RESEARCHING HOW PEOPLE EXPERIENCE EMOTIONAL SUFFERING SUBSEQUENTLY DIAGNOSED AS DEPRESSION. A QUALITATIVE INVESTIGATION FOLLOWED BY A CASE STUDY AND A LITERATURE REVIEW.

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THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY ISSUES:

pp 166-189: **Part C.** Case Study.

"My depression set in the following February. It hit me and I withdrew from life. The word depression is bandied about, but I don't think some people really understand what it is like. I am not an angry person, but I was so angry. I couldn't read; I couldn't watch television; I couldn't listen to music. I took sleeping pills and antidepressants. For two years I became this other person'. (Woman and Home, July 2012

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DECLARATION

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ABSTRACT

The aim of this study was to qualitatively explore experiences of emotional suffering subsequently diagnosed as depression from the perspective of adults who had been diagnosed with depression at some point in their lives. The focus of the study was to unearth some of the rich experiences participants underwent at the time of their pre-diagnosed depression, with particular attention being paid to experiences not documented in depression classification manuals.

Ten adults who had been diagnosed with depression and treated within the last three months participated in this study. Data was gathered through individual, face-to-face, semi-structured and recorded interviews and analysed with an interpretative phenomenological analysis (IPA).

Eight superordinate themes emerged from the data relating to how participants experienced pre-diagnosed depression and to the connection of possible life events to it:

1. Totality of life at the time
2. Embodied distress
3. Trapped in head
4. Severed social and emotional connections
5. Transformation of identity
6. Dissociation
7. Belief in a higher force
8. Disciplining the self

The research also discussed these themes in relation to possible triggers and maintaining factors in the participants' pre-diagnosed depression, how pre-diagnosed depression was experienced and those aspects which led to development of coping strategies.

This study has provided an insight to lived experiences of emotional suffering subsequently diagnosed as depression and can, therefore, be useful for counselling psychologists when working therapeutically with those emotionally distressed clients diagnosed with depression. Further studies can use the knowledge gained to further theory development in this area.

PART A: PREFACE

The thesis comprises four parts consisting of this preface and three remaining parts described below with a summary explaining how they inter-relate.

Part B: Main Thesis

The main part of the thesis consists of a qualitative investigation. The research is concerned with how people experience the emotional suffering that is subsequently diagnosed as depression. This part contains four chapters.

Chapter 1- INTRODUCTION includes a literature review of distress experiences commonly associated with a depression diagnosis. The terms emotional distress or suffering are used throughout to refer to phenomenon the clinical term depression is often used to designate. The terms depression and symptoms invariably arise when discussion is given to relevant studies, theories and classification manuals on the matter of such distress. Symptoms of depression as cited in diagnostic criteria are outlined followed by a discussion and evaluation of various theories on it. The introduction also considers some of the history, culture, biology, diagnosis, causal factors and possible interventions. The introduction aims to provide an empirical backdrop to the study findings and the chapter concludes with a rationale for the conducted research.

Chapter 2 - METHOD presents the concept of Interpretive Phenomenological Analysis (IPA) and provides an overview of its epistemological position and methodological process. The chapter includes a section on researcher reflexivity and transparency thus providing an insight in to the researcher's demographics and interests and experiences as they relate to this research. It also outlines any changes made to the study alongside the motivation for them. It notes areas pertaining to research evaluation and quality before

outlining the research procedure in detail.

Chapter 3 – ANALYSIS consists of the presentation of the findings. Here, each of the themes that emerged from the analytical process is presented, discussed and analyzed. Illustrative extracts from the raw data are used throughout to ensure that the analysis remains grounded in the participants' own voices.

In **Chapter 4 – DISCUSSION**, the previously reviewed themes are discussed in relation to the existing literature and a further theme incorporating superordinate and subordinate themes identified in the analysis is considered. Further reflections on what the research findings mean and convey are discussed.

Part C: Case Study

Before beginning my work in private practice I worked in several National Health hospitals, providing psychological therapy sessions to groups and individual clients. The groups I ran were for people who had been diagnosed with depression and anxiety respectively. These were Cognitive Behavioural Therapy (CBT) groups each consisting of eight sessions.

I therefore developed considerable experience working with emotionally distressed clients using a CBT approach. By the time I began working privately in 2010 I was adopting a more integrative approach with clients who were presenting with emotional distress previously diagnosed as depression by their GP's or psychiatrists. My work with client H, presented in the case study, reflects this.

I tend to tailor my interventions to the client in question through consideration of their life experiences, personality, attitude and therapeutic expectation. This shift came about because I found that CBT interventions alone, whilst being very effective for some clients, were less so for others.

Where clients found it less effective this seemed to be linked to the fact that they were unhappy with life circumstances and the related choices they had made. In these cases I found alternative therapeutic interventions helpful such as person centered, solution focused, psychodynamic, compassion-focused and existential therapy. I believe this case study is valuable in so far as it demonstrates how an integrative take can be insightful and flexible

The case study was written around the time I was becoming more interested in other psychological and therapeutic interventions and adopting my more integrative approach. I feel that this is expressed in both the working alliance and therapeutic interventions I adopted. Alongside some person centered and CBT interventions there is an emphasis on the therapeutic relationship, transference, attachment and acceptance. With hindsight I felt that perhaps it was these aspects that turned out to be most helpful to H.

This was a transformative time for me as a counselling psychologist, particularly with regards to the way I worked with experiences of emotional distress commonly associated with a diagnosis of depression. I began to feel that emotional suffering was not always triggered and maintained by thinking distortions that may or may not have been triggered by experiences as CBT theories suggest. I am more inclined to view emotional suffering as distress in relation to life, relationships and position in the social world and I think H's story illustrates this well.

Whilst the case study attempts to show how psychological theory and research on distress translate into therapeutic work, it also attempts to show how the professional recognition and understanding of an individual's experience of emotional suffering can support and assist them in finding their own resources to overcome it. It also reveals some of the things in life that can cause people to feel emotionally distressed in the first place. It reflects themes that also emerged in the main thesis on emotional distress subsequently diagnosed as depression such as fear, loss, change and intrusive negative cognitions.

Part D: Literature Review

One of the things that recur throughout my clinical work as well as in the thesis is the role of intrusive and repetitive thoughts. I have noticed in my clinical work, as was evident in the case study, that emotionally distressed clients often report rumination. H, like two other participants in my case study, described this as noise in the head. This stimulated my already existing interest in the role of unwanted intrusive thoughts.

I decided to elaborate on this by conducting my literature review on the effects of mindfulness interventions for those experiences commonly associated with a diagnosis of obsessive-compulsive disorder (OCD). This was because I was aware that a diagnosis of OCD would incorporate obsessive and intrusive thinking though perhaps from a different perspective. I felt it would be helpful for me as a psychologist who works with emotionally distressed clients to develop my therapeutic skills by helping them to manage and overcome their persistent intrusive thoughts.

Whilst conducting the literature review I discovered that one form of mindfulness therapy used for OCD, mindfulness-based cognitive behavior therapy (MBCT), was in fact formulated specifically to treat emotional distress subsequently diagnosed as depression. This indicated a possible overlap between experiences of distress as noted by Wahl et al., (2011). Participants in the reviewed studies on mindfulness for OCD described a reduction in their tendency to worry and ruminate combined with an increased tolerance of, and an ability to detach themselves from, their intrusive thoughts. The fact that MBCT was found to be effective for those diagnosed with OCD only strengthened my interest in the role of persistent intrusive thoughts in emotional suffering. As participants in this study and clients in my clinical practice have often reported such thoughts I have decided to take a more mindful approach in my work with clients who report them.

A focus on the role of thoughts, feelings and behaviours experienced in emotional distress and consideration of coping strategies, whether internally generated or therapeutically encouraged, thus constitutes a thread that runs through each of the components of this thesis.

PART B: MAIN THESIS

Researching how people experience emotional suffering, subsequently diagnosed as depression

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1

INTRODUCTION

1.1. Introduction

This thesis explores the experiences of emotional distress in the lives of people who have been subsequently diagnosed as suffering from depression. The terms 'emotional distress' and 'emotional suffering' are used to refer to these experiences. Usage of the terms 'depression' and 'symptoms' is avoided when possible as this might imply that the researcher is exploring matters in accordance with the disease/illness model. Whilst participants in this study did end up with a diagnosis of depression, the researcher does not necessarily adhere to that medical explanation. Nor does she believe that distress categorized as depression is appropriately conceptualized as a disease or medical illness.

