsible to her child that drinking and using drugs to numb herself to her own suffering are no longer an option for her. Her adamant stance on this matter is revelatory of J.'s ability to maintain at least some sense of priority in her life even if this prioritizing cannot yet make enough room for herself as valuable to her.

Thirdly, J. is moved by the possibility of anonymity. As long as she can pursue help anonymously, she can do so without the threat of being seen, being known, being recognized as someone who is mentally ill or as a person who is less than able to control herself. Anonymity provides a cover for being out-of-control, a designation that carries stigma for her.

Finally, in her initial efforts to seek help, which were guided mostly by fear and desperation, J. experiences feelings of positive self-value and self-confidence immediately thereafter. This increase in personal strength, however small, is sufficient to help move J. to continue actions that would bring about more self-confidence in this way. Her own responses of positive self-valuing that followed her first actions to get help for herself open her even more to accepting help from others.

The reconfiguration of J.'s attitudes is not pervasive or complete. The decision to meet with a psychiatrist continues to be a source of concern for being known as being in treatment, but J. decides for it anyway in favor of getting help. Her over-riding priority continues to be improving her life for the sake of being a good mother to her daughter.

Upon meeting the psychiatrist, J. recounts her illegal medication use to the psychiatrist, and after listening to her, he offers his evaluation and suggests that they collaborate on finding medications that will help improve her situation. She experiences the psychiatrist as caring, attentive and capable. She does not feel ashamed or embarrassed despite the fact that, contrary to her intentions, she unknowingly chose a psychiatrist that she had met earlier in her life. This begins a period of a relationship of treatment with this psychiatrist.

The Re-evaluation

After some time has gone by, J. notices that psychiatrist gives all of his attention to medication, even in moments where/when she is expecting dialogue at a level of psychological significance. J. comes to see psychiatrist as a medication manager. To be sure, she feels trust and relief in seeing the psychiatrist this way. He still appears competent in this capacity. Though J. comes to value psychiatrist as a medication manager, his lack of attention to her therapeutically has brought forth, in her, a partial lack of confidence in him. She doubts that the psychiatrist actually knows/understands the nature of her problems. But the medications, now monitored, are having positive effects for her, so he retains value for J. in his ability to supply and manage medications. She has become amenable to taking medications in the long term now, even lifelong. Nevertheless, J. still sees her needs for medications associated with her being not normal. Being able to function, though, remains a greater priority for J. than being seen as normal.

Appendix B: Data and Analysis (“Felicity”)

Protocol 2: “Felicity”

I always had a very stressful and crisis-oriented life, from about the time that I was nine years old to the present. I now, in retrospect, believe that I also suffered from depression of varying degrees from that time on. In my teen years, I soothed my depression with heavy drinking and illegal drug use. I have been in and out of counseling for the last fifteen years, learning more insight and better coping mechanisms (healthy) each time. The birth of my son with autism and my divorce are the two events that lead me to counseling. I have been taking Effexor xa for the last three years or so for depression and ADHD. The ADHD manifested itself in anxiety and the severe inability to concentrate. My current husband became physically abusive ten years ago, up until three years ago. My level of depression and anxiety became very overwhelming during that time; I was crying almost daily; I could not concentrate at work, and my anxiety level was very high. I could not give myself to my three children. My counselor at that time recommenced a psychiatrist; I made the appointment and went. She prescribed the Effexor and I felt an overwhelming sense of relief. I was deathly ill the first two weeks of taking the medication with severe nausea. I did not realize at the time the nausea was a side effect. I thought I just had a stomach virus. The anxiety was gone almost instantly. It was a godsend! I was able to start thinking clearly and looking at my life with more clarity. Everything started to fall into perspective. It was like a whole new world opened up for me.

Over the last three years I have become a lot stronger as a person. I have been able to set limits with my husband and stick by them; my self-esteem has grown; I have been able to further my education and make the high honor roll (even with my ADHD). My life has been definitely improved since I have been taking the medication. It has been a positive experience for me.

Protocol 2 Interview: “Felicity”

D: “I always had a very stressful and crisis-oriented life, from about the time that I was nine years old to the present. I now, in retrospect, believe that I also suffered from depression of varying degrees from that time on.” Can you say a little more about why or how you believe you suffered from depression, how it was you suffered from depression?

F: My schoolwork suffered. I was a very poor student; I missed a lot of days of school. I skipped school; I had no interest in school. I just remember the feeling of being alone and being depressed, basically. Thinking back as an adult, and knowing what I know now, just for the main fact that my schoolwork did suffer, and in my teen years, my acting out.

D: When you say you felt depressed, what did that feel like?

F: A feeling of no hope, a feeling of sadness. Boredom. A feeling of having no one who actually cares enough about you. Feeling like you have nobody to go and talk to. Frustration.

D: “In my teen years, I soothed my depression with heavy drinking and illegal drug use.” Can you say something about soothed?

F: By doing that, going out and partying every night, I was actually numbing. I didn’t feel the depression because I was either drunk or high. When you go on the fast life like that you don’t have time to stop and think and reflect; you don’t give yourself time, think and reflect; you don’t want to stop, think and reflect because the feelings come out and you don’t want to feel them.

D: “I have been in and out of counseling for the last fifteen years, learning more insight and better coping mechanisms (healthy) each time.” Did anyone in that time ever suggest prescription for you?

F: No. Not until three years ago. Which really surprised me.

D: “The birth of my son with autism and my divorce are the two events that lead me to counseling.” Can you elaborate on “lead me to”?

F: It was kind of happenstance. The first time I went to counseling, the very first time, was when my dad passed away. It was a little while after that. I was seventeen, and this counselor told me that I should start exploring myself. Told me I should stand in front of a mirror naked, and at that point I thought, “I don’t think I’m coming back.” I was seventeen. When Jeremy started at St. Peter’s preschool, there was a counselor there that was just part of the school. I became friends with her. I would drop Jeremy off at school and go up and talk to her. After my first husband left, it became more of a weekly thing.

D: The other thing I wanted to ask about in terms of "lead to," is there any sense of what made you say, I'm going to go get some counseling again?

F: I think Nancy was just so nice – that's the first counselor I went to – and she just kind of…I don't think I ever said to myself the very first time, I'm going to get counseling. I just think she said to me, how about this time next week?

D: When you realized you were in fact talking to someone, as it were, how was it that these two events that lead you were some kind of a driving force to get back into counseling.

F: It [dealing with autism] was very new to me. Jeremy was two to three years old at the time. Having to deal with his disability – I didn't know he was autistic at the time, I just knew he had a disability. Then the new baby was born, Dustin, and then Jim leaving. I was just very, very, very, very stressed out. Jim left after Dustin was two months old. I lost fifty pounds in a month. I was eating pears, drinking coffee, and smoking cigarettes, and that was it.

D: What else was going on for you that you were hoping to address by going to talk to someone?

F: Just getting through that.

D: Getting though?

F: The divorce, dealing with Jeremy.

D: What would "getting through" mean?

F: Eating more. Not crying all the time. Moving on with my life. Being able to be more patient with my children. Being strong enough to face the task of raising those kids on my own.

D: "I have been taking Effexor xa for the last three years or so for depression and ADHD." Let's come back to this part in a bit. "The ADHD manifested itself in anxiety and the severe inability to concentrate." Was that part of…

F: No, I didn't even realize I had ADD or ADHD until I started my medication, right before that. She said to me, "You know, you've got attention deficit disorder."

D: "My current husband became physically abusive ten years ago, up until three years ago." And at this time you're continuing the process of therapy?

F: I started going to Nancy – we're still friends, I have her phone number. Sweet, sweet lady. So I saw here for a while, then I saw some woman named Sharon. That is when I was finishing up my nursing school. I was pregnant – gosh I can't even remember. I was pregnant with Carl, and I saw her for a little while. No wait a minute, I'm sorry. After Nancy, I saw someone at the NHMR, Northern Southwest MHMR [what?], that was right in Carrick. Then I saw somebody named Julie, then I saw somebody named Sharon. It was all for the same thing.

D: It was all continual?

F: Yeah, pretty much, with little bits, maybe a month or two in between. That actually helped me start to feel better about myself. I was always very, very, very insecure. Very insecure. When I was a teenager, I would be frozen. I would be so insecure, I would be sitting in a room full of people just frozen, sweaty palms and all. You wouldn't know it now! [laughs] It was bad. That helped me through that.

D: It helped you through the course of this time, from the birth of Jeremy to the divorce, and continuing on to your second marriage. Your husband became abusive now. How far into your relationship did your husband became abusive?

F: I'd have to say a year, because I know I was pregnant with Carl.

D: And it continued until three years ago. "My level of depression and anxiety became very overwhelming during that time" – between the ten years ago and the three years ago?

F: Yeah, before I met him, I was at a point in my life where I was actually very happy, very centered, had a lot of peace.

D: This was after your divorce.

F: Yeah. I was going through school and was getting through that, and with each thing I accomplished through school, I got that much more – which each level that I passed, you gain more confidence, that much more self esteem. I was at a point where I was feeling pretty good about myself, and then Walt came into the picture. I wasn't totally – In retrospect, I was still a little needy, because I guess I'm attracted to that, I'm learning that now. And he was able to reel me in with the big [unintelligible]. I guess then he started chipping away at my self-esteem, because I went from here back down. It took awhile, because at first I was just like, you know…I still do that when he does that stuff; he still broadsides me. I expect one sort of normal reaction like you get from the general population, and I get another, and it still surprises me.

D: So at the point that he was becoming abusive, and up until three years ago, "My level of depression and anxiety became very overwhelming during that time; I was crying almost daily; I could not concentrate at work, and my anxiety level was very high. I could not give myself to my three children." So those things, the crying, the concentration, the anxiety level, and the inability to attend to your children –does that relate to being overwhelmed, feeling overwhelmed?

F: I wasn't able to function as a contributing human being to society at all. I was just so wrapped up in those feelings, the anxiety just…The feelings of anxiety and depression were just over-consuming.

D: To the point where you couldn't live your life or function.

F: Function, yes.

