"The old me could never have done that": how people give meaning to recovery following depression.

Damien Ridge[1]*
Sue Ziebland[2]

[1] Institute of Health Sciences, City University London
[2] Department of Primary Health Care, University of Oxford

* Damien Ridge now works within the School of Integrated Health at the University of Westminster

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Damien Ridge PhD[1] & Sue Ziebland MSc[2]

1. (Address for correspondence): Damien Ridge, Senior Research Fellow, Institute of Health Sciences, City University London, 24 Chiswell St, EC1Y 4TY, UK, Tel: +44 20 7040 5451, Fax: +44 020 7040 5866, Mobile: +44 7906 256 506, Email: damienridge@yahoo.com.au.
2. Senior Research Fellow, Department of Primary Health Care, University of Oxford, Old Road Campus, Headington, Oxford, OX3 7LF, Tel: +44 1865 226758 Fax: +44 1865 227036, Email: sue.ziebland@dphpc.ox.ac.uk

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ABSTRACT

Depression is usually a ‘self-limiting’ condition, and recovery is likely, even if people do have subsequent episodes. However, despite considerable research into depression, little is known about how people actually go about understanding and organising their recovery from depression. This paper draws on one-to-one interviews with people who have experienced mainly severe depression to explore the approaches and meanings attributed to overcoming depression. The study used unstructured and semi-structured interview phases to collect data, and a ‘modified’ grounded theory approach to analysis. Thirty eight men and women who had previously experienced depression (selected using the principles of maximum variation sampling through general practitioners, support groups and newsletters) were interviewed in late 2003 and early 2004. The paper explores the specific components involved in recovery (e.g. authenticity, responsibility, re-writing depression into the self), the stories people tell about their recovery, and the strategies deployed to revitalize life following depression.

Keywords: depression, recovery, narratives, authenticity, self, identity

INTRODUCTION

Globally, depression is the leading cause of non-fatal disease burden, accounting for almost 12% of all total years lived with disability worldwide (Üstün, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004). Depression is 'self-limiting' in the sense that it tends to lift over time, even if improvement takes months or years and people have subsequent episodes (Schreiber, 1996). Despite depression being limited in this way, very little is known about what people who experience depression understand by 'recovering,' nor how they go about recovering. The vast body of research tends to focus on observable and quantifiable measures averaged out over many subjects (Foulkes, 1999). A key issue then is the limited research on the personal meanings that people attribute to depression and recovery. From an interpretive perspective, the interior world of people is not directly observable. Here, the focus is on the complexities of thoughts and meanings. Additionally, such a qualitative approach allows for an investigation of the *process* of depression and recovery, rather than the usual focus on causes (Smith, 1999).

The little qualitative research that is available on depression has led to some key insights. It is clear that people who suffer from depression can develop divided, distorted and false selves from an early age; that severe depression variously involves a disintegration and rebuilding of the self; and that narrative can help people recover from depression if they can find more useful stories to tell about themselves (Bochner, 1997; Jackson, 1998; Jago, 2002; Smith, 1999). There are also a number of attempts in the literature to understand the transitions involved in depression (Beck, 2002; Karp, 1994; Schreiber, 1996). For instance, Schreiber's study on narratives of women's depression identified 6 phases of depression: the self before depression; entering the 'abyss' of depression;

struggling to tell the story of their depression; seeking an understanding of the self and the social world; 'cluing in' to who they are and the world around them; and 'seeing with clarity'. Understanding depression transitions is useful, although most research on transitions is based on interviews with women or auto-ethnographies.

Clearly, while transitions in depression are well documented in qualitative research, how people specifically give meaning to – and how they go about – recovering in the longer-term has not been specifically investigated. In this paper, we use a modified grounded theory approach with a maximum variation sample of 38 UK men and women to investigate the various meanings and processes involved in recovery. The approaches and stories told about recovering in the longer-term are elaborated. The key themes discussed include chemical imbalance, varying kinds of insight including re-writing the depression story in relation to the self, authentic living, taking responsibility and struggling with recovery.

METHODS

This paper draws on the data from video and audio recorded interviews that provided the foundation for the development of a website covering experiences of depression (www.dipex.org). Between September 2003 and May 2004, 38 people who had had depression were interviewed – usually in their own homes - by the first author, a qualitative researcher with extensive experience in sensitive research topics. People were encouraged to tell their stories in their own words, from their life before depression through to current day experiences. To be eligible for the study, participants had to be over the age of 18, identify as having had depression, and be feeling relatively well and symptom free for the interview. The study was approved by the Multi Centre Research Ethics Committee in the UK, and the interviews were copyrighted for inclusion on the

DIPEx (personal experiences of health and illness) website www.dipex.org. Eleven respondents chose to have actors speak their words for the website (the issue of stigma frequently played a role in decisions to remain anonymous), and 16 (mainly older participants) agreed to have video extracts from their interviews included on the site. The rest appeared on the website as text and/or audio only.