She will argue that emotional distress is a response to stressful and adverse life situations. It is inextricably linked to the life we lead and the worlds we inhabit. It may manifest in problematic, undesired, unwelcome and unusual experiences some of which have often been linked to the clinical term 'depression'. Whilst experienced by many of us at various points in our lives, those who are suffering emotionally will experience them in an overriding and overwhelming manner. These experiences can include overpowering and often uncontrollable emotional states, that interrupt and disturb daily lives, preventing the individual from functioning and make life appear meaningless and lacking in purpose; habitual and repetitive patterns of behaviour that generate anxiety if not adhered to; the holding of beliefs that are considered unusual, untrue or extreme; seeing or hearing things that others do not; experiencing the world as flat and grey; feeling permanently agitated or indifferent to life and lacking any

emotions.

As this thesis begins with a literature review of what this study explores, namely experiences that are subsequently diagnosed as depression, it is inevitable that the terms ‘depression’ and ‘symptoms’ will arise, notably when consideration is given to-relevant studies, theories and diagnostic criteria. In using these terms the researcher is not buying in to the medical model of depression as an explanatory ‘thing’ with causal powers. Instead, the researcher has chosen to employ the terms emotional distress and emotional suffering to convey the set of experiences she intends to explore.

The World Health Organization 2012 now recognizes a diagnosis of depression to be the lead cause of global disability and has estimated that by 2020 emotional distress categorized, as depression will be second only to cardiovascular disease in the global burden of ill health. A diagnosis of depression affects 121 million people worldwide. At its most severe it can lead to suicide and is responsible for 850,000 deaths every year (BioMed Central, 2011). It affects people across the globe.

In July 2011, the office for National Statistics revealed that doctors in the UK prescribed 39.1 million packets of antidepressants such as Prozac in 2009, more than four times the 9 million prescribed in 1991 (Ross, 2011). Distress categorized as depression is now the most common psychiatric disorder, even referred to as the common cold of psychiatry (Rapley, Moncrieff & Dillon, 2011) and it appears to be on the rise. A recent American study conducted by Pederson (2010) found that, contrary to popular belief, there has not been a reduction in the stigma associated with a diagnosis of depression and that prejudice and discrimination against it have not changed in the last 10 years. A study conducted by Barney, Griffiths, Christensen & Jorm, (2009) found that emotionally distressed people experience considerable stigma while others believe that they are responsible for their own condition and are undesirable to be around.

1.2. My aims for the study

The researcher aims to explore people's experiences of emotional suffering that is subsequently diagnosed as depression. Depression diagnoses will be acknowledged in participants, with the aim of exploring how pre-diagnosed depression experiences play themselves out and how people's lives are affected as a result.

This research aims to capture and explore what goes on for people emotionally when they are experiencing the distress that is subsequently diagnosed as depression. It aims to chart the experiential journey from the time of realizing something is not quite right until the diagnosis of depression. It also looks at how people make sense of feelings they experience during this period, as well as investigating the extent to which the onset of the participants' emotional distress was associated with any significant life changes or events.

It has been noted by Jorn (2000) that the vast majority of the public do not link feelings of personal distress to a possible episode of a depression diagnosis and are unaware of the impact such distress can have on their mood and life situation. One of the aims of this research is to explore and reveal the impact emotional suffering subsequently diagnosed as depression has on people's moods, life situations and experiences.

Lauber, Nordt, Falcato & Rossler (2003) state that not much is known about psychological disorders in the public domain and that there is a related need to increase mental health literacy. Much research has focused on triggers, causes and treatment-seeking behaviours in distress categorized as depression (Carragher et al., 2010; Lauber, Falcato, Nordt & Rossler, 2003). Jorm, Griffiths & Christensen (2003) state that there is a considerable lack of information regarding patients' own understanding and experience of emotional distress. This research aims to fill this gap in the literature by bringing into focus patients' experiences of emotional distress and the meanings people might use to make sense of it.

1.3. Between disorder and experience

Misery and unhappiness are terms that have been used to describe the human condition, which in modern times is categorized as depression. There is still great debate as to whether the term depression describes difficulties individuals have with living their lives in certain circumstances or whether it is a physical illness with physical symptoms, which are accompanied by emotional and psychological ones. Gerome Wakefield (1992) believes that disorder lies on the boundary between the actual natural world and the constructed social world, claiming that a disorder exists when the failure of a person's ability to perform harms the person's well-being as defined by social values and meanings. According to Wakefield (1992) this disorder is simultaneously biological and social and neither alone is sufficient to justify the label. He suggests that for something to be an illness it cannot be explained by life circumstances alone. There must be an internal factor as in the case of Alzheimer's, which is not environment related.

1.4. Sadness and worry

Most of us feel unbearably sad or tend to worry and ruminate at certain points in our lives. We experience distressing emotions of grief, regret or loss and are tearful. Some may even describe the world as grey, tiresome, dull, flat and lonely. In her book, Depression, The Way Out Of Your Prison, Rowe (1983) likens the peculiar isolation people feel when they are emotionally distressed to being in a prison. Linked to this is a persistent feeling of detachment. Some have even described feeling separated from the outside world, as if they are watching life on a television screen or as if there is a plastic screen between themselves and the rest of the world. Some describe feeling emotionally disconnected from other people, a form of detachment that engenders terrible feelings of isolation.

Those experiences of emotional distress, such as feelings of sadness, are not unlike the normal feelings of unhappiness experienced by most people from time to time. Worry, too, is common. Everyone worries to some extent. Statistics now show that 38 per cent of people worry every day. Whilst worry is the central ingredient in all the anxiety disorders it is also a central component in distress categorized as depression (Lehay, 2005). Moreover, patients diagnosed with comorbid symptoms of anxiety and depression are common in clinical practice and continue to pose a diagnostic and therapeutic challenge to clinicians and researchers alike (Barbee, 1998). Those suffering emotional distress tend to worry and ruminate about things that are beyond their control.

The researcher has often heard clients say things like "I cannot stop obsessing about this and I can't understand why". Do people ruminate because they are emotionally distressed or are they suffering emotionally because they ruminate? We find ourselves wondering what comes first. It seems that people have a greater propensity to worry and ruminate about such things when they are feeling unhappy, miserable or low. Indeed Smith, Lauren, Alloy & Abramison (2006) found that rumination and hopelessness were found to predict the presence of suicidal thinking.

The ongoing worry and rumination experienced by intrusive and obsessional thoughts are often the complaint of non-psychotic patients who are given the diagnosis of obsessive-compulsive disorder (OCD). Thoughts may vary from trivial memories to fears about violating social norms, to the self-critical automatic thoughts of the emotionally distressed person (Bentall, 2004). Common to these thoughts is the fact they are unwanted and impossible to expel from the mind. The presence of repetitive intrusive cognitive phenomena is central both to a diagnosis of obsessive-compulsive disorder - typically as obsessive thoughts - and to a diagnosis of depression - typically as ruminative thoughts (Wahl et al., 2011).

Beck cites unwanted and intrusive thoughts as a symptomatic of a depression diagnosis in his inventory and DSM-IV-TR (2000) also makes reference to

ruminations. Hoeksema (2003) coined the term ‘overthinking’ to describe the experience of being caught in a torrent of negative thoughts and emotions that overwhelm individuals and interfere with functioning and well being.

As Cromby, Harper & Reavey (2013) note, sadness and worry are everyday words that depict feelings of transient emotional and psychological distress. When this distress is ongoing, distracting and disturbing to individuals, they tend to become diagnosed as suffering from anxiety or depression and are consequently subject to clinical and therapeutic interventions. It is interesting to note that individual experience of emotional distress diagnosed as depression and possible recovery might be different in the absence of a 21st century diagnosis with its psychological and pharmacological interventions.

It is evident that those who experience ongoing sadness and worry for which they seek professional help or receive a diagnosis of depression are suffering at a more distressing and all-consuming level than someone who feels these things in a transient manner. For those who experience pervasive and persistent sadness or excessive worry, trying to identify the cause for their distress can be itself a confusing experience which may contribute further to their suffering.

It seems that those who are bewildered by the ongoing presence of sadness and worry are the ones who are most likely to present to the health services and end up with a depression diagnosis. Smail (1993) observed that those who suffer profound, unexplained sadness and worry are most likely to be the ones who present to the mental health service for help.