D: "My counselor at that time recommended a psychiatrist; I made the appointment and went." Based upon the recommendation of your counselor?

F: Yes. I trusted her completely.

Can you say a word or two about this last counselor?

F: Carol?

D: How would you talk a little about the relationship you had with her?

F: Oh, very good, actually. I mean, she still sends me Christmas cards. [laughs] She was excellent. I could probably call her up. I don't because I don't want to cross that line, of course.

D: I think the next four words are the answer to b[in the research question]: "She prescribed the Effexor". Can you tell me about how she presented the prescription to you?

F: You know what, it's hard to remember, but I will do the best I can. I was in such a state when I went to her. But she sat down; she asked me some questions. I explained to her exactly what was going on, you know you have to summarize your life in, oh, fifteen minutes. [laughs] And she looked at me, and she said, "Here, this is what I'm going to start you on." She wrote it down and she gave it to me, and she told me exactly [how she wanted me to take it]. I just said, "OK, thanks." She said, "If this doesn't help, we'll try something else or we'll do something in conjunction. I want to see you back in a month." She was very nice.

D: Very nice?

A; Yeah… she had a concerned look on her face, like empathy. She talked to me sympathetically about what I was going through. She wasn't intimidating.

D: I think that does it for that. Now the third one, your thoughts and feelings the moment you received the prescription, as well as your thoughts before and after being given the prescription. You say, "she prescribed the Effexor" – which we just discussed, "and I felt an overwhelming sense of relief." Can you say more about that?

F: Let me think about that…[long pause]. I just remember thinking, "Finally, I'm going to get some help."

D: Was that right at the moment, after she had given you that?

F: Yeah, but it wasn't as strong as it was after I started taking it. The anxiety just went away. And I just remember thinking, this is great stuff.

D: Let's talk about the time *between* when she wrote it down and the time when you actually first took it. We can talk about the time you first took it also, but I want to focus on that [first] period first.

F: You know…I was very eager, very gung ho. I had no thoughts of any kind of trepidation or anything like that. I was just like, "yeah!"

D: You were eager.

F: very, very eager. I'm in the medical profession; I know that pills help.

D: You're a registered nurse.

F: I'm a registered nurse. I'm so surprised I hadn't thought of it before. It just never occurred to me before to do this. Never, ever. I think if someone would have suggested it sooner, I would have done it sooner.

D: You felt eager, and you thought, "At last I'm going to get some help."

F: Basically. I don't know if it was those words, or even that thought process. It was just like, "Yeah!" If that'll work. I was just happy, very happy, that this is going to stop.

D: Can we back track to that moment, between "I made the appointment and went" when you walked in the door of her office, and she prescribed the Effexor. Do you remember that period of time, when you first made the appointment and when she prescribed the drug? You said your thoughts did not include, "Maybe I'll get some medication." Because you said just a second ago that it didn't occur to you.

F: It didn’t occur to me before – I knew when I made the appointment, I was going to get medication. It never occurred to me in the past to go and seek it. But from the time I made the appointment, I couldn’t wait until it came.

D: So can you tell me about the moment you made the appointment? Was there a decision-making process?

F: No, it was suggested to me, I got the name, and I did it. I was just so eager to get better, to feel better.

D: So the eagerness you had after she wrote the prescription was there prior to when she actually wrote it?

F: I couldn’t wait to get in and see her. When I made the appointment, I think I had to wait two weeks. And it was the longest two weeks, because I thought I was losing my mind and I was desperate to feel better.

D: Better. Could you say more about what being better would be for you?

F: Well… It was the physical things, you know… the tightness in the chest, the tightness in the muscles… um… my hands were always shaking… I had racing thoughts… negative racing thoughts.

D: Did your being a mother and being a worker, being employed as a nurse and so on have any relation to “getting better”?

F: Yes. The physical things were so consuming that it was difficult for me to do any of those things. I felt like I just wanted to be in my room alone all day.

I knew in my heart I wasn’t losing my mind, but it was so very hard. Like if you have a headache or a sore throat – You’re ill and you want to go see the doctor. I was ill; I wanted to go see the doctor.

D: The feeling you had was of eagerness and desperation and anticipation of being, of feeling better. What were you thinking at the time? You said that you thought you were maybe losing your mind; what else did you think about making this appointment?

F: Again, I was thinking I was finally going to get something that was going to make me feel better. I can only parallel it to going to a doctor with a bacterial infection. You know you’re going to get an antibiotic and it’s going to make you feel better…The reason – an acquaintance said to me, that really didn’t know my life history someone I worked with, she said to me, and this kind helped me with my eagerness, she said, “You look like me before Paxil.” She knew me to say, “Hey how you doing?” and we worked very well together, we worked in close proximity. But she knew nothing about my life, and she knew nothing about what I was going through. She just knew the physical…

D: What did it mean to you to hear that?

F: That, "Oh my god, is it that apparent? It must be bad."

D: What is "it"?

F: The depression, the anxiety, the illness, so apparent that someone who doesn't really know me can see right through me, can see it?

D: Did that apparency help the process in anyway?

F: Yes, it did. Just because I thought to myself, "This girl doesn't even know me. She doesn't even know what I'm going through and she can pick up that I need help." It must be bad; it must be something that needs to be addressed.

D: Ok.

F: And when she was just so happy and everything else; she explained a couple, "I did this and I did that" [tape bad] I thought, there must be something to this.

D: It seems after you got the prescription, you felt an overwhelming sense of relief as if there was an anticipation of the same effect coming to you.

F: Yeah, and it was amazing. After I took the medication, the whole world opened up to me.

D: That's this down here when you say, "The anxiety was gone almost instantly."

F: Yeah, I was sick for two weeks. I was very sick for two weeks.

D: Because of the side effects?

F: I guess. I could not leave the couch. I was just so nauseated. I actually thought it was a virus. But it wasn't, it was…I lost all kinds of weight. And I was a little off-kilter, too. Like when you turn your head real quick, it felt like it had to catch up. But that went away too.

I was deathly ill the first two weeks of taking the medication with severe nausea. I did not realize at the time the nausea was a side effect. I thought I just had a stomach virus.

D: “The anxiety was gone almost instantly. It was a godsend!” What was a godsend?

F: that the anxiety was gone. Have you ever felt anxiety?

D: Yes.

F: It is hell.

D: Yes.

F: and to not feel it is heaven.

D: “I was able to start thinking clearly and looking at my life with more clarity.” Is that connected?

F: Yes, everything that was muddled became very clear. It was like I had this huge giant light bulb that went off over my head, and it was like, “Ah! Ah!” all these revelations. “Is that why? Is that why?”

D: Can you give me a for-instance?

F: My husband being abusive. I always thought, if I was prettier, if I was better, if I did this or I did that. It was all me, me, me, me, me.

D: “What’s wrong with me?” or “If I were different.”

F: Yeah.

D: and after the “light bulb?”

F: It doesn’t matter how pretty I am, it ain’t going to make a difference. Because it’s not my issue it was his. It wasn’t like all of a sudden. Certain events would come up and I would say, “OK this is why I felt this way.” And I started saying, “Dammit, I’m not allowed to feel this way.” I started to get more of a sense of…I was getting more assertive.

D: Is that why you say, “Over the last three years I have become a lot stronger as a person?”

F: Yes! He would be screaming at me and I would be in a fetal position on the floor, crying – in this very kitchen. It would get to the point where I would think, “I’m just a piece of shit. Why don’t I just kill myself right now?” After the medication, it was like, “I’m not a piece of shit, and I’m not going to let you do this to me, and I have every right to feel this way.”

D: I want to go back one step, when you said about looking about life with more clarity. Is that related to, what I'm thinking of, what was all muddled up was being lost in the, "what's wrong with me" kind of thing.

F: And in the insecurity. I was very, very insecure. I was so afraid of Walt leaving me, I'd have extreme anxiety and have to keep him by me. I don't know if that was a side effect of the abuse – you know, women get clingy. I don't know if it was that, and the anxiety went right along with it.

D: Feeling and thoughts afterwards: "I have been able to set limits with my husband and stick by them; my self-esteem has grown". Is there anymore to that than what you've already said?

F: Yes, in that I'm going a step further. I'm working on that now, on…that becoming second nature and I don't have to emphasize that so much. It doesn't have to be said, it's just the way I live my life. I'm trying to have more empathy for others…. I live my life.

D: These last things, "furthering your education, making the honor roll" are other ways that you are living your life better now? You've been making your life better?

F: Yes… I've even made it into a nursing honors society, Sigma Theta Tau.

D: Congratulations. These are the achievements you're making for yourself that have followed from the gains that you have made from treatment.

F: Exactly.

D: How do you think making these achievements would have been if you had not been in treatment?

F:I don't think I could have because I wouldn't have been able to concentrate at school, y'know, when I had everybody here, there was a lot to do. And then to go to school.. I don't think I would have been organized enough to be able to do it. And the anxiety, y'know, of … I used to have anxiety attacks just thinking about "Oh my god, I have to have the dinner done, and the clothes washed, and this one needs this and that one needs that… and to put school on top of that, I wouldn't have been able to do that. Now I can.

Meaning Units: "Felicity"

1. S.'s experience emerges out of long history that S. has come, retrospectively, to understand as depression. Suffering and depression manifest as [poor academic performance, frequent absenteeism, lack of interest]; feeling of aloneness and feeling hopeless, sad, boredom and frustration.
2. S.'s history of suffering becomes grounds for teen alcohol and drug use in an effort to soothe or palliate the suffering (detailed in #1). Substance use has the effect of insulating and distancing S. from suffering.
3. S. has first experience in counseling at age 17 to address issues of grief relative to death of S.'s father
4. S. becomes confronted with the demands of an infant son, an autistic child, and the difficult, painful struggle of marital separation and impending divorce. S. begins to talk with a counselor (whom she'd previously spoken to informally) in an increasingly formal, regular fashion.
5. In being confronted with high demands in her relationship to her children and with suffering in the breakdown of her marriage, S. experiences feelings of extreme duress, significant weight loss and serious disruption of eating along with increased smoking and caffeine use.
6. Counseling presents itself to S. as a resource that offered support through her struggles and held the promise for S. of abating painful feelings and encouraging (improving) a return to better eating, decreased crying, and the ability to face the demands of single parenthood. This also includes a return to having the capacity

to move toward a promising future. S. continues therapy with a series of therapists over the next (approx.) twelve years, which continue to be helpful.