Sample selection and recruitment

To examine the experiences of people who have had (mainly severe) depression, a UK-wide maximum variation sample was sought. One of the aims of the study was to explore a broad range of different perspectives and experiences. Participants were recruited to include men and women, different age groups, ethnicities, and social classes, people from a wide variety of locations in the UK, people with different types of depression and treatment experiences, and those who had been diagnosed recently and many years ago. This maximum variation sample was obtained by finding participants through a variety of carefully selected avenues including psychiatrists, GPs, patient support groups and newsletters. Table 1 shows that a relatively diverse sample of participants was obtained. For instance, 16 men were willing to come forward to talk about their feelings about depression, even though other studies describe difficulties in finding men to talk about their mental health (O'Brien, Hunt, & Hart, 2005).

The interviews

Open-ended, in-depth interviews gave respondents as much time as required to talk about their lives in their own words and to focus on issues about depression and getting better that were important to them. Because some interviewees were still experiencing some depressive symptoms, the interviewer adopted an approach that allowed participants to define the boundaries of the information they volunteered. Participants were closely

listened to and encouraged with a recursive interviewing and the interviewer (DR) adopted an unconditionally warm style.

A topic list was used in the second part of the interview to ensure that broad topics of relevance to the study had been considered for discussion. Topics included: life before depression; the period of time when things seemed 'not quite right'; the depression experience(s); getting better; social issues in depression; help seeking; the role of health professionals; treatment experiences; hospital experiences; personal coping strategies; evolution of the 'self'; life after depression; and feelings about the future. Interviews ranged from 90 minutes to 180 minutes, and were audio or video recorded with the informed consent of each participant.

Analysis

The audio recordings from the interviews were professionally transcribed, corrected by the first author, and returned to the participant for review. The software NUD*IST v6 was used to aid the coding, organization and searching of narrative sections from each interview (Richards & Richards, 1994). NUD*IST enabled sections about themes across a range of interviews to be compared and linked for a systematic analysis. The first author identified emerging themes using a 'modified grounded theory' approach and multiple levels of analysis as described elsewhere in the literature (Glaser & Strauss, 1967; Ridge, Minichiello, & Plummer, 1997). The analysis was a cyclical process: The research continually moved between reviewing the literature, data collection and coding, linking codes and revising and reshaping the analysis. The analysis was scrutinized by both authors through regular meetings and electronic exchanges. Any names used in this paper are pseudonyms.

None of the participants in this study reported suffering from mild depression, and most reported that their depression was towards the severe end of the spectrum. Most (34) had experienced multiple or prolonged episodes of depression, 18 had been hospitalized for depression or mania, and 10 reported mania as well as depression. Nevertheless, reported episodes of depression tended to be self-limiting. And even though only 8 people had had a diagnosis by the age of 20, 28 out of the 38 participants reported that their difficulties had begun in childhood or their teenage years.

The distortions and 'collapse' of 'self' that participants linked to severe depression are the subject of another paper. Striking descriptions of re-emergence from depression were particularly prevalent in the stories of those who responded well to medication. However, recovery as an ongoing process is more than just feeling better in the short term. Participants mainly described recovery as being gradual in the main, taking place over months or even years. It was also frequently partial or unstable with subsequent episodes of depression being common. Years after emerging from the worst of depression, some participants still complained they could no longer concentrate as well as they once did, nor get over their social anxiety. Many of the older participants felt they had only begun to recover after a lifetime of depression. Recovery was at times a 'tortuous' life journey.

RESULTS AND DISCUSSION

The recovery process

Of critical importance, as with grappling to describe the experience of depression itself, participants needed to grasp a language of longer-term recovery. This language was not automatically available to them. For one 33 year old woman (Belinda), the idea of her being able to tell a story of recovery had never occurred to her until, after 9 years of

depression, she attended a conference on recovery. Along with supportive counselling, the conference gave her a language and framework to organize her discovery of pleasant feelings and experiences as to do with recovering from depression, rather than being perpetually trapped in mental illness:

> I feel as if I have been in actually.... in recovery for a few months now, or perhaps longer since May 2002, June time. June time say, but I hadn't actually realized I'd been in recovery. I had to go to a recovery conference to kind of realize I was in recovery [laugh]. It means that life is changing. It is not changed. It's a constant thing, its always changing. It changes every day and I notice things that I didn't, that I haven't noticed for years. I can listen to music and appreciate it in a different way.... it can move me now. Something on the TV can move me now, and I have, I feel things and things affect me. I was so cut off. I'd put up, you know, sorry to use the really bland expression of putting up a brick wall, a very good brick wall, but I really had built up a very good high brick wall and nothing came in or out. And I didn't feel much at all about anything. I just functioned for a long time.