The researcher’s experience as a counselling psychologist in private practice has exposed her to individuals presenting with distressing levels of sadness and worry, which they cannot explain. They simply cannot attribute their low mood to anything in particular. They may say things like “I just woke up one morning feeling terrible and it just got worse and worse” or “I don’t feel I am the person I used to be and I don’t know why”.

1.5. Sadness and worry in history and culture

Most would agree that whilst feelings of sadness and worry do not make a positive contribution to the well being of individuals, these feelings do have a purpose in life. For example, worry makes one aware of a possible threat, which may elicit caution in the presence of danger. Similarly, sadness encourages us to withdraw and disengage which may assist in managing and adapting to changes in social status (Cromby, Harper & Reavey 2013). There appear to be reasons why our biological systems are capable of inducing these experiences in us (Cromby, Harper & Reavey, 2013).

The Bible, the Koran and the ancient Greeks all made references to experiences of emotional suffering. Shakespeare's play Macbeth contains agitation, insomnia and guilt, not to mention the compulsive hand-washing of Lady Macbeth, an accomplice in the King's murder, just weeks after he is killed (Cromby et al., 2013).

In the Middle Ages monks were sometimes known to suffer from a condition called accidie, which consisted of feelings of boredom, misery and disgust. This was attributed to a loss of faith in God and the abandonment of their duties (Harre & Finlay-Jones, 1986). Though these signs of distress were not recognized as symptoms of psychological disorders in the way that they are today, it is clear that they were observed and the characteristics of emotional suffering noted. As Rowe (1983) has stated: "depression is as old as the human race, and rare is the person who has not felt its touch". Though the emotions of sadness, misery, agitation and worry have been evident and noted from time immemorial, our understanding, experience and interpretation of them have changed a great deal.

In his book Hysteria, Andrew Scull (2009) describes how, in the 19th century, many women were diagnosed with 'hysteria', derived from the Greek word for the womb. In the 20th century most doctors agreed that hysteria was a psychological disorder described as an affliction of the mind expressed through a

disturbance of the body. Prior to that, it had for centuries been recognized as a purely somatic disorder. The majority of patients were women and the illness was associated with female biology and resulted in gruesome treatments including clitoridectomy. This formerly recognized condition has now vanished and is not seen in modern-day psychiatric texts. It later came to be reclassified as post-traumatic stress disorder and was seen as a problem for weak men in wartime. The disease labelled hysteria has undergone a compelling cultural and historical change.

The psychiatric notion of emotional suffering categorized as depression, used to be split between melancholia, a form of lunacy, and neurasthenia, the suffering of nervous exhaustion. In the 19th century mopishness was a form of melancholia attributed to the lower classes (Mac Donald, 1981). A diagnosis of depression as a unitary term for emotional suffering came after the demise of melancholia, neurasthenia and mopishness.

Interestingly, neurasthenia is still a recognized condition in China and its symptoms include headaches, backache, muscular weakness, fatigue, noise in the ears, irritability, difficulty concentrating, hopelessness, morbid fears, phobias, dizziness, insomnia, poor appetite, indigestion and sweating. This reflects the cultural differences in our understanding of the relationship between somatic illness and distress diagnosed as depression (Cromby et al., 2013). Though neurasthenia as diagnosed in China includes symptoms of sadness and worry, the predominant symptoms appear to be of a physical nature.

It has been found that not many people are diagnosed with depression in China but that those diagnosed with neurasthenia describe symptoms that mirror a diagnosis of depression. Kleinman (1986) found that diagnoses of depression were rarely given in China. Out of the 100 people who participated in his research in China who had been diagnosed with neurasthenia, 87 met the criteria for major depressive disorder. In addition, it was found that those suffering from neurasthenia also displayed symptoms of anxiety disorders as defined by DSM-IV-TR (2000) (Cromby et al., 2013).

Kleinman (1986) proposed that western cultures tend to emphasize the cognitive aspects of sadness and worry. He distinguished between the notion of a disease, a condition that is biological and ongoing, and an illness, which may be more culturally shaped. He proposed that it was more beneficial to work with an illness than a disease, perhaps because the term illness denotes a more general state of poor health, which, unlike a specific disease, involves the subjective experience and perception of the sufferer. This more subjective and philosophical take on sadness and worry is pertinent to this research, which will be exploring people's experiences of emotional distress subsequently diagnosed as the psychological disorder depression, a western objectively defined disease.

An important thing to consider in the differences of experience and presentation is the influence of cultural legitimacies, values, expectations and even language. Claims for the universality of emotional distress categorized as depression have consequently been challenged by those who point out that the concept and language to describe it does not exist in many non-western cultures (CRE, 1993).

The West is well known for its commitment to dualism whereas other cultures may be less likely to separate mind and body in their approach to illness. However, according to Rowe (1983), distress diagnosed as depression is a profound, emotional experience and this upsets the body's functioning. She suggests that every emotion, whether it is pleasant or unpleasant, is accompanied by physical changes, which become more profound as the emotions persist. For example she notes that emotionally distressed people are more prone to catching colds and flu. She also points to the fact that some women feel distress in the lead up to menstruation. Mind and body, even if they can be theoretically separated, clearly do work together.

Overall, it seems that the emotional suffering of sadness and worry has both historical and cross-cultural variations and this suggests that the character, meaning and distribution of sadness and worry can vary a great deal. This

research will explore the variation that exists across individual experiences of emotional suffering subsequently diagnosed as depression.

1. 6. Diagnosis

We have a modern system of classifications such as DSM-IV-TR (2000) and various theories and these will be listed below. Distress categorized as depression has been described by the medical model of DSM-IV-TR (2000) as five or more of the following symptoms being present during the same two-week period and representing a change from previous functioning. At least one of the symptoms must be either distressed mood or loss of interest in pleasure.

(A)

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others.
- Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

(B) The symptoms do not meet criteria for a Mixed Episode. (C) The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. (D) The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism). (E) The symptoms are not better accounted for by bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation. (Diagnostic and Statistical Manual of Mental Disorders, fourth edition, American Psychiatric Association).

A fifth version of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, or DSM-5 was published in 2013. A notable change from DSM IV was made regarding the 'bereavement exclusion'. Using DSM IV clinicians were urged to not to diagnose emotional distress as major depression in those individuals in their first 2 months suffering the loss of a loved one. This meant that grief was in a sense protected from major depression diagnosis. This bereavement exclusion has now been removed supposedly helping prevent a diagnosis of major depression from being overlooked.

This bereavement exclusion was removed from DSM-5 for several reasons. Namely, because of the suggestion that grief of loss of a loved one only lasts 2 months when in fact bereavement counsellors and physicians claim it is more like 1-2 years, and as bereavement is recognsied as a precipitator of a depression diagnosis in vulnerable individuals, with the potential to begin soon after the loss. Moreover, when a diagnosis of major depressive disorder occurs in the

context of bereavement it
adds an additional risk for emotional suffering and the prognosis is worse compared to bereavement alone. Such bereavement related distress diagnosed as depression is more likely to manifest in individuals with past personal and family histories of major depressive diagnoses. Finally, the emotionally distressing experiences associated with bereavement may be alleviated with anti depressant treatment (Perper, 2013).

There is a concern that this removal could lead to pathologising normal grief and over diagnosing such appropriate distress as depression. There has been much controversy about this. There is however now more guidance in DSM-5- on how to separate normal bereavement from emotional distress diagnosed as depression. Ultimately, DSM-5- aims to provide a depression diagnosis for those deemed in need of one and no diagnosis for those who are supposedly not in need of treatment but appropriately sad grieving the loss of their loved one (Perper, 2013).

A diagnosis of depression can be mild, moderate, severe and psychotic. It can be deeply rooted in early developmental stages where there has been emotional deprivation or abandonment; it can be a reaction to stress or life events in which case it can be referred to as an adjustment disorder, plus there is evidence too suggest it can be a biological illness. All these theories will be considered and evaluated later on in this introduction.

DSM- IV-TR (2000) claims to be purely descriptive and atheoretical, not relying on concepts that have their origins in pre-existing theories. For example it eschews a term such as 'neurosis' originated in psychoanalytic theory. DSM- IV-TR (2000) claims to be a set of descriptions observed by clinicians. Related disorders are then suggested by panels of experts subject to consultation before being accepted and incorporated into the manual by a central committee.