7. After her first divorce, S. experiences a time of increased happiness and personal accomplishment. During this time, her confidence and self-esteem grow.
8. S.'s second husband physically abuses her beginning 1 year into their marriage, while she was pregnant with her third child, continuing for 7 years until stopping 3 years ago. S. continues therapy.
9. S. experiences increased depression and anxiety as abuse is unabated. S. experiences increased crying, decreased concentration and ability to parent her children, insecurity and a plummeting level of self-esteem. This culminates in S.'s feeling overwhelmed and inability to function.
10. S. begins to suspect that she was possibly becoming seriously mentally ill, though this notion does not take root.
11. S. encounters an acquaintance who identifies S. as depressed bearing despite having the lack of personal knowledge of S. S. experiences herself as depressed/anxious/ill in a way that was undesirably visible to others. S. realizes that despite her efforts, she is not able to conceal her suffering, though she thought she had.
12. S. assesses the import of her own visibility and discovers that her inability to conceal her suffering is unacceptable. S. resolves to see a psychiatrist to address this.

13. S.’s counselor, who S. respects and experiences as helpful and caring, recommends that S. see a particular psychiatrist. Based on S.’s positive relationship and trust in the counselor, S. makes and keeps this appointment.
14. S. realizes that seeing a psychiatrist will involve taking medication. S. is surprised she hadn’t considered it herself earlier. S. begins to feel eager, even desperate, and anticipates feeling better. S. feels that seeing the doctor will bring this about.
15. S. sees psychiatrist while in an agitated state. S. experiences psychiatrist as: concerned; sympathetic; as relating to S. attentively and with care.
16. S.’s initial positive experience of the psychiatrist is followed by the psychiatrist’s suggestion for medication. S. accepts with thanks.
17. Psychiatrist offers continued efforts and assistance if original prescription should turn out to be ineffective.
18. S. experiences a sense of great relief after receiving the prescription an that S. perceived the medication as help.
19. S. experiences increased eagerness after receiving the prescription, even before she has it filled. Based on her experience working as a nurse, she sees the medication as helpful. Eagerness involves anticipation that her suffering is going to decrease and/or stop.
20. After taking the medication, S. experiences, despite physical side-effects, positive results and also a subsequent increase in feeling relieved. With this increase comes also a greater sense of openness and ability to engage the world more freely.

21. As her suffering decreases, S. also experiences an increased level of positive self-esteem and self-security.
22. S. finds herself free of much of her suffering and in the process becomes able to look at her life and see therein what had previously been unclear. One of the most significant manifestations of this is S.'s ability to see that she does not deserve her husband's abuse. She comes to see his abuse as a fault of his, no longer as hers.
23. Instilled with newfound clarity on her life and increased personal strength and self-esteem, S. becomes able to make and maintain concrete changes to improve her situation, most especially with regard to setting limits with her husband.
24. S. experiences, for the second time in her life, a period of increased happiness and personal accomplishment. During this time, her confidence and self-esteem grow. She finds herself able to meet the many demands of her children, her education and career and of her life.

Situated Structure: “Felicity”

The Preliminary Circumstances and History

F.’s experience emerges out of long history (beginning around 9 years of age) of suffering and difficulties that she has come, retrospectively, to understand as depression. Suffering and depression manifest as themselves in this understanding as: her poor academic performance, frequent absenteeism, and lack of interest in school; feelings of aloneness as well as hopelessness, sadness, boredom and frustration. F. sees herself as unloved, uncared for, disregarded and without another to share her feelings or thoughts. F.’s history of suffering becomes, when she is a teen, grounds for her use of alcohol and drugs in an effort to soothe or palliate the suffering. Substance use has the effect of insulating and distancing her from her suffering and allows her to eliminate the loneliness and isolation from others by the social use of drugs and alcohol, which serve as a point around which to gather with others.

Following the occasion of to death of her father, F. has her first experience in counseling at age 17 to address issues of grieving and of her previous suffering. The counselor suggests at some point that she explore her body by looking at her naked self in the mirror and F. is disillusioned and dissatisfied with this suggestion. It is an unpleasant experience for her and she doesn’t return.

Later in her life, F. becomes confronted with the demands of an infant son, an autistic child, and the difficult, painful struggle of marital separation and impending divorce. Through a coincidental encounter, she begins to talk with a counselor, first informally, and then in an increasingly formal, regular fashion. This relationship carries the possibility for F. to relate to another person about those things which are most important and of greatest concern to her, including the parts of her life that hold suffering and pain. This counselor is an other with whom F. can be herself.

In being confronted with high demands in her relationship to her children and with her own suffering in the breakdown of her marriage, F. experiences feelings of extreme duress, significant weight loss and serious disruption of eating along with increased smoking and caffeine use. F.'s suffering in relation to her relations with others in her world and with the projects of her life (i.e. being a mother, being a wife, etc.) manifests itself in: the way F. finds herself emotionally; the way her body diminishes (as she becomes less, becomes smaller) in relation to her own care and feeding of herself, including her use of stimulants.

Ongoing counseling presents itself to F. as a resource that offers to support her through her struggles and holds the promise for F. of abating painful feelings and encouraging (improving) a return to better eating, decreased crying, and the ability to face the demands of single parenthood. This also includes a return to having the capacity to move toward a promising future. She continues therapy with a series of therapists over the next (approx.) twelve years, which continues to be helpful.

After her first divorce, F. experiences a time of increased happiness and personal accomplishment. During this time, her confidence and self-esteem grow.

F.'s second husband physically abuses her beginning after about one year into their marriage, while she is pregnant with her third child, and continuing for 7 years until stopping 3 years ago. F. continues therapy during this time.

F. experiences increased depression and anxiety as abuse is unabated. F. experiences increased crying, decreased concentration and ability to parent her children, insecurity and a plummeting level of self-esteem. This culminates in feeling overwhelmed and unable to function, both for herself and her children. She also begins to believe she might be deserving of the abuse she is receiving, either because of some flaw in herself or some shortcoming or failing of hers.

After continued abuse, F. begins to suspect that she was possibly becoming seriously mentally ill, though this notion does not take root.

F. encounters an acquaintance who identifies her as depressed bearing despite having the lack of personal knowledge of her. F. experiences herself as depressed/anxious/ill in a way that was undesirably visible to others. F. realizes that despite her efforts, she is not able to conceal her suffering, though she previously thought that she had.

The Decision to Seek Help

F. assesses the import of her own visibility and discovers that her inability to conceal her suffering is unacceptable. F. resolves to see a psychiatrist to address this. Her counselor, who she respects and experiences as helpful and caring, recommends that F. see a particular psychiatrist. Based on her positive relationship and trust in the counselor, F. makes and keeps this appointment.

At the time of resolving to make the appointment, F. realizes, for the first time, that seeing a psychiatrist will involve taking medication. As she is a nurse and is around medication all the time, she experiences surprise that she hadn’t considered medications as a possibility for herself earlier. F. begins to feel eager, even desperate, and anticipates feeling better. She believes that seeing the doctor will bring this about.

F. sees the psychiatrist while she is in an agitated state. She experiences psychiatrist as: concerned; sympathetic; as relating to F. attentively and with care. Her initial positive experience of the psychiatrist is followed by the psychiatrist’s suggestion for medication. F. accepts the prescription with thanks. Psychiatrist offers continued efforts and assistance if original prescription should turn out to be ineffective. F. experiences a sense of great relief after receiving the prescription. She perceives the medication as help.

After the Prescription

F. experiences increased eagerness after receiving the prescription, even before she has it filled. Based on her experience working as a nurse, she sees the medication as helpful. Her eagerness involves anticipation that her suffering was going to decrease and/or stop and also that she will be able to take up the project and relationships of her life with renewed hope and possibility.

After taking the medication, F. experiences, despite physical side effects, positive results and also a subsequent increase in feeling relieved. With this increase comes also a greater sense of openness and ability to engage the world more freely. As her suffering decreases, F. also experiences an increased level of positive self-esteem and self-security.

F. finds herself free of much of her suffering and in the process becomes able to look at her life and see therein what had previously been unclear. One of the most significant manifestations of this is F.’s ability to see that she does not deserve her husband’s abuse. She comes to see his abuse as a fault of his, no longer as hers.

Instilled with newfound clarity on her life and increased personal strength and self-esteem, F. becomes able to make and maintain concrete changes to improve her situation, most especially with regard to setting limits with her husband and stand by them. She experiences, for the second time in her life, a period of increased happiness and personal accomplishment. During this time, her confidence and self-esteem grow. She finds herself able to meet the many demands of her children, her education and career and of her life.

Appendix C: Data and Analysis ("Amy")

Protocol 3: "Amy"

a) In the spring of this year I had on several occasions physical "things" happen to me that scared me. One time my tongue started tingling and became partially numb. I also felt like I couldn't talk.

Another time my right arm felt "detached". I was looking at it and wasn't aware of it. It was very strange. I became scared because my paternal grandmother's side of the family suffered from strokes.

The spring of this year was a difficult time for me. My husband and I weren't getting along at all, constantly fighting, and I was considering moving out of our home with our two kids. Also I was working a nearly full time schedule as BSC in a human services agency, dealing with families and individuals with all kinds of difficult backgrounds. My schedule was fit around my kids' school timetable, meaning that I spent several nights a week catching up on my paperwork and reports. I didn't sleep enough, had stress at work, at home, kids that needed me to be stable and a husband that was not only not supportive but contradicted a lot of my efforts.

I am trained in professionally dealing with stress, but this was too much. I knew I was burning the candle at both ends but hadn't realized that I couldn't handle it anymore the way I had been able to the years before. I was very sad about the fact that I wasn't receiving the support I thought I deserved.