Many complained that the language of recovery was not readily available to them in the UK NHS (National Health Service) services and hospitals. Instead, people told the researcher ‘anti-recovery’ tales citing long-term patients in hospitals maintained in ‘vegetative’ states by medication, and experiences of rapid institutionalisation in hospitals and loss of independence. However, as Belinda also noted, there could be comfort in being in a kind of limbo, being feeling safe and ‘contained’ and not having to ‘think about anything’ including recovery.

> I think I became… in eight weeks, I very quickly became institutionalized myself. I was scared to come out because I was in this enclosed world where I knew what was going to happen. There were routines, mealtimes, getting up times, medication times, OT times. There were routines and I had no responsibilities. I didn't have, because I live, I'm single and I, you know, I pay a mortgage on this house. I have responsibilities, I have to work to pay the bills and things, and the bills need to be paid and the cat needs to be fed and, you know, I don't have children but I have certain responsibilities and suddenly I had no responsibility. I was being cared for, or I was in a place where I didn't have to think about anything, and nobody could touch me.

Participants recognized that it could be near impossible to think positively while depressed. However, even when depressed, the narratives suggested that professionals could still encourage a 'recovery attitude': i.e. that patients are likely to get better, even if they do not feel it is true right at the moment. Some examples of recovery attitude messages which participants found helpful at the right time included: 'depression is only a part of you, not all of you', and 'what doesn't kill you can make you stronger'.

Given how horrendous the depression experience could be, interviewees at once feared – and were highly motivated to avoid – a recurrence of depression. They generally worked in various ways to try to avoid future episodes of depression, or at least better manage and limit future episodes. Regardless of how severe and prolonged their depression had been in the past, people could adopt long-term recovery as a narrative and organize their experiences accordingly. In the next section we will consider how the respondents tried to develop personal narratives of more lasting recovery, or at least looked for a different, more helpful way, of telling their story about depression.

Meanings attributed to recovery

Getting better meant different things to different people, and people aimed for different levels of recovery. Some people just wanted to get back to how life was before depression, feel ‘normal’ or ‘human again’, and enjoy life instead of dreading it. While these people wanted to return to their former lives, another group of participants wanted more than this. Recognising that depression could return, that their recovery was only partial, and/or that they had not functioned well before depression, these participants grappled with narratives about their longer-term recovery prospects. The key themes and tasks uncovered around the recovery process are grouped under headings below, including fixing chemical imbalances, types of insight, authentic self and living, and assuming responsibility for depression and recovery.

Fixing chemical imbalances

Many believe that their depression was caused by a ‘chemical imbalance’ in the brain. For these participants, recovery was about fixing that imbalance in the short term, usually with medication. Some, like 31 year-old Mathew, appeared to be defying anyone who might suggest that recovery has any other aetiology than biology.

> I mean it's chemical, you know I'm quite, you know I'm quite happy to admit there's something screwed up about my brain chemistry, you know. But you know, some people are diabetic, they take drugs, you know. And I know people say, ‘Oh, it's not the same.’ But I'm afraid it bloody well is. It's just, you know, you're trying to undo several hundred years of cultural difference between the brain and every other organ…. And when people say to me "Oh I'd be worried about the long term effects?" Well alright let's say Seroxat is more likely to make me I don't know, let's

> say…. or even to take five years off the end of my life. I'd say 'Well it's better than feeling fucking awful now.' Which is, you know, I can honestly say anti depressants work, work well.

The 'chemical imbalance' explanation could potentially be used to excuse the person from other efforts to bring about their recovery, but there was little evidence of this in the interviews. While the chemical recovery narrative interweaved with participant stories, it did not necessarily exclude non-biological explanations for depression that could coexist with - or even surpass – the biochemical. Instead, there was a complex relationship between the chemical and the social. Like this 75 year old man below, those participants who adopted a chemical narrative also reflected on the potential social factors.

> I thought about it so much [er] [pause]. I don't think I shall ever know. I suspect it was inherited. Endogenous if you like. I think that's what it was. That sort of gets me of the hook as [er]…. If you like, but I think that's what it may have been. The environment as well [er]… Because [having a mother with a mental illness] was quite….. Very difficult as a 10 or 11 year old to experience.

Even Mathew (quoted above) who strongly endorsed the chemical imbalance theory of depression found it powerfully healing to connect with his 'inner child' in therapy to work through his difficult feelings.

> …we (in therapy) talked a lot about childhood experiences and we, I definitely, it sounds clichéd but I did reconnect the pain that I felt as a child, and that I hadn't properly processed or hadn't been told it was okay. That was incredibly powerful and it hurt a hell of a lot….