It has however been argued that DSM- IV-TR is far from being unbiased and impartial and that it furthers and supports the interest of the psychiatry profession as well as pharmaceutical and insurance companies, where a diagnosis is often needed to reclaim costs of treatment. A further concern is that DSM- IV-TR has medicalised everyday life by encouraging people to classify daily problems and tensions such as shyness as 'symptoms' of 'illness' such as social anxiety disorder that requires 'treatment' (Cromby, Harper & Reavey 2013).

Can clinicians reach the same diagnosis consistently using the same diagnostic procedures? Reliability and validity have both been proven difficult to achieve (Carson & Butcher, 1992). The difficulty is encapsulated in the concept that subjective judgments, upon which diagnostic criteria are based, do not yield high levels of reliability. Unified agreement on diagnosis is also challenging for clinicians. For example, it has been found that clinicians only agree on a broad diagnostic category such as 'personality disorder' about 50% of the time (Kirk & Kutchins, 1994).

There is also uncertainty regarding the strength of validity in relation to diagnosis. Validity of diagnosis refers to receiving the correct diagnosis. This should result in the correct treatment and prognosis, known as predictive validity, which presupposes reliability of diagnosis. Due to the subjective nature of diagnosis it is much harder to give an accurate diagnosis and prognosis to a psychological disorder than physical because of lacking objective signs. It can be hard to make a valid diagnosis as some people have different experiences of distress linked to different psychiatric disorders. The National co-Morbidity Survey in the USA discovered that over 50% of people with one diagnosis also qualify for at least one other diagnosis whilst 23% are assigned three of more diagnosis (Kessler et al, 2005).

Overall, it seems the arbitrary nature of the manner in which emotionally distressing experiences, otherwise known as 'symptoms', are clustered into categories and diagnostic criteria are profoundly problematic. One might argue

that psychiatry is too quick to classify anything but routine happiness as a mental disorder.

1.7. Theories of distress categorized as depression

Various theories of emotional distress have been postulated, some of which are outlined below and are widely accepted. They include: the biological model (Pinel, 1997) which states that emotional distress diagnosed as depression is a result of a chemical imbalance in the brain and can be genetically inherited; the cognitive model (Beck, Rush, Shaw & Emery, 1979) which proposes that such suffering is triggered by negative attitudes and beliefs that are shaped in childhood; the psychoanalytic theory (Freud, 1917) postulates that loss of a significant person (such as a parent) or the withdrawal of love and affection at an early age can cause someone to experience emotional distress later on in life; the interpersonal theory (Sullivan, 1953) which emphasizes the importance of good connections and strong relationships in life and links distress to a lack of these; the social model (Bandura, 1977) which suggests that a lack of positive reinforcement from others evokes a negative self-evaluation accompanied by feelings of hopelessness; and, the learned helplessness model (Seligman, 1975) which argues that a perceived absence of control over situations triggers distress categorized as depression in some individuals. With the exception of the biological model the theories outlined below suggest that emotional distress is a result of environmental factors. They point towards social experiences people undergo that shape and maintain emotional suffering. The biological model however points to the chemical and neurological triggers in experiences of emotional distress.

1.7.1. The biological model

Biological factors have been thought to play a role in emotional distress since the 1970s. Experiences of distress are indeed both psychological and physical. Standardized depression measures enquire about both somatic and cognitive

elements of emotional suffering. Recognized somatic symptoms include weight loss, sleep disturbance and changes in appetite as stated in DSM-IV-TR (2000). These symptoms reflect some sort of biological dysfunction and neurobiological differences in brain structures such as increases in the volume of the amygdala (Roozendal, 2009) and decreases in the volume of the hippocampus (Campbell, 2004).

Numerous studies comparing antidepressants to placebos in controlled blind trials report effectiveness in the reduction of emotional distress to be between 50 and 70 per cent, which is 20 to 40 per cent higher than it is for placebos (Thase & Kupfer, 1996). Current guidelines recommend antidepressant treatment for people with a diagnosis of moderate to severe depression (National Institute for Health and Clinical Excellence, 2004a) and these guidelines are based upon placebo-controlled studies indicating that antidepressants are superior to placebo in combating symptoms of distress categorized as depression.

For many physical illnesses there is sound evidence of cause and sometimes specific biological pathways have been identified. However, for psychological illness the evidence is not so strong. According to neurobiological theory, a serotonin deficiency in the brain causes experiences that come to be diagnosed as depression; similarly, emotional distress has been successfully treated with serotonin-boosting drugs such as Prozac and other serotonin selective reuptake inhibitors (SSRIs).

However, it is not clear if increased serotonin levels are responsible for eradicating such experiences or are a consequence of their remission. Furthermore, some studies have found no significant difference in serotonin levels between people diagnosed with depression and controls (Meyer et al., 2004) while others have even found significantly increased serotonin activity in those with a depression diagnosis. (Parsey et al., 2006; Reivich, Amsterdam, Brunswick, Shiue, 2004).

Distress categorized as depression has also been linked to thyroid problems (Hage & Azar, 2011) and premenstrual syndrome and menopause (Freeman, Sammel, Lin & Nelson, 2006) indicating a possible link between distress and hormones. The fact that today many people are also successfully treated for emotional suffering with hormonal drugs lends support to the belief that its origins can be biological.

A theory outlined by Cantopher (2012) provides clear evidence as to how biological aspects of emotional distress manifest and how life experiences interact with them. According to Cantopher the limbic system controls many of the body's processes such as sleep/waking cycles, temperature control, temper control, eating patterns and hormones; every hormone in the body is directly or indirectly under the control of the limbic system which keeps all of these functions in balance with each other. The limbic system is a reverberating circuit and in addition to controlling all functions its most important role is to control mood.

A mood is generally stable and returns to normal quite quickly after life's various ups and downs. If someone wins a million pounds on the lottery that mood will rise for a few days and then return to normal with occasional peaks, mostly within the first few weeks after the win. However, a few weeks later the mood could be no different than how it was before this life-changing event occurred. This is an example of how mood is subject to control by the limbic system. The limbic system can thus be likened to a 'mood thermostat'. However, like every other system and structure in the body it has a limit and can break. Factors such as viral illness, hormonal conditions, illicit drugs, excessive alcohol consumption and major life stresses or changes may bring about a disruption of the limbic system. The most common trigger, however, is stress. If the limbic system is taken beyond its design limits it will malfunction and the balance of transmitter chemicals in the brain such as serotonin is disrupted. When the limbic system malfunctions a characteristic set of experiences of distress arise often referred to by psychiatrists as symptoms of clinical depression (Cantopher, 2012).

Cantopher's theory demonstrates how biology interacts with life events and stressors. If correct then it would seem reasonable to conclude that biology plays some part in emotional distress but does not fully provide an explanation for it. Despite the fact that, as mentioned earlier, some people diagnosed with depression do not show changes in serotonin levels, it appears that life stresses and events have the ability to impact on the way the brain functions. It seems that whilst biology is not irrelevant to emotional distress, it may not be the primary cause of distress. It may be that our biology enables us to feel emotional distress rather than simply causing it.

Having debated the influence of biological factors in emotional distress in more detail the researcher will now proceed to consider social influences in emotional distress. Environmental differences that have been identified repeatedly in a wealth of research include relational/social influences, early experiences, trauma and abuse. In particular the influence of family relationships has been linked to various forms of emotional distress subsequently diagnosed as depression, eating disorders and borderline personality disorder.

1.7.2. The social learning and attachment theory

Social learning theory models of human development emphasize the importance of early childhood experiences in the family environment. People given a diagnosis of borderline personality disorder are often seen as having a failure of early attachments leading to a life long difficulty in regulating emotions and forming stable relationships (Bateman & Fonagy, 2006).

Evidence for the importance of family dynamics as a contributing factor in emotional suffering also comes from attachment theory. The child psychologist Bowlby described how the effects of leaving a child for long periods without its mother were initially weepiness and withdrawal and, later, retardation of development and poor relationships with peers. He also claims that these children would often grow into adulthood feeling anxious, excessively needing love and attention, tending to feelings of anger and vengeance thereby becoming

prone to feelings of guilt and other experiences associated with a diagnosis of depression. He argued that in such cases these children had been deprived of a need for attachment, which he described as an evolutionary need, keeping infants close to their mother for protection in a hostile environment. It has however since been noted that children can manage quite well as long as they have a central, reliable and protective figure, whether this be the mother or someone else (Cantopher, 2012).