I went to the doctor expecting the worst, physically, like finding out that I had in fact suffered a mild stroke, that my heart was not working properly or that my blood work would show something scary. I did not expect to be given a prescription for psycho pharmaceuticals.

b) At the first visit the doctor took a lot of time and listened to all my physical concerns and had the tests done that would show if my worst fears were true. She didn't think they would be. She touched my neck and felt that I was very tense. She said it is possible that the symptoms with my arm, my tongue and language could come from being very cramped in the neck shoulder area. She prescribed a muscle relaxer and ibuprofen at prescription strength for two weeks. She wanted to see if the symptoms get better with this treatment.

I know from previous back pain that it is important to take pain medication in order to release pressure on nerves that might be pinched and agreed to go along and give it a try.

During those two weeks I took the medication until I was certain - from the test results and the effect of the drug - that in fact I was responding to "loosening up". After that I used **all** techniques that I know for deep relaxation. I started taking the prescribed medication less.

When I went for my second visit after two weeks the doctor told me she was not concerned with my blood pressure and heart and brain blood circulation. In fact she said I was doing fine. She was more concerned with the fact that she thought I couldn't handle my life's stresses and needed to take good care of myself. I took that very seriously. I had kind of started thinking in that direction. Like having to make some changes in the way I was doing things.

She then proceeded to give me a prescription for a medication that one of my 12 year old clients was taking. An anti-depressant. I immediately said there was no way I would take that. She then changed the name and told me about the benefits of becoming more emotionally stable and being able to make it through a hard time better. She said it wouldn't be for a long time, just to get my on my feet again.

When I kept declining she gave me the prescription anyway and said that I should call and could call any time and just talk to her. I felt very comfortable with the way she told me the information. She wasn't intruding at all. She was very genuine and I believed everything she said. I also know that she didn't say it all and I wasn't interested in further talk with her. I took the prescription but didn't get it at the pharmacy.

c) I have already elaborated about my view of the whole thing above and will summarize here:

When my doctor proceeded to give me the prescription I was certain that I wouldn't take it. I believe in having to make changes when my body "tells me that something is wrong" by means of symptoms. I had begun to think about my life during the two weeks of treatment with the muscle relaxer. I wasn't done thinking because the consequences I needed to think about included possibly separating from my husband.

As far as anti-depressants go I am not interested in taking anything "mind altering". I can't stand drugs. I need to be in control and if I can't be I need to remove myself from the situation that causes me trouble. I am not sure why I took the prescription at all. I think I may have thought that if I really separate things might get so bad that I would maybe change my mind. That is the picture the doctor was painting without saying it in so many words. I think that she thought it wouldn't have to be the worst in order to want to be stabilized. I am pretty certain though that that would be the only situation ever: A short relatively overseeable period where I just really need to keep my senses together. That is in my eyes a paradox. Keeping my senses together I can only do when I know what is right. I will never need substances for that. I do believe in healthy nutrition and sleep and exercise.

That is exactly what I did. I took better care of myself, did what I know to be right for myself and withdrew from as many conflicts as possible while sticking up for myself strongly. I also talked to my closest friends who were very understanding and helpful. I realized that I wasn't crazy, others agreed with me that things at home were not supportive the way they should be. I am still with my husband and the situation has only improved a little. We have not at all figured out our differences and come to livable agreements. I continue to be unhappy about that and know that I will not tolerate too much grumpiness per time unit. I am not sure I will continue this forever. I am sure I will never take medication just to live with a grumpy man. I know of a friend who takes Prozac and now just laughs about her husband's complaints. That seems very wrong to me.

Protocol Interview: “Amy”

D: So… “In spring of this year, I had on several occasions physical things that happened to me, things that scared me.” This is the first part here. These are things that follow from it: the tongue, couldn’t talk, the thing with the arm. “I was looking at it and wasn’t aware of it.” These are preliminary things, and these sort of set the stage?

A: Right…

D: … for what we are about to talk to in the sense that…

A: At that point, it felt all physical.

D: OK. So… “The spring of this year was a difficult time for me…” “My husband and I weren’t getting along at all, constantly fighting, and I was considering moving out of our home with our two kids.” This is the next part is… In other words, this ends up being….

A: Explaining stress?

D: “I am trained in professionally dealing with stress, but this was too much.” Can you say more about “too much”?

A: It went past the point that I could deal with it. I didn’t have, the, you know…

D: When you say here, “I was burning the candle at both ends but hadn’t realized I couldn’t handle it…” Could you speak a bit to how you previously handled it and how that was somehow [different]?

A: I think of it like a pitcher with a lot of liquid in it, with that being all the energy. You dump it out on the kids, a cupful for the kids, a cupful for work, a cupful for maintaining household... which isn’t easy [laughs]…When I was in school, the papers I had to write. Parents, grandparents, people who wanted stuff from me. The pitcher was always refilling itself. There were other things, like fun events, nights off where I was hanging out with my friends. Or even here, after we moved here, and I had a friend here, I could take the kids over there, and we were just hanging out. I just left a lot, avoided a lot of complications.

D: Once you started working this different job, and was it at the same time that –

A: That my friend moved away, so I didn’t have her anymore.

D: And also at the same time that things began to get difficult with your husband?

A: No, they were always the same [difficult]…The more that I think about that, to put it in the framework, I think the problems that he's having…When I leave him on those days, and leave him with his own troubles, everybody's better off. If I stay and try to make it better, it just gets bad for everybody. Even after I typed this [the protocol], I started doing that again, I'd just leave for the weekend. Leave in the morning; come back at night. If I stay here, try to get housework done; we're just fighting all day. It's just terrible.

D: "Feeling sad about the fact I wasn't receiving the support I deserve." Is that also connected to the pitcher… uh… the pitcher being empty?

A: Yeah, and being past the point where I could replenish my energy.

D: The next thing is, "I went to the doctor expecting the worst, physically, like finding out that I had in fact suffered a mild stroke, that my heart was not working properly or that my blood work would show something scary. I did not expect to be given a prescription for psychopharmaceuticals." Ok… wait… those seem to be two different things.

A: I really thought something was just wrong with me.

D: Can you say a little bit more about that? …especially the decision to go to the doctor.

A: The first time the thing happened with my tongue, my tongue went numb, it was just something that went away, and I could've ignored it. Then a few months later, it happened again, and then relatively shortly after, a third time. It just got scarier the more often it happened. It wasn't a pattern, but it seemed to get closer and closer together. I definitely thought it was something physical. Like something was actually needing some..

D: So when you went to the doctor, you were just expecting a physical diagnosis?

A: Yeah.

D: And you were expecting a diagnosis in those terms because of your training in psychology or your knowledge of…?

A: Pretty much because of my grandmother dying from strokes. And my whole father's side of the family having gone that direction with things. It had nothing to do with my training.

D: "at the first visit the doctor took a lot of time and listened to all my physical concerns and had the tests done that would show if my worst fears were true. She didn't think they would be. She touched my neck and felt that I was very tense. She said it is possible that the symptoms with my arm, my tongue and language could come from being very cramped in the neck shoulder area. She prescribed a muscle relaxer and ibuprofen at prescription strength for two weeks."

A: It was in fact physical, but it wasn't the worst I had feared. I'm very critical with doctors. It takes [a while] for me to believe it, and when I believe it, I still make up my own opinion, if I need to take that [the medication] or not. I still have some of that prescription; I didn't use it all up.

D: The medication we're talking about here is a muscle relaxer?

A: Yes.

D: During those two weeks I took the medication…"

A: "…until I was certain"… that I was in fact loosening up.

D: "…from the test results and the effect of the drug - that in fact I was responding to "loosening up." "After that I used all techniques that I know for deep relaxation. I started taking the prescribed medication less." Can you tell me a little bit about "loosening up"?

A: Those cramped muscles…. What had happened with my arm was that the nerves in my arm were pinched from the cramping in my neck. I did in fact get numb. It was not because I had a blood clot somewhere in my body – thank god, knock on wood – but it was not happening anymore because I didn't have the cramped shoulders anymore.

D: [The medication] was actually showing positive effects in decreasing the things you went to see her for.

A: Yes.

D: "I started taking the prescribed medication less." Can you say more about that, please?

A: I don't think I really took it that much anymore at all. Maybe when I noticed I was getting tight. I became a lot more aware of how tight these muscles are – I don't know what they're called, the muscles where your shoulder hangs from your neck...Instead of sitting like this I was sitting like this – I constantly held my shoulders about two inches above where they should be…I didn't take the medication anymore unless I had a headache. I noticed that I get a migraine – which I've always had since I was a teenager and which has never troubled me, and has always responded to medicine very quickly without a lot of trouble. I noticed I was getting those much more severe. They were not responding to the aspirin I used to take for them; they were responding to more medication. I was not fine. I was getting making it through my usual day for three days in a row, but I was not good. I used to be a little out of sorts, but not for three days. After this, that also got better. When I get discomfort, like from a migraine, I get tight. I respond with my shoulders being pulled up.

D: "When I went for my second visit after two weeks the doctor told me she was not concerned with my blood pressure and heart and brain blood circulation. In fact she said I was doing fine. She was more concerned with the fact that she thought I couldn't handle my life's stresses and needed to take good care of myself." She expressed these concerns to you?

A: Yes. So far I agreed with her.

D: Yes, "I took that very seriously." That's part of the same thing? "I had kind of started thinking in that direction. Like having to make some changes in the way I was doing things." Can you say a little bit more about, "I had kind of started thinking in that direction?"

A: Well, the "kind of" means I had stopped thinking something physically wrong with me. In those two weeks, as I was responding to the medication that I started taking, I was thinking, if I'm really that tight then that's why I'm having these symptoms, I'm really going to have to start making some changes. I can't keep taking 600 mg of ibuprofen and a muscle relaxer on a regular basis. I don't know how long that will work.

D: It sounds like you're making a connection there, like you crossed something off the list and you're moving on.

A: Right. Exactly. I hadn't heard from her yet that I was fine, until the second visit. I had kind of thought since they didn't call me with bad news that I was probably OK. But after she said it, that's when I was able to put it into words.

D: "Bad news," like meaning there's something wrong with your blood work?