Types of insight

There are a number of very brutal ironies about the way that people's understanding of themselves collapses in depression. While depressed, people may feel they only have the energy to focus on themselves and thus their distress. They feel extraordinarily isolated, and they have frequently learnt to present a false self so convincingly others may not even notice their severe depression, as was the case for this 33 year old man:

> I couldn't cope with, with other people at all. And also I developed coping mechanisms. I had managed quite well to, to hide it. And if someone sort of, you know at work sort of said, "Well how's everything going?" I could snap out, "Everything's fine thanks. It's great we're doing this, this, this and this and we're doing that." "That's good" and they would go. And boom. I'd go back to staring at my feet. So you know I could sort of put on a front at times and it was, yeah I think it was mostly, mostly a successful front.

Further, even though people can feel they are so damaged that they are beyond redemption, it is actually out of the disintegration of the façade of self in depression that a more useful understanding of the self has a chance to emerge. Depression can herald a 'heightened reflexive awareness' that allows the creation of a more useful story about the self (Jago, 2002).

> … When you're depressed, because you're very kind of sensitive…. I think that you try to understand more things that you can't explain or you didn't even question when you're functioning like a machine, that I think most of us are most of the time… I come out (of depression) very strong, and every time I come out I

> come a bit more [er] how could I say? I think I become more understanding of other people… (44 year old Brazilian male)

Participants gained insights of various kinds as part of their recovery. Consistent with the literature already, one type of insight discussed was about moving from a position of 'not knowing' to becoming more aware of themselves and their place in the world. Participants variously gained insight into their destructive thought patterns, distortions in the concept of themselves, and difficulties in their personal circumstances. In relation to depression, this process has been called 'cluing in' (Schreiber, 1996). In addition, the current study found that gaining insight went hand-in-hand with certain tools to promote insight. While not the only road to insight, therapy was highly valued by participants. The majority of participants talked about counselling or therapy as among the most helpful approaches they had used to deal with depression. While short courses of cognitive behavioural therapy were useful, those like Belinda who identified that they had deeper problems felt they needed longer-term therapy.

> It's like you can't sum it up in a sentence, what's the matter…, you know. I've just spent a year in therapy and I still don't really…. haven't got to the bottom of what's the matter with me. It takes time, you know. It takes discovery and it takes courage and it takes persistence and energy.

There were also highly valued non-therapy approaches used in gaining insight. Such approaches were wide and included reading self-help books, prayer, attending social support groups, doing personal development courses, yoga, and finding distractions from rumination (see www.dipex.org for a comprehensive discussion). One 59 year old woman cobbled together many different self-development tools (e.g. self help books and

tapes, counselling classes, social support groups, therapy) as part of recovery. A chance viewing of a documentary on dyslexia that led to her dyslexia diagnosis was also described as a crucial part of her recovery.

> So along come all the courses in personal development which is confidence building. It helped me to feel good about myself that I was… I wasn't worthless, I was worth something. I am a good person, I feel good about myself, and just go on… it's done over a period of years and so people can do that for themselves. No-one else can do it for you, I'm actually doing it for myself…. The major changes were in the 80's, so I always say "life began at 40". People say "does life really begin at 40?" Well it did for me. Because it was really, that's, yes I suppose I was 40 when I started on these classes…. I firmly believe that my depression came from the dyslexia… The person that did the (dyslexia) assessment said "you've actually got a very high IQ," and the joy of knowing that I had a problem, what my problem was, alongside the sorrow of all those missed opportunities... Because I know today, up to a point, that would be very different, because there is a greater awareness of dyslexia. And there is a certain amount of anger in me still that it wasn't picked up. But, hey, you can't turn the clock back.

At another level, and as evident in the previous quote, gaining insight could lead to quite profound shifts in the way that people felt about themselves. This was because gaining insight was linked by participants to feeling more positive and at ease with themselves. As part of this process, people often came to see that the distorted messages about themselves they picked up in childhood contributed to their suffering. Many came to realize that they were not the failures they once thought, and that they could grieve for

what they had missed out on or lost in growing up, feel better about themselves, and so begin to move on.

> …[um] but I think therapy gave me permission to say 'Yeah I was right', rather than just somehow still thinking as a child I was failing because I felt very stressed with my parents. And I.... because I think when you are a child anyway, you tend to think your parents have, or are this fount of wisdom, and they are right and you are wrong. And, you know… to sort of to think 'Yeah I was right' when I thought Mum shouldn't have said that, or done that, or that wasn't very wise or whatever. Because I was brought... I was ruled entirely by manipulation. That I guess again is just a different generation I guess. I can be quite magnanimous about it now. I could have killed at the time, but I was ruled entirely by manipulation and controlled that way. [Um] Very downtrodden kid… (50 year-old woman)

As part of gaining insight, participants need to separate out from their sense of who they are the distorted cognitive thinking that is part of depression. In doing so, people could *re-write* their experience of depression into the self in ways that were not so detrimental to the self. For instance, for those who had multiple bouts of depression, accepting that depression probably would occur again – and that they would also recover (even if each time depression came, recovery seemed like a remote chance) – could turn depression into a more manageable experience. This shift was about coming to view depression as *part* of the experience of self, but not the same thing as the self. That is, depression is not banished from the self. Rather, it is re-written into the self in a more helpful way, as Mathew illustrates.