Bowlby suggests that those children who are insecurely attached may be more likely to experience self-criticism, feelings of abandonment, hopelessness and helplessness and related depressive symptoms. There is a considerable body of empirical work validating Bowlby's ideas about attachment security in infants and its consequences for healthy or maladaptive development (Blatt & Homann, 1992).

The cognitive social learning model proposes that adaptive skills and cognitions are learned during childhood and states that parent-child interactions that lead to the child's acquisition of dysfunctional self-schemas or negative explanatory styles set the stage for vulnerability to distress diagnosed as depression in the face of stress. The modeling of emotionally distressed parents' views of the self or world may enhance the cognitive vulnerability to experience such distress under trying circumstances (Hammen, 1998).

A considerable body of research indicates that the effects of social support cushion the ill effects of stressful life events (Paykel & Cooper, 1992; Billing & Moos, 1985; Kessler & Mc Leod, 1985; Swindel, Cronkite & Moos, 1989) and this lends support to the theory that difficult social relationships or a lack of them can be significant contributing and maintaining factors to a diagnosis of depression.

Studies of non-human primates permitting experimental control over mother-infant separation and quality of care have provided clear evidence of the importance of mother-infant attachment to healthy development as mentioned

above (Suomi, 1991a). It was also found by Brewin, Firth-Cozens, Furnham & Mc Manus (1992) that recollections of inadequate parenting were often associated with self-critical tendencies and that such cognitions might predispose someone to depressive reactions.

Relational difficulties are also central to distress, which is later diagnosed as depression and impact negatively on those around them (Hammen, 1998). A variety of controlled, simulated laboratory experiments documented that interacting with an emotionally distressed person often gives rise to negative emotional reactions in the other persons (Gotlib & Beaty, 1985), lending support to the notion that people's feelings can be transmitted to those around them. Such distress disrupts relationships, which can in turn potentially exacerbate emotional suffering.

1.7.3. The psychodynamic theory

The psychodynamic model of distress diagnosed as depression was the dominant theory within psychiatry during the first part of the 20th century. The emphasis on the role of loss in emotional suffering similar to that of bereavement led in turn to Object Relations Theory (ORT). The loss of an important object is central to ORT, which suggests that the early experience of loss of an important person not only triggers sadness and mourning but also self-deprecation, guilt and anger turned inwards plus related distress experiences cited as symptoms of the depression syndrome (Hammen, 1998).

Studies have revealed that there are significant associations between early loss and later distress categorized as depression (Lloyd, 1980). However, later studies conducted by Harris, Brown & Bifulco (1986) revealed that it was not so much early loss of a caregiver that created a vulnerability to emotional suffering but rather the quality and the consistency of the care after the loss. Lack of such care was recognized to be a trigger for vulnerability to a diagnosis of depression rather than the loss itself.

Though CBT has become the most popular method of therapy for treatment of emotional distress, a study conducted by Taylor (2008) showed that the benefits of short-term psychodynamic therapies are equivalent to the effects of antidepressants and CBT, and that whilst the benefits of CBT may occur more quickly, those benefits of short-term psychodynamic therapies may continue to increase after treatment.

1.7.4. The interpersonal theory

Interpersonal Therapy (IPT) has success rates for emotional distress diagnosed as depression founded on the assumption that emotional suffering can result from and lead to difficulties in the interpersonal relationships among persons diagnosed with depression and their significant others. The therapy aims to alleviate the experiences of emotional distress by improving interpersonal functioning through clarification, refocusing and the renegotiating of the interpersonal context linked to the onset of the diagnosed depression (Weissman & Klerman, 1990).

A study conducted by Parker & Fletcher (2007) comparing IPT and CBT approaches found that both therapies were effective treatments and that CBT was a more effective treatment for a diagnosis of severe depression. However, a study conducted by Freeman & Power (2007) set out to compare the efficacy of both treatments in people receiving outpatient treatment for diagnosed depression and found that both IPT and CBT were both equally effective, suggesting that the supportive nature of the therapy and the therapeutic relationship have a substantial effect on the outcome of the treatment of emotional distress.

1.7.5. The learned helplessness theory

It was observed by Seligman (1975) that animals subjected to uncontrollable aversive conditions failed to take action to escape such situations even when it was within their power to do so. This is because they had learned to be helpless. Seligman suggested that the same processes are at play in human emotional

distress, thereby proposing that if someone does not have control over a situation, for example, by being able to obtain a desirable outcome or preventing an unwanted one, they will fail to act at some later stage even when it is within their power to do so and may consequently suffer emotional distress leading to a diagnosis of depression.

Research on the cognitive theory of emotional distress categorised as depression has shown that people who are suffering emotionally are particularly prone to struggle with feelings of hopelessness and helplessness (Sacco & Beck, 1995). A sense of hopelessness reflects a negative view of the future, which includes expectations of personal dissatisfaction, failure and a continuation of pain and difficulty; ultimately it is a belief that nothing will get better.

Feelings of helplessness reflect a negative view of the self. Emotionally distressed individuals view themselves more negatively, their self-esteem suffers and consequently they have little or no self-confidence. They do not believe they have any control or that they can help themselves to feel better, resulting in an urge to give up on life.

1.7.6. The cognitive theory

Beck's well known and widely recognised cognitive theory of emotional suffering diagnosed as depression (Beck et al., 1979) suggests that early childhood experiences shape the development of long-term dysfunctional attitudes, perceptions and beliefs about the self, the world and the future. As a result a negative triad of beliefs of a worthless self, perceptions of the world as unfair and feelings of hopelessness about the future. Beck proposed that enduring dysfunctional attitudes shaped in an individual's early years can lie dormant for years and can subsequently become activated in times of stress or life difficulty.

Beck emphasized the following dysfunctional thinking styles in emotional distress: unhelpful thought processes such as dichotomous, all-or-nothing thinking, where people tend to think in rigid black and white terms; filtering,

when one magnifies the negative details in a situation and filters out the positive; emotional reasoning, where one concludes that because one feels something it must be true; personalisation, thinking that everything people say or do is some kind of reaction to them as a person; and, catastrophizing, whereby one fears in many situations the worst possible scenario.

In addition he emphasized how one's negative thoughts influence behaviour. For example, if an individual believes they are stupid and boring, this may affect their behaviour and they may withdraw socially because of this; this social isolation may in turn lead to maintained or increased feelings of emotional distress. He concluded that dysfunctional thinking styles both triggered and maintained emotional suffering in those who are predisposed to it.

The aim of cognitive therapy is to help the client develop more positive, if not realistic, thoughts and beliefs about themselves, others and the surrounding world. This can be done through Socratic questioning where the therapist encourages the client to question, challenge and modify unhelpful beliefs about themselves and their worlds. Cognitive Behavioural Therapy (CBT) is a structured and goal-directed therapy (Gilbert, 2009).

Perhaps the strongest evidence for Beck's cognitive theory of emotional distress categorised as depression is the success rate of CBT, now recognised by the current National Institute for Clinical Health and Excellence (NICE) guidelines as one of the most effective psychological treatments for a diagnosis of depression. The efficacy of cognitive therapy for such distress is well established, as can be attested in several outcome studies and reviews (Williams, 1992; Blackburn, 1998; Stravynski & Greenberg, 1992) and meta-analytic studies (Dobson, 1989; Robinson, Berman & Neimeyer, 1990). Moreover, a recent study conducted by Brothers, Yang, Andersen & Stunk (2011) found that distress categorised as depressive symptoms in cancer survivors receiving CBT intervention declined significantly, as demonstrated using intent-to-treat analyses. Change was evident on both self-reported and interviewer-rated

measures of those distressing experiences and accepted indicators of clinical change.

There is limited literature providing evidence against Beck's cognitive theory of emotional distress. Perhaps the most compelling is a study conducted by Persons & Miranda (1992), which found that dysfunctional thoughts in individuals diagnosed with depression tended to remit as the emotional distress remits. This contradicted the belief that negative schemas are stable cognitive structures and suggested that negative thinking styles might be the manifestations rather than the causes of distress.