A: Like she would say, "You have to take this medication right away because there's something worse coming your way." If she thought I might have had blood clots or, you know…She said right away that if I had had a mild stroke, I would not have been able, that things would have been a lot worse, that they [strokes] don't come in those mild doses.

D: But during those two weeks as the medication starting working on those symptoms…

A: I thought, all right, I'm probably not suffering from strokes here; I'm very tight, very tense. It was easy to say that was the case and that I have to do something.

D: So when you say "the way I was doing things" is that also the same as what you said earlier? In other words…

A: Refilling my pitcher? Having more fun in my life? Yeah, caring better for myself.

D: Taking better care of yourself, managing your life. With all these other concerns…

A: Closing my ears like my kids can when I speak to them. So the stuff I can't deal with, that are not changeable, I'm not hearing them.

D: The things you're talking about are your job, your husband, your kids, and your home, all of those concerns.

A: Yeah. My job I had under control; my kids I most likely had pretty much under control. The thing I couldn't control was if my husband was on the happy side or the sad side, and if he was on the sad side, there was nothing I could do. That's what I am seeing more and more; especially lately…I just have to get away. I should probably point out to him that he needs to do something. I'm also going to see.

D: "She then proceeded to give me a prescription for a medication that one of my 12 year old clients was taking. An antidepressant." Ok.

A: Tell me a couple, and I'll tell you which one it was.

D: Well… uh…there's Prozac, there's Paxil… there's….

A: Paxil.

D: "I immediately said there was no way I would take that. She then changed the name and told me about the benefits of becoming more emotionally stable and being able to make it through a hard time better. She said it wouldn't be for a long time, just to get my on my feet again."

A: She seemed very pharmaceutically strong. She did not insinuate or hint at anything else I could be doing. She was basically pointing out that what she thinks I need.

D: "When I kept declining, she gave me the prescription anyway and said that I should call and could call any time and just talk to her. I felt very comfortable with the way she told me the information. She wasn't intruding at all. She was very genuine and I believed everything she said. I also know that she didn't say it all" … "didn't say it all?"

A: "Didn't say it all.'

D: "Didn't say it all and I wasn't interested in further talk."

A: Yeah… she knew that I wanted to stick with information, that I didn't want to have a much deeper conversation. There were some things she didn't have to say.

D: Like what?

A: Like, You need to take better care of yourself. She stuck with what could be helpful for a hard-head like me, by taking something that's going to stabilize things emotionally.

D: I'd like to talk about when you say "I went to the doctor" the first time. How did you choose this doctor?

A: My neighbors recommended her to me. I had a different doctor who did a work physical for me, and I was not impressed. I was not impressed at all. And I know they [my neighbors] have all kinds of situations with allergies and a bunch of stuff that they have to see doctors regularly. And I had a good experience with their recommendation before.

D: And did your experience with this doctor confirm your neighbor's recommendation?

A: Totally. I mean… I don't expect to see a doctor and get answers of stuff I don't know. I just expect them to kinda be like a car technician. I understand how a car works. I'm not a mechanic so I don't know how to fix it. But if they tell me it's this or that, I know if what they telling me is B.S. or if it's somewhat realistic. So I have a high expectation of them telling me stuff and they already know, from how I respond, that I understand a whole lot of stuff and how things are working. So... um… if they're telling me as far as... those… those… like the stuff that's in bananas that makes you happy… [laughs] you know… I mean, there's things that make you feel good and there are things in life that make you feel bad, and you can do stuff about how you feel… I have a lot of understanding about things and I don't expect them to miraculously tell me exactly what's wrong with me.

D: When you say here, "I've already elaborated my view of the whole thing…" in what whole thing? You mean the whole experience, the whole moment?

A: Well…"And I will summarize here." When I got the prescription, I knew I wouldn't take it. When there is something wrong in my body, I believe I have to make changes in my life. Because my body has problems, the purpose of that is to tell me I have to do something differently. To use a chemical and to continue on cannot be the right answer.

D: In other words, you understand these problems as emerging from things in your life?

A: Absolutely.

D: “I had begun to think about my life during the two weeks of treatment with the muscle relaxer. I wasn’t done thinking because the consequences I needed to think about included possibly separating from my husband” The consequences were…

A: …the changes were getting a major stressor out of my life…What I didn’t mention in there is that I didn’t think I was going to be able to continue with the job I had the way I was having it. I was working on a very flexible schedule, which is great to spend the daytime with your two-year-old child, but it’s rescheduling every hour you’re going to make ends up overwhelming, sometimes. Missing hours and having to explain everything, or not working, and not getting paid. That’s the other option: canceling and not getting a penny.

D: When I’m asking about your thoughts and feelings beforehand [before receiving the prescription], part of your feelings were that your problems were initially physical.

A: Yes.

D: Those were thoughts or beliefs?

A: It was really fear. I was really in fear that something [was wrong]. I was thinking, “what if I have strokes?” I’m such a thinker, and [doing] the work that I do, you have to really get into the people. It’s not like I’m just putting stamps on the paper and forwarding them. I have to really look at the people and observe and understand and put it in context with what I know about them. I understand other people all the time. So I need my head. If something were wrong with my head, I wouldn’t be making a penny anymore. I’m thinking, “What am I going to do if I can’t make money?” I’m thinking if my whole life ends here as far as my choices, if I can’t be a mother to my kids. That’s a big ball of fear. That’s a big mass that’s unspecific.

D: And these are the feelings you had prior to the prescription?

A: Yes, prior to the first visit [to the doctor]. I was already a lot relieved after the first visit, even though I was not sure at that point because the blood work hadn’t been done.

D: As you go through the first visit into the two weeks when the original prescription for muscle relaxers starts to decrease the symptoms you’re having and you start to, as you say, “change your thinking” that things are going to be maybe leaving the physical and into the realm of the psychological or the interpersonal.

A: Right. The emotional stress I hadn’t put into perspective before.

D: At the moment that you’re given the prescription, can you tell me at that moment when she hands it to you and she says…

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A: When I saw the word “Paxil”, I’m like, “No way.” [laughs] I’m not taking that.

D: Can you tell me how that felt?

A: I thought: this is ridiculous. This is not going to…no way.

D: You felt resistant to the idea?

A: I felt like laughing. I’m like, come on already, I work with people who take this. I’m not going to take this myself. How am I going to do my job thinking I can tell people what to do or I can direct them in the right direction if I’m taking the same medicine they’re taking?

D: That felt funny … or absurd?

A: Absolutely absurd… on the funny side of things, even though it’s not a funny context, but I’m like, no way.

D: Are there any other feelings that go along with that, with that particular moment?

A: It was interesting that she prescribed me the exact same name that my client was taking. Where if she had prescribed me Prozac, I would have probably thought of Lady Di and paparazzi, or whatever. I’m pretty sure I would not have taken it either. But it wouldn’t have had the same absurdity.

D: So it felt almost unreal?

A: It felt very real, but it felt very real like, “What am I doing here? This doctor’s not going to tell me what to do.”

D: Was that part of the feeling, that you were being asked to do something you didn’t want to do? Maybe not “compelled,” because she didn’t know it was something you didn’t want to do…

A: She was so very nice; I would have never felt negative about her. I was very firm. I would have never gone that way, and I will never go that way.

D: But you did take the prescription from her?

A: I think it was mostly because I was doing here a favor.

D: She was nice.

A: Very nice.

D: Which is interesting because this is a person you encounter who is asking you to do something that you very strongly feel against doing, and yet you are able to maintain a…

A: She's just doing her job. I've had similar things with doctors before. I don't want to have tests done; I don't want to have this done. I've gone through two pregnancies; I've gone through a life-threatening situation after the first birth. Believing what doctors tell me is not in my nature after that, for sure…I really have, after all my complications, which has nothing to do with this, I've started seeing doctors as mechanics. When you go, they will tell you a way to get out of it, but that doesn't necessarily mean that's the answer. You know when your car breaks down, they always do something, they always charge you for something. But that doesn't mean the car's going to run.

D: Let me ask you this: Is that a thought or a feeling that you had afterwards that sort of reaffirmed the "doctor as mechanic" thing after you left?

A: Sure.

D: In other words "she's just doing her job" in part, means, "she's just being that mechanic?"

A: Yes. My kids are six and a half and three and a half, and neither of them has ever taken antibiotics. But if I were to put all the prescriptions into a cabinet in my kitchen, it [they] would fill at least one and a half of them. All this amoxicillin you get for every little cold – it's ridiculous. My daughter would be on asthma medicine, my son would be on cortisone for his skin. Neither of them have anything

D: "As far as anti-depressants go I am not interested in taking anything 'mind altering'. I can't stand drugs. I need to be in control and if I can't be I need to remove myself from the situation that causes me trouble."

A: When I said drugs there, I didn't mean medical drugs. I meant illegal drugs.

D: Oh…ok. "I think I may have thought that if I really separate things might get so bad that I would maybe change my mind."

A: I had almost forgotten about that sentence. There is a possibility. I have seen friends go through the actual divorce, and…um… where things have been bad, and they have separated, things were getting much better, and then they were confronted with situations, and things get really, really bad. I think that possibly that might play a role. I was thinking, "I might have to get through something really, really tough."

D: So there is a situation or a context where you might…

A: I don't think so. I really don't think so. But it was a possibility that I thought that when I took the prescription.

D: It was on the table as a possibility, as a very unlikely and extreme possibility, maybe?

A: You know how sometimes you think things that you don't really think, but they're somewhere in the back of your head as a possibility? That's how far removed it was. It was not a clear thought of mine.

D: Ok.

A: You know when you're walking up steps, and you know you're doing the right thing as you shift/ walk? You what to do but you don't think it? It was like that.

D: Ok. "That is the picture the doctor was painting without saying it in so many words." "That" meaning, "things getting so bad?"

A: Yeah…No, you can leave the "that" away. "I really thought if I really separate…" That's what she was insinuating.

D: You thought that she thought it wouldn't have to be extremely bad in order for you to want it to be stabilized. Whereas for you, it would have to be the absolute worst, it's so far remote of a possibility.