> Now if it happened to me again, which I dare say it will, I'll never think, 'Oh God, I thought I was out of that', because I think I've kind of accepted that it is something that's there now. And people will say "Oh how sad that is", and I don't think it is really, without saying yeah it's something that's there, but I know the signs, and I know what to do, and I know you get better.

While it was easy to construct depression as the enemy to the self – particularly in the depths of depression – a number of people found a way to re-write their depression story from personally detrimental to personally beneficial. In these accounts, depression is seen as meaningful – it comes for a reason. Depression is re-written as the psyche *forcing* engagement with an essential self at a deeper level, to promote greater self-awareness and a better life, as this 58 year old woman – Elizabeth – suggests.

> It's not helpful to think of it as an enemy. [Um] And it's not helpful for me to think badly of myself because I'm depressed. It seems to me it's ok, in the sense, I am ok, not the whole of me is depressed, a part of me. This depression is a manifestation of a malaise, of a need to become more whole. That's how I look at it. If I am depressed, then I have the opportunity to change. I get to a point, when the depression is not so severe, I get to a point, and only I know when that is, and I know in my bones, when I can choose either to change certain ways I live, attitudes I have, or to go back to the old ways which will probably result in another depression. It's rather like having a dream which is telling me something. I take no notice so it recurs and recurs until I do.

Some were able to re-write depression as a beneficial spiritual journey. Depression could be constructed as an experience that a higher power wanted them to have in order to

eventually lead a better and more useful life. As Elizabeth further illustrates, a key value of the spiritual explanation was that it allowed participants to comprehend (and at times endure) very high levels of suffering, all the while helping to promote hope – an important ingredient of recovery.

> I mean, I didn't feel it (prayer) was doing me any good (at the time). And an image I did use, and I've used since to help other people, is of the iceberg in the sun. That although I wasn't aware that any melting was about to take place, or going to take place, of the iceberg of depression. An iceberg will be melting in the sun, and there will come a point when it's obvious and it's visible. And that's what I held on to, that there would come a point when I would begin to feel less depressed.

Finally, with another kind of insight, people discussed the potentially different qualities of self that lay beyond depression. People found they could not only move beyond the limits of depression (e.g. negative thinking, low confidence, limited social relations, false self), but they could approach themselves and their lives in different, more invigorating ways. This shift in insight was particularly associated with those who had had long-term therapy. One 40 year-old woman (who had had dysthymia and bouts of severe depression all her life) felt she was on the verge of discovering a very new way of being in the world, including a more robust self. But this also meant moving beyond the familiar confines of a depressed identity into an experiential ‘void’ and self that was constructed as an entity to be discovered. Although the prospect was frightening, she said that she was committed to finding meaning in life beyond the metaphorical prison of her depression.

> I didn't imagine that two and a half years later I would still be having weekly therapy, to get better. Um…. it's scary, if you're used to living in a very constrained band in your life, then the actual idea that you can take charge of your life… The bigger world is very scary. Um, I think it's something to do with when you live with depression the way that I have, you are limiting your life. You don't necessarily know why you are limiting your life, but through your thought processes and the way you are as a person, you concentrate on surviving life. You know, you're getting through life but you don't necessarily get any pleasure from it…. But if I choose to live differently, if I choose to, and can, set aside the depression, and think, right, I'm going to live life as other people seem to live it, that's really scary because that's been so much part of my life. And to actually live life without worrying every minute about what's going to happen next, about what people think of me, about what, am I doing a good enough job, you know to actually take life as it is, and to take knocks on the chin, and you know, dust myself off, and not worry about it, it's just a completely different way of living. And it's scary because I've never done that before, and I clearly need a lot of help to get to that point. But I do know that I want to live life and be more happy, and be more settled, and have a point to my life, you know, have a purpose, other than just getting through it.

<u>Authentic self and living</u>

A repeated narrative about recovery was the quest for more authentic living and self. Reminiscent of the 20th Century language used by gays and lesbians about coming out of the 'closet', many talked about how they had lived a lie to survive life and 'pass as normal.' People came to the conclusion that this problematic self needed to be re-worked in recovery. Many felt that depression had given them an opportunity to stop and rethink

their lives, and identify what was most real and important to them. As part of recovering from depression, people like this 44 year-old female health professional tried to put their lives into perspective, changed their lifestyles to care more for themselves, and pursued activities that felt right.

> If I want to go and walk in the hills on the weekend when I'm off. I will go and do it, whereas before there was always other people that I had to consider. And it's not that I waltz out now and leave them all [her 4 children and husband]. I make sure that everything is alright.