Furthermore, a randomized trial of behavioural activation, cognitive therapy and antidepressant treatment in the acute treatment of adults with a major depression diagnosis found that the effects of cognitive therapy were not significantly different to placebo in treating a diagnosis of depression (Dimidjian et al, 2006).

A study conducted by Longmore & Worrell (2007) found little evidence that specific cognitive interventions significantly increase the effectiveness of therapy and little empirical support for the role of cognitive change as causal in the symptomatic improvements achieved in CBT. Furthermore, Hayes (2004) found that CBT treatment is often associated with a rapid, early improvement in symptoms that most likely occurs before the implementation of any distinctive cognitive techniques and that changes in cognitive mediators (the thoughts and beliefs held by the cognitive model to underpin disorder) do not seem to precede any improvements in symptoms.

Like other facets of human experience, causality in emotional suffering is various, intricate and over-determined. Research and clinical experience have indicated that there are many interacting causal factors of cause in emotional distress, some of which have been outlined above. As noted by Cromby, Harper & Reavey (2013) the causation involved in emotional suffering is not as straightforward as that which occurs between the molecules in a test tube. To

explore and comprehend causal influences in distress we need to recognize that these causes will not operate in a straight forwardly mechanical fashion but collectively reflect the multitude or the factors that influence our lives. The open-ended and often unforeseeable nature of the world allows the causal factors in emotional distress to operate in an unpredictable manner in such a way that any one influence on distress has the potential to trigger other influences in surprising and unexpected ways. There are many possible influences on distress each of which has the potential to trigger other influences in different ways.

All the models of emotional distress, outlined in this thesis are meaningful in various ways to different people. After reviewing them the reader may feel an understandable uncertainty as to whether emotional distress is biological or social. The non- biological theories point to environmental influences in the onset and maintenance. It has been noted that clear and non-controversial evidence for primary biological causes of emotional distress (in the form of well designed, high quality reliable and valid studies) are hard to find (Cromby, Harper & Reavey, 2013). As mentioned when outlining the biological theory, despite evidence supporting a serotonin deficiency in emotional suffering, there is also evidence to the contrary. Whilst some studies have found reduced serotonin activity at relevant receptors (Sargent et al, 2000) some studies have found no significant differences between those diagnosed with depression and controls (Meyer et al, 2004). Moreover, some studies have found considerable increased serotonin activity in patients diagnosed with depression (Parsey et al, 2006 & Reivich, Amsterdam, Brunswick & Yannshiue, 2004). This might imply that low levels of serotonin are not a necessary or sufficient cause associated with a diagnosis of depression.

Although there is a substantial body of psychiatric theory that claims that emotional distress is caused by biological influences, the distinction between functional and organic diagnosis is important. Depression, anxiety and other psychiatric diagnoses are recognsied to be functional in contrast to those where there is a biological cause (Cromby, Harper & Reavey, 2013). In those cases where a biological cause of dysfunction has been demonstrated, as in dementia or syphilis, the diagnosis is deemed to be organic.

The former adheres to behaviour deemed to be dysfunctional with no proven corresponding organic basis and the latter to conditions where a biological influence of dysfunction has been demonstrated. Depression, anxiety and many other psychiatric diagnoses are recognsied to be functional in contrast to those where there is a biological cause (Cromby, Harper & Reavey, 2013).

Perhaps it is relevant to distinguish between necessary causes and sufficient causes. Necessary causes are those influences or events that must be present for a specific outcome. For example, if a serotonin deficiency were a necessary cause of emotional distress only those with this deficiency would become emotionally distressed. Sufficient causes on the other hand are influences or events that do not have to be present to cause emotional suffering but always result in such suffering if they are present. Therefore, if a certain sort of trauma were a sufficient cause of emotional distress then everyone who experienced such a trauma would become emotionally distressed. It would not follow from this that everyone who is distressed would have to suffer the trauma in question.

It may be more appropriate to suggest that biological factors rather than being necessary or sufficient causes, are germane to emotional suffering and not the main cause. None of the stated biological features such as increase in volume of the amygdala or serotonin levels or decrease in volume of the hippocampus are present in every person given a diagnosis of depression. They are therefore not necessary causes. Nevertheless, some of these features have been observed in people who have not received a depression diagnosis. Hence they are not sufficient causes either. For most common illness in physical medicine there is good evidence specific biological pathways have been recognized, their functions identified and effective relevant medical treatments are evidence based. However, for a depression diagnosis this is not the case. There are no precise links between particular types of distress and specific biological components. There is only a great mass of inconsistent evidence with no certain links between biological features and diagnosis (Cromby, Harper & Reavey, 2013).

This explains why there are currently no blood tests, brain scan, or different objective diagnostic procedures that can recognize, endorse or reject a depression diagnosis. Such a diagnosis is detected through interview and observation involving self-reports of experience and expert assessment of mood and behaviour. In light of all this it seems reasonable to conclude that biology plays some part in emotional distress while not fully providing an explanation for it. One might conclude that our biology enables us to feel distress and that our brain structures and process can reflect this when it happens.

In conclusion it would appear that none of these causal influences are necessary or sufficient causes of emotional suffering as none of them appear in every case and none them always result in emotional distress subsequently diagnosed as depression. There appear to be many ways in which social and biological influences play their part and their influences are always conditional and mediated by other influences. It would be extremely hard to foresee that someone would experience emotional distress as a result of his or her socio-economic status, gender, ethnicity and family history. The conclusion therefore must be that there is no easy answer as to what causes emotional suffering subsequently diagnosed as depression.

1.8. Background perspectives relevant to this research

As a counselling psychologist who has worked with distressed individuals, the researcher has observed how some view their personal distress as a transitory phase whilst others seem to view their confusion and uncertainty as permanent conditions. For some, emotional suffering seems to persist despite all the best therapeutic and medical treatment available; whilst for others as little as eight psychological counselling sessions successfully eradicates the distress.

Although long-term severe emotional suffering is generally harder to overcome and treat than mild distress, the researcher has in her own practice seen people suffering from severe distress recover at the same pace as milder sufferer's. Attitude, personality, social support and life satisfaction may play a

part in the recovery process; alternatively, there may be something not yet identified that enhances some individual's recovery. Is it an illness for some and a transformative period for others? Might the idea that it is a transformative period itself be an aspect of emotional distress, one that could lead some down a self-destructive path motivated by a desire to make great changes in their lives they may later regret? Or could the emotional distress be a real warning to some that they need to turn their life around to find fulfillment and be content?

1.9. Self-control - Inside and outside

According to Smail (1993) the great flaw of psychology has been to see individual meaning systems as belonging to and being under the control of the people in whom they are present. All too frequently the assumption is made that attitudes and beliefs are located inside a person and subject to operations of his or her will.

This suggests that one can decide to alter beliefs or attitudes, which may have become inappropriate or inconvenient. Smail suggest that people are an interaction of body and world and cannot control their attitudes and beliefs, as people *are* in fact their attitudes and beliefs. Attitudes and beliefs may be constituents of our personhood and there may be no person who can be objective to this constituency, adjust and return to it as CBT proposes.

1.10. Emotional distress and existentialism

Phenomenology is a research technique that involves the careful description of aspects of human lives as they are lived. Existentialism, deriving its insights from phenomenology, is the philosophical attitude that views human life from the inside rather than pretending to understand it from an external, objective point-of-view (Spiegelberg, 1965). As this research is concerned with recording and interpreting lived experiences of emotional suffering subsequently diagnosed as depression, I will now discuss some of the concepts behind existentialism.

Existentialism acknowledges that humans are thrown into a world of pain, frustration, sickness, contempt, malaise and inevitable death, and that these conditions alone are enough to evoke understandable feelings of sadness and worry in people. Existential psychiatry was developed in the 1940s and placed emphasis on the existence of humans in relation to a lack of purpose and meaning in life.

Pilgrim (1999) suggested that clinical diagnosis does not enhance humanity. He proposed that it does not help people to find meaning whilst failing to address philosophical questions that are generated from human existence. Often, people who present with emotional distress feel that their lives lack meaning resulting in feelings of hopelessness.

As the well-known existential psychotherapist Yalom stated, "self-awareness is a supreme gift. This is what makes us human. But it comes with a costly price: The wound of mortality" (Yalom, 2008). Similarly, the proverb "Death alone can kill hope" recognizes that hopelessness, a manifestation of emotional distress, may be an understandable feeling about life and the inevitability of death.