A: The deciding question is can I be a parent to my children, or am I just going to be a crying, sobbing person who can't get out of bed. I can't see myself ever getting there, but who knows? I don't want it to go that far. But the doctor was clearly insinuating that. I know, just looking back on my story, a lot of people would have been divorced a long time ago. I don't know why I'm not. I kind of think I'm not because the problems have nothing to do with me. I'm just constantly swimming in them, swimming upstream, trying to deal with someone else's problems.

D: Does that connect to this sentence at all, about needing to be in control?

A: You mean I'm in a situation where I can't control what's going on with my husband? Yeah…I can decide if I let it get to me or not. That's my control. I can't control his problems. Some wives might try to do that, but I've decided I'm not going in that direction for a minute.

D: I'm trying to understand, now, this part here…

A: You know what…I take that back, because I used to be that way. I used to just go (leave). And now I've been hanging around a lot more, and I get a lot more of the beating. Not a literal beating.

D: Used to be what way?

A: Gone. Away. I used to be in school, I used to be here and there. We used to only have one child, and then. I used to just be… um.. not in the line of the fire the whole time.

D: You used to not be around all the time

A: I used to avoid…

D: There was a lot less conflict.

A: Yeah. I think I learned early on in my life that other people's problems are other people's problems. I still have enough of my own; I don't need other people's problems on top of mine. Unless I choose to ask them about what's going on.

D: You say, "As far as drugs go…" both prescription and illegal…

A: I can't stand them. I don't like anything that's mind altering, something that might make me drowsy – I don't like any of those things.

D: Is that what you mean right here in the next line when you say, "I need to be in control?"

A: Yeah.

D: Being in control of…?

A: How I'm doing, how my body is doing. I can't stand when something happens to me and I don't know why. Like you take a pill and you don't know what it's going to do to you? I know what a glass of wine is doing to me. I know what ten glasses of wine are doing to me. And that's my choice. But if I take something that I don't know what it's going to do. One day…I don't know what things are out there. You can take something that's going to make you sad one day might make you crazy the next…I can't let go and enjoy the ride.

D: Like you could with the glass of wine?

A: I know what the ride is going to be. There're no surprises with wine.

D: Just hypothetically, if the doctor had explained to you exactly what was going to happen, what it would feel like [to take the medication] would it have been any easier?

A: To take it? I don't think she would have even attempted because she already knew it was no option…. No, I don't think so.

D: Ok.

A: I think that's the way I'm going to have to go when things get really tough. I'm going to have to really know what exactly is going to happen, how long to I have to take it, do I have to take it forever, can I just take it for a panic attack, do I have to take it daily?

D: It sounds like there's some element of mystery in it for you.

A: Totally. Every person I've ever met who takes something like that, like Prozac or…well anyways, they don't know why or how [it works]. Nobody's ever been able to explain to me what exactly happens. Any medicine I've ever taken, or given to my kids, I've got some understanding of how they work. I've always been more into the mechanical aspects of medicine. This is doing that. Say you're using an expectorant when you have a head cold, and you know what it does. It breaks up the sulfur connections in the slime in your body, so it can get washed out. It's not a mystical thing that someone puts on my nose that's going to make it go.

D: And Paxil?…You're reiterating all this in the text here. "I am pretty certain though that that would be the only situation ever: A short relatively overseeable period where I just really need to keep my senses together. That is, in my eyes, a paradox." In other words… the paradox of "Keeping my senses together I can only do when I know what is right. I will never need substances for that. I do believe in healthy nutrition and sleep and exercise." Is that [healthy nutrition, sleep, exercise] an additional thing? Or is that connected to…

A: If you're in a torture camp where people really twist your mind where you have to fear for your kids safety, and you have to do something that's very wrong to keep them safe. Or let something happen to you so they don't get that.

D: It would be some kind of very deep compromise on your part to take medication, a compromise of your own integrity?

A: Exactly, and that's why it wouldn't happen. That's the paradox. It would kind of mean that I'm not…mostly realizing that there was so much stress that my physical, my actual body was giving up, that was best step I could do. It put the emphasis on, "I have to do something to do that [stay healthy]." Healthy nutrition, sleep and exercise.

D: And is this also when you were talking about "in those first two weeks I used all the techniques that I know…?"

A: Yes.

D: Self-care. "That is exactly what I did."

A: Right. I've had, through two pregnancies, and several operations, I've learned other relaxation and muscle techniques than other people know.

D: This is interesting because not all the problems are resolved. Although they were in a way; you and your husband haven't "figured out your differences and come to livable agreements." "You say," I continue to be unhappy about that and know that I will not tolerate too much grumpiness per time unit."

A: He knows he can't piss me off too much or things are going to get really terrible. I don't let him do that too much.

D: "I'm sure I will never take medicine to just live with a grumpy man."

A: This is the example of one of my best friends. She is not very happy with her relationship, and she blames it on PMS. She's been taking the medicine and she's been taking it for months, says that's helping her maintain her relationship. And I just think if you're that grumpy, you have to do something.

D: Let's go to: "That's what I did…I took better care of myself, did what I know to be right for myself… I also talked with my closest friends.." This, "I realized I wasn't crazy…"

A: What was happening a lot was to realize that my view of the things going on was not distorted. I know with every conflict, both sides have something to do with it. That part…when I talked to my friends…some people might say, "Oh he just stinks, he's just terrible." That's never been my point. My point has always been, there's a problem with him that he's not facing; there's something that he's not working on with his goals in his life and his happiness based on his achievements, and those kinds of things, that he's letting [taking] out on me. I really found in talking to my closest friends and some strangers, some professionally related people, that that's really the case. It confirmed my observations that he's a lovable man, he's done some great things, but he also has some severe problems that are radiating over to my life in a way that they shouldn't. That's my problem; that I can't let that happen to me.

D: On one hand you have this marriage, that you do value; on the other hand you have your own self, which you value too, and you want to protect from this very thing that you are talking about. So my question is at this point, the things for which the doctor wanted to give you the Paxil, it sounds like…can you talk about how that has changed *or* not changed… or changed *and* not changed?

A: The reasons she wanted me to take it? I think she was worried that I would lose it right away; that I would lose my normal ways; that I would get out of control. I don't think she could guess or even be responsible as a doctor, and not give me that thing that I might not make it, that I might not be understanding enough to take better care of myself.

D: Was the tightness in the shoulders and everything, was the only manifestation of this, "I was very sad"? I guess that's what she was prescribing for, was the experience of sadness, as it was depression.

A: Yeah, isn't muscle tightness also [a symptom of] depression? The way I've been reacting to things, I've not gotten to my life to the point where I don't think there's something I can do. As long as I can think that way, I'm not thinking of myself as depressed. There may be minutes or hours where I am low, that I'm not on a high or a balance, but I think they're healthily low. Because they help me understand the parts that hurt over being, or giving into that completely and being sad and not getting out of bed anymore.

D: Is this in the same way you said, "When my body gives me symptoms…?"

A: In a very simple way, when you get tired, you need to go to sleep. That's a very basic one. When you get hungry, you need to eat. When you get worn out, you need to rest. When you get --

D: …sad…

A: When you get sad and depressed, you might have to make sure you get more fun into your life… on top of the other stuff. But that's not [the case that] when you get sad you need to take medicine.

D: Did this moment of being prescribed a medication, was that any kind of a turning point for you?

A: Yes it was. It was a big turning point realizing that there was a real situation that I could do something about. I could handle it. I've not gotten anywhere in my life where I've thought, "I can't handle this." I've had situations where I think, "I don't want to handle this." Instead of saying I can't and trying to, I would say, I don't want to, I will not do this.

D: Maybe that connects to that remote possible situation where you might have to…

A: No, I won't. The more I think about it, that won't happen.

Meaning Units: “Amy”

1. S. experiences, in the space of a few months, several instances/occasions of physical (illness, “things”, dysfunction, difficulty?). Remembering that there is a history of stroke in her family, she becomes concerned for her physical health/safety.
2. Concurrent to physical concerns, S. experienced difficulties in her marriage (fighting with husband).
3. Concurrent to her marital difficulties, S. experiences herself as being stressed by and unable to handle the demands of her job, the running of her household, raising her children and caring for their daily needs, the loss of social support (as her close friend moves away).
4. S. begins to feel unable to cope with/handle all of the simultaneous concerns. She feels “empty” and overwhelmed when her habitual ways of caring for herself, or navigating conflicts/concerns, becomes insufficient or unavailable.
5. S. feels very sad in the face of lack of support from her husband.
6. In the face of physical symptoms, S. suspects an underlying physical health condition. S. happens to discuss concerns with a neighbor, who personally recommends a particular physician. S. decides to seek the help of this physician. S. has not yet considered the possibility of the existence of non-physical problem or relief (i.e. psychopharmaceuticals). S.’s choice of doctor is informed by her previous experience, a negative one, and by her attitudes about doctors in general. Doctor-as-mechanic.

7. S. encounters doctor as sympathetic and comforting and concerned, listening to S.'s account in full.
8. S. encounters doctor's examination and assessment. Doctor prescribes a muscle relaxant and ibuprofen. S. feels her suspicions of physically-natured roots of symptoms is confirmed.
9. S. takes medication and experiences a lessening of her physical symptoms. She augments the taking of the prescription with helpful adjuncts (techniques of relaxation) with which she is familiar.
10. As S. notices symptoms lessen, she begins to take less medication, using it as needed or only when symptoms are more noticeable.
11. As S. responds positively to prescription, she begins to suspect non-physical etiology for her symptoms.
12. S. returns to the doctor for check up. Doctor expresses concern for S.'s level of stress and for an increase in caring for her own needs. S. agrees with this assessment. S. experiences a confirmation of he growing suspicion that the nature of her problems are not physical in origin.
13. S. concludes that since no physical etiology, she will address the concerns/symptoms by taking action (doing something).
14. Doctor prescribes Paxil to S. S. recognizes Paxil as a drug taken by a child with whom S. works.
15. S. tells doctor that she will not take the Paxil.