The repeated narratives from the people we talked to was to be you, put yourself first, take time for yourself, look after yourself better, move away from personal isolation and disclose your condition and true feelings, at least to a trusted few.

> And depression, albeit it is still stigmatized I think.... Is less stigmatized among young people that it was... You should tell someone now, it doesn't have to be the doctor or a therapist, it can be a friend you know. The older I've got, the more I've found that it's acceptable to say to people, "I'm depressed at the moment," and they know what it means.

‘Authenticity’ is more than just a narrative turn. Re-storying around authenticity was commonly commended for its ability to (re)invigorate lives. Critically, the mood here was more about accepting an essential self – warts and all – rather than trying to force change onto the self. Indeed, some were rather militant in their discourses of self-acceptance and authenticity, as was this 49 year-old gay male Christian.

You've got to live; you've got to be yourself. If you're [um] if you are gay, if you are an argumentative person, no matter what you are, if you are a bit of a [um] bit of a snob, just be it. And, and sod anybody and everybody, anybody else.

I: Why is it important to sod other people's opinions?

R: Well, whose life is it? You've got to live your life according to your morals, principles, likes, preferences and the rest. And it's your story [um]. You do what you like so long as you're not hurting, offending and upsetting other people. [Um] But how many people do we all know who live nice protected lives because their parents expected of them, because peer group pressure, because everybody in this village behaves like this? Well sod that.

Some who felt successful in authentically re-narrating their post-depression self talked about an 'old' and 'new' self. Therapy, medication, prayer and getting back into paid work through voluntary work were the main approaches used by the 50 year-old woman quoted previously. She looked back at her achievements after getting better following 5 years of a debilitating depression and stated 'the old me… could never have done that.'

I would never, ever have believed I could be this well. I am more well now than I have ever been in my life. My quality of life is better in terms of... I've got a bounce in my step. I have fun. I don't kind of live for weekends or live for holidays, I enjoy every day…. You know, I have got well and I'm taking my tablets and I'm happily going to take them for the rest of my life. I'm not going to muck about with them.

Assuming responsibility for recovery

Those with long histories of depression in particular believed that they needed to take full responsibility for recovering from depression. This group of participants were convinced

that recovery and self-development had to be directed by the person with depression. Like this 59 year-old woman (also quoted previously) they relegated medication, talking therapies, self-development approaches, and professionals to the status of 'tools' that could be of assistance in the recovery journey, rather than experts.

> In fact, the only person who can get yourself out of it is yourself, and no-one else. It doesn't mean to say other people can't help you, therapists, medication, whatever, going to classes, there are other people who can help you. But you have actually got to do an incredible amount of work yourself.

People's ways of taking responsibility for their depression were varied, and included researching their condition and treatments on the Internet, attempting to do the things depression had stopped them from doing (e.g. socialising), being more assertive about their needs, and being more proactive in gaining expertise and adequate care. As this 55 year old man explained, taking this approach could also help people to challenge the value of the treatment they were offered.

> But the point that the Internet has done, has kind of demystified authority, so in the past doctors would prescribe something, and you'd just take it because the doctor said so. Now most folks will look up on the Internet, what are the side-effects, what do we know about this drug before we take it? So I think that's informing more people, and probably the same will happen with psychiatric conditions. People will look up what's been said and you know, is there any dispute about this? Are you…. Is this the… the truth or is it just a version of the truth.

Some like this 43 year-old divorced woman found that assuming greater responsibility for managing their own depression could ultimately change the way they related to professionals, and how professionals related to them.

> ... I came to the point where I was able to sort of (say) "hang on this is my body here and this is me", speak up for myself and I started to question the psychiatrist what they were doing for me, or what they.... And finding that suddenly I started getting respect from psychiatrists because I was starting to think for myself and questioning "Is this right for me, is this not right for me" or "What do I think is right for me?" [Um] And it was only though constant pressuring the psychiatrist and the NHS that I got psychotherapy. You have to fight for it; you have to fight for it. It's not a thing that is automatically given.

Struggling with recovery

Despite widespread motivation to avoid depression, participants had varying levels of success in getting better and establishing a recovery narrative. A minority of participants were unable to tell some sort of long-term recovery story. These participants really struggled to tell a story that allowed them to go on with living. The quote below from a 35 year-old male demonstrates that ‘getting better’ is closely tied in with finding a narrative to support meaningful existence in an ongoing way.

> I mean, as I say I find living at the moment [um], what I would call living of course... Quite tricky at the moment, really as I've already, you know, I said now before because [clears throat] [um]. I mean, I have to take it, as I say, day to day really now. Day and night time too of course, but mostly in the daytime because of how I'm feeling or.... Or not knowing how I'm going to feel, that's the trouble. [Um]

> You know I often think, oh, what am I doing, and although it sounds rather dark, sort of wh- what am I doing in the world? You know and what is the purpose, what is the point of, say this, what is exactly going on, but, you know, [er] in some ways we all have to know that.