In his book Existential Psychotherapy, Yalom (1980) cites that all humans have an instinctive fear of death and, for most people, this increases with age. At the root of this fear is the thought of dying alone along with the extinction of one's identity. Some people find religion helpful as it often promises life after death and it can promise some control over the experience after death in relation to heaven, hell, reincarnation and other alternatives.

Hopelessness may well be an understandable feeling in this context and this line of thought may be said to denote a type of depressive realism, suggesting that people diagnosed with depression might have a more accurate perception of reality than those affected by optimism bias. Perhaps people who are not

emotionally distressed see things in an overly positive light whilst distressed people perceive things in a more realistic perspective.

The utility of optimism has been supported by research on social cognition. Taylor & Brown (1988) theorized that positive bias is beneficial for people's general well being and mental health, and found that people tend to show a positive bias when they perceive themselves and the world as being better than they actually are. One example of a positive bias is unrealistic optimism. Some people believe that the present is better than the past and, moreover, that the future will be even better than the present. This is in direct contrast to depressed beliefs that the future is hopeless and bleak (Beck, 1979). Taylor & Brown (1988) found that positive bias, such as optimism about the future, can make people "happier, more caring and more productive" and that optimism is beneficial in many situations.

However, research by Nordgren (2009) shows that optimism can sometimes lead to failure. In particular, people can sabotage themselves when they overestimate their capacity for self-control. If people believe they have high self-control, they may subject themselves to more temptation than they can handle and consequently fail to resist it. Exhibiting what Nordgren calls the "self-restraint bias", depressed individuals on the other hand may be more likely to believe they are powerless and have little control over their life (Thompson, 1999).

1.11. The causal role of environment and social status

Though it may be true that emotional suffering subsequently diagnosed as depression has a biological and genetic component (Pinel, 1997) one cannot ignore the evidence suggesting that it is are also strongly linked to living conditions.

The gulf between the poor and rich of the world is widening. Within the UK

itself the financial gap between the wealthy and the poor is growing and differences in health between social classes are becoming greater (Smith, Bartly & Blane, 1990). It has been established that poverty and social inequality have direct and indirect effects on the social, mental and physical well being of an individual (Murali & Oboyde, 2004). Moreover, it is important to note that poverty and inequality are closely linked. Poverty is a multidimensional phenomenon, encompassing the inability to satisfy basic needs, lack of control over resources, poor education and health. Poverty can be intrinsically alienating and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioural and psychiatric problems (Murali & Oboyde, 2004).

Emotional distress is known to be more prevalent amongst those of lower social status and with lower income levels. Studies have indicated that poverty increases the risk for all forms of psychological disorder and whilst it must be acknowledged that the correlation is bi-directional - namely that those with disorders are often too impaired to sustain work and income - poverty is a stress that has the capacity to overwhelm coping and well-functioning people too.

Bruce, Takeuchi & Leaf (1991) conducted a study which investigated people below the poverty line and looked for the onset and development of disorders six months later in those who were previously well. They discovered that the people in poverty were twice as likely to receive a depression diagnosis as those who were not.

In addition to acknowledging that poverty is a predictor for emotional distress it is also interesting to note that unemployment is a contributing factor as are low status employment and occupation levels. It may not just be the status of being unemployed that is linked to emotional suffering but the lack of occupation itself as it has also been noted that being a homemaker (hence, not being employed outside the home) is also associated with higher levels of depression diagnoses (Brown & Harris, 1978; Blazer, Kessler, McGonagle & Swartz, 1994). This may be linked to lack of routine, social interaction, change of scenery and possible

objective praise or recognition. Depression diagnosis is found to be more common among those with lower levels of educational attainment and this is probably because these are more likely to lead to occupations with lower status (Hammen, 1998).

From a social perspective, emotional distress is believed to result from individual responses to adverse social and environmental agents such as stressful life events, socioeconomic disadvantage and lack of interpersonal support (Brown & Harris, 1978; Nicolson, 1998; Oakley, 1980; O'Leary, Helgeson, Gallant, Keita & Royak-Schaler, 1997). The role of context in determining the impact of negative life events on adjustment has been documented in various work, namely Brown, Bifulco & Harris (1987) Brown & Harris (1978) Brown & Prudo (1981).

Brown and Harris's (1978) model of distress categorized as depression includes vulnerability factors, which are defined as factors that increase the risk of depression diagnosis following a negative life event. These vulnerability factors reduce people's ongoing ability to feel in control and optimism regarding their future.

Thus, when a negative life event occurs, cognitions of hopelessness may be amplified and emotional distress may ensue (Brown & Harris, 1978). An example of a vulnerability factor is the absence of a supportive spouse or romantic partner (Brown & Harris, 1978). In light of this literature it will be interesting to see if vulnerability factors or significant negative life events emerge in the participants' stories about their experiences of emotional suffering.

1.12. Society and emotional distress

The clinical psychologist David Smail cites society as a cause of distress. In his book The Origins Of Unhappiness (1993) he suggests that society is responsible for an individual's distress. He proposes that individuals do not have

inherent weaknesses that predispose them to mental illness and that symptoms of distress should not be viewed from a medical perspective.

Smail believes that individuals can become emotionally distressed as a result of the ways in which society forces them to live. This is in contrast to Beck's cognitive theory of distress diagnosed as depression, which suggests people suffer emotionally as a result of their beliefs and interpretations of experiences and the world. Smail believes that if people are subject to too many adverse life experiences they can become psychologically and emotionally harmed. He proposed that some people are more perceptive and sensitive than others and may suffer in life in a way that more resilient people who might have had a more stable and caring start in life do not.

He also suggests that people become whom they are as a result of how they learn to think about themselves as children and that confidence develops through the relationships they have with other people. Whilst Beck also considers early experiences to be pertinent to the development of distorted cognitions linked to emotional distress, he does not cite society as a trigger for emotional suffering in the same way that Smail does. Given that he believes distress arises as a result of adverse living experiences, Smail suggests that it is not always easy for family and friends to help those who are suffering emotionally as they are so often implicated in the problems. He proposes that people turn to other sources of help such as mental health professionals.

He claims the value of therapy consists in: the demystification and clarification of the presenting problem; the received comfort of an hour of undivided attention from another person; and, the encouragement the client receives at having identified the problem and having established a relationship with a therapist which allows them to think together about what to do to bring about change. He places much emphasis on the support, time and opportunity to share a problem which therapy can offer distressed individuals. This suggests that emotional distress may not require medical or therapeutic expertise to treat it so much as the time and support that people struggle to provide each other in modern life.

His beliefs about the benefits of therapy reinforce his ideas that people suffer emotionally as a result of the strains of everyday living.

Social factors play a significant role in generating feelings of entrapment. Entrapment is triggered and maintained by the ways in which people are forced to live by society and this in turn can influence their psychological and emotional well being (Smail, 1993). There are situations where escape is motivated but blocked or prevented. A known defensive mechanism common in many species is the fight or flight response with the latter emphasizing escape. It has been observed that particular emotional distress responses occur in highly stressful situations where escape is motivated but potentially thwarted, otherwise known as "arrested flight" (Dixon & Fish, 1998).

Dixon & Fisch (1998) described an ethological paradigm for studying arrested flight in humans. Participants were interviewed while sitting in a chair fixed to the floor. The fixed chair signified the prevented escape from the interview situation when challenging or stressful questions arose. In this situation, a marked similarity was identified between the defensive behaviours exhibited by animals and those displayed by the human participants (Dixon & Fisch, 1998). Amongst these were gaze aversion, minimal scanning of the surroundings and few facial expressions. These behaviours are visible and recognizable in participants diagnosed with depression compared with healthy controls (Dixon & Fisch, 1998).

The experiment lacked ecological validity due to an artificial and localized instance of blocked escape, yet it does suggest that similar defensive mechanisms may be evident in humans to those observed in animals. This suggests that the blocking of defensive motivations to escape stressful or defeating situations in life is central to the onset of experiences categorized as depressive symptoms (Gilbert, 2001a).

Gilbert & Alan (1998) proposed that entrapment could be classified in two ways: external entrapment relating to life events and circumstances that may be

difficult or impossible to change, such as lack of resources, relationships, health problems and aversive emotions such as internal entrapment involving thoughts and feelings (Gilbert & Gilbert, 2003) which may be intrusive or unwanted. It could be considered that society inevitably entraps everyone, sometimes through personal choice, expectations and needs in situations such as marriage, parenting and employment to name a few.