16. Doctor persists in trying to persuade S. to consider medication. S. continues to decline medication.
17. Doctor writes and offers S. prescription accompanied by an offer to talk in a therapeutic context.
18. S. experiences the doctor as sincere and well-intended vis. being of help.
19. S. experiences doctor as recognizing S.'s desire to refrain from therapeutic talk as giving S. respectful distance and respect for S.'s freedom to refuse the suggestion to take medication.
20. S.'s thoughts and feelings prior to receiving prescription are largely informed by her pre-existing attitudes.
21. Having been confronted with physical difficulties, S. reflects upon her life prior to receiving prescription and discovers that the origin of her difficulties is directly related to the conflicts (marital, familial, occupational) that are overwhelming or taxing her.
22. S. expresses desire/need to feel in control of herself, unaltered by medications or illegal drugs.
23. S. alludes to feeling that for her to change her stance on medication taking would require a strong level of breakdown in her everyday life in the form of a compromise of the roles of her life.
24. S. reflects on her evolving understanding of the nature of her problems and is able to grasp that the origins of her greatest difficulty (i.e. her marriage) are not solely constituted by her and thus, not a matter she should have to control or solve.

25. S. has a clearer sense of what she can control, what actions she can take in a co-constituted situation to make things better for herself.
26. S. alludes again to remote possibility of consenting to psychopharmaceuticals, revealing that one aspect of psychopharmaceuticals for her is the uncertainty of how medication will affect her. For S., control equals knowing what will happen to her, bodily, perceptually, emotionally.
27. S. alludes to possibility of psychopharmaceuticals in the context of a paradox, namely doing something wrong for the sake of greater good or more important cause. For S., it is a serious compromise to take medication.
28. S. alludes to the notion that this compromise would be an admission that her preferred modes were no longer viable.
29. In the time that follows being given a prescription, S. has had to come to terms with “her stressors,” S. has done so in part by fortifying and clarifying what she considers what is acceptable and unacceptable between her and her husband in their marriage. Having faced psychopharmaceuticals appears to restore her resolve to do this.
30. S.’s renewed resolve manifests in S. using resources available to her (i.e. friends; refusing to engage in fighting while at the same time maintaining up or defending her wants/needs/self).
31. Taking better care of herself brings S. to realize that she “isn’t crazy,” i.e. she is not wrong or faulty or ill for having the responses to conflict that she did. This is confirmed externally by S.’s friends.

32. S. has clearer grasp of her own role in constituting her conflict/difficulties.
33. S. has a clearer grasp of and renewed trust in her own perception, including perceptions (even bodily) of being hurt by being in conflict.
34. The confrontation with the possibility of taking meds comes to be an experience that challenges and renews S.'s sense of being able to handle/manage her life.

Situated Structure: “Amy”

The Preliminary Circumstances

In the space of a few months, A. experiences several occasions of physical difficulty or dysfunction. She remembers that there is a history of stroke in her family; she becomes concerned for her physical health/safety. At this same time, A. is experiencing difficulties in her marriage. She and her husband often fight and A. feels unsupported emotionally and practically by her husband in their home. Relative to her marital difficulties, A. finds herself feeling stressed by and unable to handle the demands of her job, and the running of her household, and raising her children and caring for their daily needs. To make things even more difficult, she endures the loss of social support as her close friend and confidant moves away. The sphere of her relations with others is narrowed. The ability to bodily carry herself in and through her world of engagement and concernful dealings is threatened. The projects with which she engages herself (i.e. career, motherhood, general daily adult responsibilities, etc.) are compromised in her being overly burdened and without the appropriate marital support.

A. begins to feel unable to cope with/handle all of the simultaneous concerns. She feels “empty” and overwhelmed when her habitual ways of caring for herself and of navigating conflicts/concerns becomes insufficient, unavailable and/or nor longer viable.

A. feels very sad in the face of lack of support from her husband.

Regarding her physical symptoms, A. suspects an underlying physical health condition. She happens to discuss these concerns with her neighbor, who personally recommends a particular physician. A. decides to seek the help of this physician. A. has not yet considered the possibility of the existence of non-physical problem or corresponding relief (i.e. psychopharmaceuticals) thereof. A.'s choice of doctor is informed by her trust in her neighbor, previous negative experience of her former doctor, and by her attitudes about doctors in general: A. conceives of doctors as "mechanics."

During her first meeting with the physician, A. encounters this doctor as being sympathetic, comforting and concerned. She listens to A.'s account in full and then proceeds with her examination and assessment. The doctor prescribes a muscle relaxant and ibuprofen. A. feels that her initial suspicions that her symptoms are essentially physical in nature have been confirmed. A. takes the prescribed medication and experiences a lessening of her physical symptoms. She augments the taking of the prescription with helpful adjuncts (techniques of relaxation) with which she is familiar.

As she notices symptoms lessen, A. begins to take less medication, using it as needed or only when symptoms are more noticeable. As she responds positively to her prescribed medication, A. begins to suspect, due to a lack of complete symptom resolution, non-physical etiology for her symptoms. She returns to the doctor for check up. The doctor expresses concern for A.'s level of stress and suggests an increase in caring for her own needs. A. agrees with this assessment. She again experiences a confirmation, this time of her growing suspicion that the nature of her problems is *not* physical in origin. For A. this situation signifies a need on her part to take action. She concludes to herself that since there is no physical etiology, she will address these concerns/symptoms by doing something about them.

The doctor, on the other hand, prescribes Paxil for her. A. recognizes Paxil as a drug taken by a child with whom A. works. A. tells the doctor that she will not take the Paxil. The doctor persists in trying to persuade A. to consider medication. A. continues to decline medication. The doctor writes and offers A. the prescription anyway and accompanies it with an offer to talk in a therapeutic context. A. experiences the doctor as sincere and well-intended in the light of this offer to talk. She perceives the doctor as wanting to be of help. Furthermore, A. experiences this doctor as respectful of A.'s wishes in the sense that A. notices that the doctor recognizes A.'s desire to refrain from therapeutic talk and respects A.'s freedom to refuse the suggestion to take medication.

A.'s thoughts and feelings prior to receiving prescription are largely informed by her pre-existing attitudes of viewing doctors as technicians, i.e. people with a highly specialized knowledge and way to articulating that knowledge. For A. this structure supports the possibility of doctors being able to withhold information, either deliberately or unintentionally. This exclusivity of knowledge and privileged communication is encountered by A. as the power to deceive or at least speak without being questioned. A. does not like being in the position of feeling that the doctor knows something that she doesn't know or feels she can't understand. S

As A. gives reflective consideration to her physical difficulties as they occurred prior to receiving a psychopharmacological prescription, she comes to the conclusion that the origin of her difficulties is directly related to the conflicts (marital, familial, occupational) that are overwhelming or taxing her. She comes to understand her original problems differently, now that an organic/physiological etiology has been ruled out.

Implicit in this experience for A. is the desire and need to feel in control of herself, unaltered by medications (or illegal drugs). This attitude towards medication is an established part of her set of beliefs. For her to change her stance on medication taking would require a very strong level of breakdown in her everyday life in the form of a severe compromise of her ability to live out the roles of her life. For her, this exists only as the most remote and final of possibilities. One meaningful aspect of psychopharmaceuticals for her is the uncertainty of how medication will affect her. For A., control is equivalent to knowing and understanding what will happen to her, bodily, perceptually, emotionally. Thus for A., the possibility of taking psychopharmaceuticals presents itself to her in the context of a paradox: namely doing something wrong for the sake of greater good or more important cause. For A., taking this kind of medication constitutes a serious compromise of important beliefs and values. Futhermore, A. is aware that for her, the meaning of this compromise would be an admission that her preferred modes of handling the situations and conflicts of her life were no longer viable.

As she reflects on her evolving understanding of the nature of her problems, she is able to grasp that the origins of her greatest difficulty (i.e. her marriage) are not solely constituted by her and thus, not a matter she should have to control or solve alone. Living through this experience, A. has arrived at a clearer sense of what she can control, what actions she can take in a co-constituted situation to make things better for herself.

In the time that follows being given a prescription, A. has had to come to terms with “her stressors,” she has done so in part by fortifying and clarifying what she considers to be acceptable and unacceptable exchange and relation between her and her husband in their marriage. Having faced psychopharmaceuticals appears to restore her resolve to do this. Her renewed resolve manifests in A. using the resources available to her (i.e. friends; refusing to engage in fighting while at the same time maintaining up or defending her wants/needs/self). Taking better care of herself brings A. to realize that she “isn’t crazy,” i.e. she is not wrong or faulty or ill for having the responses to conflict that she did. This is confirmed for her through her friends, with whom she shares trust and confidence. As mentioned before, living through this experience has brought A. to a clearer grasp of her own role in constituting her conflict/difficulties. Moreover, she has a clearer grasp of and renewed trust in her own perception, including perceptions (even bodily) of being hurt by being in conflict. The confrontation with the possibility of taking medication comes to be an experience that challenges and renews A.’s sense of being able to handle and manage her life.

Appendix D: Informational Materials for Participants and Participant Referral Sources

RESEARCH PARTICIPANT GUIDE

The purpose of this study is to gain a fuller understanding of the experience of individuals who have received a prescription for medication for depression. It is hoped that increased knowledge in this area will help others who have had this experience by helping to expand and develop the understandings of those who prescribe medications. As a participant in this research, it is essential that you know exactly what is expected of you, and how your privacy will be protected. Your comfort and well-being are of the utmost importance, so please read the following carefully and ask for any needed clarification.

1. The first part of this research involves your responding to the research question (attached). Your original description can be received in writing, through a taped interview, or both. This interview typically lasts between 60 and 90 minutes, and can be conducted at a location of your choosing.

2. Within three weeks of receiving your original description, the researcher will inform you whether any further participation will be requested. If none is requested, your participation is complete and you will be thanked for your contribution. If further participation is requested, the researcher will arrange a follow-up interview.

3. The follow-up interview will be tape-recorded. At the beginning of this interview, you will re-read your original written description or the transcription of the first taped interview. If you have difficulty reading, the researcher will read the description to you. The researcher will then slowly go back through the description with you, and will ask you to clarify or elaborate at different points along the way. The purpose of this interview is to fill out your original description, so that the researcher gets as rich an understanding of your experience as possible. This interview will last approximately one to two hours.