Those struggling with telling a recovery story also tended to have few helpful tools that really worked to support their recovery: This was particularly the case if medication failed or was inadequate. Recovery stories and adequate tools seemed to go hand-in-hand. For one 33 year old male, severe depression was largely considered a chemical imbalance. He relied mostly on his psychiatrist to get the medication right. And even though he once called a telephone help-line when he had tried to hang himself, he thought: 'I don't know what to say. What do you say? … So I didn't do anything.' The medication was only partially successful for him the last time. His fear of future episodes of depression in his account was a tangible presence in the interview room. He feared that his next episode of depression might well mark his demise.

> So the thing that really worries me about the future is about every six years I have a major depressive episode, and each one has been worse that the last. This last one, very, very nearly killed me. And what worries me more than anything is what's the next one going to be like, because I know it will come, and you know, I try and prepare for it, try and warn those around me when it happens. You've got to take me to the doctor's but you know, you never know. … Yeah, every one [episode] ends, yeah. That's what worries me. Yeah, what's that end going to be like [laugh]? Is it going to be sort of soft ending of tailing off and being stoked up on drugs, or is it going to be the hard ending of a, at the end of a rope. [Um] but it's going to end.

CONCLUSION

The paper started from the premise that much research and health practice neglects the meanings people attribute to recovery from depression (Lews, 1995), and so recovery as a process needs further exploration. Getting better happens in the short-term when people emerge from subjective states of depression. Recovery itself is more usefully considered a longer-term project where people attribute meanings to depression, getting better and the self, and use tools to minimize depression and aid recovery. A significant part of recovery involves telling specific types of stories about depression and the self that allow one to go on living – and at times live better. This paper adds to the literature by including both men and women in the analysis; by identifying the specific types of insight which are sought in recovery; by showing how people going about re-write their depression stories in various ways; how they strive for greater authenticity and why this important; how they use chemical imbalance explanations without necessarily excluding more social explanations for recovery; and how some attempt to take on the responsibility for their own depression and recovery. Encouragingly, it was found that a longer-term recovery narrative could be adopted at any age or stage of depression.

Despite the obvious successes in the sample in overcoming depression, people can struggle with narrating a recovery, and depression can also be about open wounds, stagnation, failing, recurrent episodes and even considerations of suicide. This was particularly so for participants who had identified few useful tools to aid their recovery, such as medication. As Arthur Frank notes, serious illness can involve a loss of direction and map for living (Frank, 1997). For the fortunate and skilled, getting better is part of depression and a more useful narrative of self can arise from depression. For those who struggle to find their way, outcomes are necessarily more mixed. Narratives in depression have the power to reconstitute the self, for better or worse (Smith, 1999).

We were only able to interview people who were willing to talk about their depression, so we are unlikely to have identified some of the most isolated and immobilized. Our participants mainly regarded themselves as being in 'recovery' and were willing to help others by having their story on a website (www.dipex.org/depression) and so were likely to be 'role models' for recovery. It is likely that people who were seriously struggling in their recovery would not feel well enough to come forward for interview. We do not claim numerical representation (this is not the purpose of maximum variation sampling), but we are confident that we have a sample that can reveal a broad range of experience and complexities about the recovery experience in the UK. We made considerable efforts to include people from ethnic minorities, but interviewed few. We might have identified additional perspectives on recovery if we had been able to interview more people from ethnic minorities. Additionally, we have not examined how men and women differ in their approaches to depression and recovery here as this is explored in more detail in an upcoming paper (Emslie, Ridge, Ziebland, & Hunt, 2006).

The majority of the sample had used and valued talking therapies as a means of gaining insight into their thoughts and feelings. Therapy discussions helped people to move away from isolation, make discoveries about themselves, and think about the self in more useful ways. Through talking therapies, people reported being better able to think more positively about themselves, have greater security in who they were, greater optimism about recovery, and make changes to improve their lives. However, much insight work was also occurring outside of therapy (see www.dipex.org/depression).

The current research goes beyond other narrative research that has identified 'gaining insight' as a major task in recovering from depression. We found that gaining insight of

at least four types was important: a). moving from not knowing, to greater awareness of self and other; b). working out that the self is different to distorted messages picked up in social interaction; c). re-writing the depression into the self in a more useful way; and d). discovering the different and perhaps unknown qualities of self that potentially lay beyond depression. The paradox is that while depression involves intrusive and distorted thoughts and problems with the self, on the other hand, people with depression may also come to see themselves and the world with greater clarity than before (Solomon, 2002).