4. During the analysis of the data, the researcher will remove or alter all identifying information so that you will remain anonymous. Your will be referred to simply as “Participant”. Original data (written descriptions and tape recordings) will be stored in a locked file cabinet in the researcher’s home, and will be destroyed when the research is complete.

5. During the analysis of the data, the researcher may contact you for further clarification of ambiguous material from the follow-up interview. For the most part, however, your participation is complete after the follow-up interview. Upon request, you may receive a copy of the final results.

6. You can discontinue your participation in the research process ***at any point***, if you choose. Furthermore, your participation in this project is in no way meant to effect, influence, or interfere with your participation in therapy or with your compliance or participation in your medication regimen.

The time and effort you will put into this study are greatly appreciated. If you have any questions or concerns pertaining to this study, please feel free to ask the researcher. If you feel that the researcher cannot adequately address your concerns, please feel free to contact Dr. Michael Sipiora, director of the research, at (412) 396-6512.

Daniel R. Mangine, M.A.

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: **The Appropriation of the Prospect of Taking Medication for Psychological Complaints: An Empirical-Phenomenological Investigation**

RESEARCHER: Daniel R. Mangine, M.A.
Tel. 412-716-3047

DIRECTOR: Michael Sipiora, Ph.D., Dept. of Psychology.
Duquesne University. Tel. 412-396-6512

AFFILIATION: This study is being conducted as partial fulfillment of the requirements for the doctoral degree in clinical psychology at Duquesne University.

PURPOSE: I understand that the purpose of this study is to gain a fuller understanding of the experience of receiving a prescription for medications for a psychological complaint. I understand that my participation involves a written or tape-recorded description of my experience, as well as at least one audio taped follow-up interview. I understand that the location of the interview(s) will be of my choosing. I understand that the taped interviews will also be transcribed.

I understand that these are the only requests that will be made of me.

RISKS AND BENEFITS: I understand that if I experience any discomfort during this study due to the subject matter, I will be able to contact a therapist or psychiatrist to address my concerns. I understand that the researcher will not provide therapeutic services to me, but will answer any questions regarding the research itself. I understand that my participation in this study is not meant in any way to affect or influence my participation in therapy. I also understand that my participation in this study is not meant in any way to affect or influence my compliance or participation with my medication regimen.

COMPENSATION: I understand that there will be no compensation for my participation. However, I acknowledge that my participation in the project will require no monetary cost to me. An envelope will be provided for return of my response to the investigator.

CONFIDENTIALITY: I understand that the original description that I provide will be transcribed by the researcher and included in the study, but that all identifying data will be removed or altered so as to preserve my anonymity. I also understand that any follow-up interviews will be audio taped and transcribed, and that all identifying data will again be removed or altered. I understand that my name will never appear on any survey or research instruments. No identification will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher's home. I understand that my response(s) will only appear in statistical data summaries, and that all data and materials will be destroyed at the completion of the research.

RIGHT TO WITHDRAW: I understand that I am under no obligation to participate in this study, and that I am free to withdraw completely at any time. Furthermore, I am not obligated to participate in this study by anyone who may have referred me to take part in this study. My participation or discontinuing of participation will have no bearing on my participation in therapy or with my medication regimen.

SUMMARY OF RESULTS: I understand that I will have access to the results of this research at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. I am comfortable with the measures taken to protect my privacy. On these terms, I certify that I am willing to participate in this research project. I agree to donate 2-4 hours of my time to this project. I authorize the researcher to use my written and interview data for this research.

I understand that should I have any further questions about my participation in this study, I may call Dr. Michael Sipiora, director of this research, (at 412-396-6512)or Dr. Mary de Chesnay, Chair of the Duquesne University Institutional Review Board (412-396-6553).

Participant's Signature **Date**

____ ____________________

Researcher's Signature **Date**

Researcher’s Certification: I certify that the nature and purpose, the potential benefits and possible risks associated with participation in this research study have been explained to the above individual and that any questions about that information have been answered.

____ ____________________

Researcher's Signature **Date**

Formal Communication to Participant-Referring Professionals

Dear Dr. _______:

As per our previous conversation, I am writing to you to formally convey the details of my study, insofar as they pertain to your assessment of the particular people that you might refer to me to participate in my research.

This study is an investigation into attitudes about taking prescription drugs. The purpose of this study is to examine the phenomenon of the experience of the prospect of taking medication *as it is lived meaningfully* by people *in the contexts of everyday life*. Thus, this study is a work whose approach is existential-phenomenological in nature. It is also an empirical study in that concrete descriptions of lived experience that illuminate this phenomenon will be gathered and investigated for inherent structural meaning. Data will be gathered in the form of written protocols and followed up by interviews between the researcher and the individual participants. Should a participant be uncomfortable with writing out his/her experience, the open-ended interview format will be employed and the taped interview will be transcribed. The collected data will be examined via an analysis and methodology based on that which was outlined by Giorgi (1985) and furthered by Wertz (1985). Briefly stated, this methodology seeks to explicate the general structure of the lived phenomenon by way of individual or situated structures that are generated from the raw data of individual protocols. It is a methodology that is entirely appropriate for this project precisely because it aims to unfold a phenomenon as it lived by an individual within the context of his/her own life-world. This is exactly the contribution this work wants to make with the phenomenon of appropriating the prospect of taking medication.

In accordance with the discussion above, adult individuals to be chosen as research participants for this study will have been given a diagnosis, as determined by the DSM-IV, for a depressive disorder of some kind. Those with other diagnoses, and those who were diagnosed or given prescriptions as minors, will not be included. Participants will only be eligible if they have received a prescription for medication as a form of treatment for their depressive disorder. Furthermore, participants' protocols must reflect their first experience of receiving such a prescription. Male and female participants will be included.

Furthermore, individuals to be chosen as research participants for this study must meet the following criteria: 1) they must be currently receiving psychotherapeutic care of some kind, or have easy access to a therapist or psychiatrist, and 2) they must be able to participate comfortably in all phases of the research, including interacting with the researcher and being recorded on tape. Every effort will be made to choose individuals who can participate with minimal or no risk of emotional distress. Therefore, individuals will not be chosen if they have had recent episodes of suicidality or hospitalization for an episode of major depression. To insure that they can make the most informed decision possible regarding participation, participants will be given informational materials (i.e. the “Research Participant Guide” attached herein), which will be reviewed with researcher, on the nature and purpose of the study itself. Also, participants will be give a Consent Form (also attached herein), to review with the researcher, and sign, that describes all of the precautions that will be taken to safeguard participant safety and confidentiality, including the elimination of all personal identifiers and the handling, storage and post-research elimination of the physical data (both printed and tape-recorded). These precautions will be carried out in strict accord with the guidelines given in the Graduate Handbook of the Psychology Department as well as the Institutional Review Board of Duquesne University. Both the Participant Guide and the Consent Form are attached to this letter.

Because there is the possibility of touching on sensitive or difficult personal subject matter, the researcher will do everything possible to assure the safety of the research participants. Solicitation using posted flyers or advertisements will ***not*** be utilized for several reasons. First of all, eliminating this kind of solicitation removes concerns of the validity and/or accuracy of the potential participants self-report of his or her diagnosis, history and also his or her singular assessment of ability to participate in the study. Rather, participants will be received through referral only, from colleagues and associates of colleagues who are seeing people in a therapeutic capacity. This will benefit the researcher with greater certainty regarding the diagnosis of the potential participant, as well as an assessment, additional to that of the potential participant, on the participant’s ability to participate comfortably in the study. The therapists referring potential participants will be able to preliminarily screen out those who might be vulnerable in some way or endangered in any way by participation in the study.

The researcher is keenly aware that there exists the possibility for the participant to feel pressured by the therapist who would refer him or her. Therefore, it is asked that you not only refrain from any sort of pressure on the potential participant, but that you also will actually, explicitly inform potential participants that they are under no obligations to participate in the study. Also, I ask you to communicate to potential participants that their participation will in no way jeopardize their participation in therapy or their compliance with a medication regimen, if one exists. Furthermore, this is reiterated in the consent form that the potential participant will review with the researcher and sign. Please refer only those potential participants who are most able to make sound judgments about their own participation. Participant solicitation has been done solely in this manner because it provides, beforehand, measures to protect the participant (within the pre-existing therapeutic relationship between therapist and patient) in the event of discomfort or negative reaction on the part of the participant.

This is the question I propose to ask my research participants:

> **I am interested in how people think and feel about taking medication for psychological problems or complaints.**
>
> Please describe, in as much detail as possible, your experience of how you came to take medication for psychological complaints. Please include a

> description of: a.) what lead up to your seeing the person who gave you the prescription; b.) how he/she presented the prescription to you; c.) your thoughts and feelings at the moment you received the prescription as well as your thoughts and feelings before and after being given the prescription.

This is its proposed form. Should indications be discovered that alteration or amendment is required, it will be made with a full and thorough explanation to all parties involved as well as with appreciation for the phenomenon in question.

It is important that you keep in mind the following considerations when considering a person for recommendation to participate in this study. Participants must understand that they are under no pressure in any way to participate. They must understand that participating in this study should in no way effect or influence their attitudes toward or involvement in therapy nor should it influence their compliance with their drug regimen, if one exists. I will trust that you will screen potential participants with regard to vulnerability to becoming upset or unstable relative to talking about the circumstances that led to receiving a prescription. Please reassure every person you recommend for participation that if they experience any distress over participating that they can withdraw ***at any time*** without fear of any recourse. Furthermore, should a participant become distressed through participating in the research, he/she should understand that you are available to help them address such difficulties. Please make every effort to ensure that any potential participant is fully able to enter into this study of his or her own free will and with the ability to completely form his or her own consent. Finally, please let them know that you have reviewed with me the procedures for protecting their privacy and confidentiality and that their safety and security is confident.

I thank you for your help and contribution in this regard to my work.

Sincerely yours,

Daniel R. Mangine, M.A.