In re-writing the experience of depression and self in a way that re-energized life and did not equate the self with the experience of depression, people came to see that disturbing thoughts and feelings were 'mental events' that pass, rather than true representations of who they really are. In effect, there can be a separation between peoples' identities and their episodes of depression with associated negative thought states (Mason & Hargreaves, 2001). Health professionals broadly have a good opportunity to support recovery by challenging thinking that contributes to negative thought patterns in depression, or conflates the self with depression, provided they can find the right 'moments' and salient messages to challenge the client in a supportive way. The danger here is that poorly timed or thought out messages will be experienced in unhelpful and negative ways.

Authenticity is a notoriously difficult concept to define, since it depends on a person's inner-experience, their character, and relation to an outside world that contains agendas apart from encouraging absolute authenticity. Nevertheless, the quest for authenticity was a deep yearning in many of the interviews, and has been noted elsewhere in the narrative research on depression (Jackson, 1998; Schreiber, 1996). Being true to an authentic self is valued in a post modern world that is distinguished by multiple ways of identifying

and social fragmentation (Holt & Griffin, 2003). For instance, feeling ‘different’ as children, living a lie to hide behind, passing as ‘normal’ and the assertion of a more authentic self are all very familiar concepts in stories of depression told to us, as well as well known in stories of ‘coming out’ as gay. For participants in our study, the pursuit of an authentic self was about navigating complex (and at times dangerous) interior and outer worlds in order to discover essential truths about the self. There is considerable discomfort in existing and moving within the tensions of identities, difference and yearning (Yngvesson & Mahoney, 2000). Consistent with existentialist writers such as Jean-Paul Sartre, participant narratives show there can be pay-offs in the sometimes unpleasant struggle for authenticity, including reinvigoration of lives and quite radical changes in the way that people relate to the world.

While Schreiber noted that women may take more responsibility for the self as part of recovery from depression, the current study found that highly experienced participants talked about needing to take full responsibility for their depression and longer-term recovery. This relegated treatments, professionals and carers to the status of recovery ‘tools’. If these participants are right - and recovery requires the individual to find their own voice and ‘tools’ - then ultimately, personal choice and agency must be encouraged and supported by professionals. From a narrative perspective, agency is fundamental to rebuilding a more useful narrative of the self in recovery: Stories cannot usefully be imposed on people. It was also acknowledged by participants that personal responsibility is a very difficult concept for depressed people to grasp, and may only become salient relatively late in life. ‘Responsibility’ would be an inappropriate narrative to encourage in the depths of depression or early on in recovery when people are grappling with the basics of getting better. However, some professionals who were highly valued by experienced participants were treating them as experts who could have responsibilities in

their own care. The difficult juggling act here is for health professionals to encourage personal responsibility without encouraging clients to feel they are to blame for their depression.

The analysis points to the importance of people establishing hopeful and authentic life narratives as a key to longer-term recovery. Despite the diversity of experience of depression, recovery involves an integration of common meanings and tasks (see www.dipex.org for a wider discussion). There is now a growing mental health 'recovery movement' worldwide, challenging what is considered a relatively negative mental health system. The participants in this study were part of this movement, being their own experts in themselves and how they might give meaning to – and narrate – a better life story. The current study makes a contribution to this movement by fleshing out how recovery is specifically constructed as a long-term project.

> "Recovery is about seeing people and people seeing themselves as capable of recovery rather than as passive recipients of professional treatments.
> It is about working out strategies and taking control of our own lives.
> Within the Recovery Approach individuals are encouraged to learn more about their experience and to find ways to deal with their mental health experiences.
> People are actively supported to acquire skills, knowledge and strength to reduce the prevalence of harmful experiences in safe, simple and effective ways.
> A key element to Recovery is about people taking control and moving away from a negative mental health system. It is about working out ways of helping themselves, taking responsibility and having hope. Each person's recovery is individual; there are differing views but also common themes. There is a growing movement in the

UK and we are learning a lot from people in other countries…." Piers Allott (http://www.rethink.org/recovery/index.htm)

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TABLE 1: Participant characteristics

Age at Interview	
<30	**3**
30-40	**14**
41-55	**11**
56-65	**6**
66+	**4**
Gender	
Male	**16**
Female	**22**
Residence	
London	**7**
Oxon	**6**
Glasgow & Edinburgh	**4**
Kent	**3**
Brighton	**2**
Manchester	**1**
Other	**15**
Age at diagnosis	
<20	**8**
21-29	**9**
30-39	**15**
40-49	**4**
51+	**1**
Unknown	**1**
Beginning of reported problems associated with depression	
Since childhood	**22**
Since teenage years	**6**
20s or 30s	**8**
40s or later	**2**
Main type of depression reported	
Unipolar	**28**
Bipolar	**10**
Ethnicity	
White British	**33**
Black	**1**
Asian	**1**
Southern European	**1**
Northern European	**1**
American	**1**
'Most helpful' treatment (not mutually exclusive)	
Medication	**24**
Talking therapy	**31**
Hospitalisation	**5**
ECT	**1**
Doctor support	**8**
Holistic/complementary approach	**9**