1.13. Life choices, events and crisis

Some of the life situations that may be capable of evoking feelings of entrapment may also have the potential to prevent emotional distress, thus maintaining happiness. There is a large body of research showing an association between marital status or quality and emotional distress. Whilst marital distress has the potential to trigger episodes of diagnosed depression and marital conflict, thus prolonging emotional suffering diagnosed as depression or precipitating relapse (Hooley & Teasdale, 1989; Gotlib & Hammen, 1992; O'Hara, 1986), other lines of research suggest that being happily married to a supportive partner protects against a depression diagnosis despite potential major stress factors (Bebbington, 1987; Brown & Harris, 1978; Gotlib & Hammen, 1992; O'Hara, 1986).

Work may also give rise to feelings of entrapment. However it is worth noting that whilst some people feel stressed and trapped by their jobs, many people are fulfilled and happy in them. Emotional distress is linked to poverty, unemployment and low educational attainment (Hammen, 1998) and this may be partly because people in these situations are missing some of the positive benefits others experience as a result of fulfilling work they might enjoy.

Another trigger for emotional suffering is the life crisis. This study aims to generate more subjective information about experiences of emotional suffering subsequently diagnosed as depression, experiences that are often referred to as life discontent or a life crisis. It will therefore investigate whether the onset of the participants' emotional distress was associated with any significant life changes.

I will be interested to see if participants in this study experienced any adverse life events throughout the course of their emotional suffering or around the time it began. Lauber, Nordt, Falcato & Rossler (2003) discovered that distress diagnosed as depression is hardly recognized as a psychological disorder among the general population in Switzerland; instead, it is often interpreted as a life crisis. Whilst it is true that a diagnosis of depression can be missed as it may be masked by unhappiness linked to life events or various physical conditions, emotional distress can also be over diagnosed as depression when other interpretations are possible such as manifestations of grief.

Leaving home, leaving school, getting married and getting divorced are life events or life choices. Persons who have self-harmed are described as having experienced four times as many stressful life events compared to the general population (Aldridge, 1998). Within life event literature, a general hypothesis is that life events play a role in the aetiology of somatic and psychiatric disorders and provide necessary conditions for such disorders (Dohrenwend & Dohrenwend, 1974). However, what must be considered is the way in which major life events and lifecycle changes are dealt with which may differ amongst individuals.

1.14. Loss

Brown & Harris (1978) noted that the immediate response to loss of an important source of positive value is likely to be a sense of hopelessness, accompanied by a range of feelings such as distress, depression, shame and anger. Loss events can be viewed as the deprivation of sources of value and reward. It has been suggested that what is important about such loss in the creation of emotional distress is that it triggers an inability to hold positive thoughts about ourselves, our lives and those close to us (Brown & Harris, 1978). It may also trigger the loss of faith in one's ability to attain a goal of value and importance (Melges & Bowlby,1969).

The implications of loss stretch beyond the fact of the loss itself. Brown &

Harris (1968) believe that feelings of hopelessness are key factors in emotional suffering and suggest that loss is the most likely cause of hopelessness. Feelings of hopelessness are a likely reaction to profound experiences of loss that may lead to thoughts about the hopelessness of one's life in general. Beck (1979) also cited thoughts and feelings of hopelessness as central to emotional distress and negative thinking. A revised hopelessness model of distress that is categorized as depression has been articulated by Abramson, Metalsky & Alloy (1989) and hopelessness is the cognition that immediately causes reactions of emotional distress.

Though clear links between hopelessness and emotional distress have been established, there seem to be people who endure loss in their lives and do not go on to receive a diagnosis of depression. Brown & Harris (1978) suggest that a personal response to loss is mediated by self-esteem. Therefore by experiencing low self-esteem and low feelings of mastery before a major loss, individuals may be more likely to struggle with the idea of emerging from their distress. Low self-esteem may therefore make someone more likely to experience emotional distress in reaction to a loss. Loss of self-esteem was given prominence as a critical intervening variable in the aetiology of distress categorized as depression by the psychoanalyst Bibring (1953). Employment, intimate and supportive relationships, plus not having three or more children under the age of 14 at home, have been cited by Brown & Harris (1978) as protective factors which provide interpersonal identities and create self-esteem.

Loss of identity is linked to emotional suffering and this has been well documented in the case of illness and disability when loss of identity is often experienced as a result of people feeling they are no longer the person they used to be (Silver, Surawy & Sanders, 2004). Traditionally, depression has been regarded as the response to, or expression of, loss, either of one's identity or of the meaning in one's life (Chesler, 1972). Emotional distress often occurs as a result of events that disrupt roles by which people define their self worth, particularly when these people lack alternative sources of self-definition.

It is generally accepted that women can suffer from emotional distress soon after becoming a mother and whilst there is some evidence that there may be a biological component to this, such as changing hormone levels soon after birth or even the chronic sleep deprivation which many new mothers experience, there is also a strong argument that the changes new mothers encounter personally, socially and physically can lead to a type of identity crisis (Nicolson, 1998).

Many new mothers are surprised to experience feelings of loss in relation to altered relationships with partners, becoming unemployed, becoming financially dependent on someone else for the first time, changes in physical appearance and changed relationship with one's own mother who assumes the role of grandmother to the newborn child (Nicolson, 1998). There has been some interesting qualitative work done in this area that explored individual experiences of post-natal distress. A study conducted by Graham, Sharp, Chamberlain, Folkes & Turner (2009) highlighted the feelings and experiences of mothers with a diagnosis of post-natal depression. The exploration of these experiences generated themes such as loss of control or loss of identity in the mothers' lives. Psychological aetiologies such as the stress of parenthood and changed relationships were sometimes cited as symptoms.

Some further in-depth qualitative work on post-natal depression was conducted by Paula Nicolson (2001) in her book Postnatal Depression: Facing The Paradox Of Loss, Happiness And Motherhood which focused on the stories of 24 women trying to negotiate their lives as mothers. She challenges the expectation that it is normal to be a happy mother, claiming that many new mothers experience some form of emotional distress that traditional medical accounts tend to pathologize. She argues that in fact many of the issues linked to post-natal distress are social rather than biological. She sets mothers' own accounts alongside expert evidence, providing a thorough critique of the traditional medical and social science explanations. The book provides a systematic feminist psychological analysis of women's experiences following childbirth and argues that, far from being an abnormal, undesirable, pathological condition, post-natal distress diagnosed as depression is a normal, healthy

response to a series of losses as outlined earlier.

1.15. Self-esteem

Many distressed people feel robbed of self-esteem and spiral into a state of hopelessness, which may in turn affect self-identity. A study conducted by Demir, Kaynak-Demir & Sonmez (2010) found that there was a close association between depression symptoms and identity confusion-related distress in adolescents who tend to have a heightened sensitivity to psychiatric disorders. Moreover, Silver et al., (2004) cited that meanings attached to being ill or disabled could affect mood or self worth commonly concerning loss of identity (e.g. “I’m not the person I was”).

Feelings of low self-esteem conjure up phrases such as self-image, self-worth and self-perception, all referring to the overall picture one has of oneself. Negative thoughts about the self reveal themselves in many ways including thoughts about the self, behaviour, emotions and relationships. People who are emotionally distressed almost always see themselves in a negative light (Fennel, 1999) and may be vulnerable to seeing any aspect of themselves negatively, whether this is their life choices, personality or appearance.

A study conducted by Tao et al (2011) found differences between emotionally ditressed subjects and controls in the brain circuits associated with feelings of hate, namely the superior frontal gyrus, the insula and the putamen. The links among these components of the hate circuit had become largely disconnected in the emotionally distressed group. It was found that people diagnosed with depression might experience deep self-loathing because such distress seems to uncouple the brain’s “hate circuit”. Sufferers may find it hard to cope with such disconnected hate feelings and project them onto themselves instead.

Low self-worth and increased self-loathing can manifest in many ways depending on the individual; if connected to the way they look, they may begin

to feel intensely unhappy or dissatisfied with their appearance and become overly concerned with their body image. In his literature on body dysmorphic disorder (BDD), a disorder where one has a distressing and impairing preoccupation with an imagined or slight defect in appearance, Veale (2004) states that there is often a large difference between the perceived ideal and perceived real self and this in turn causes emotional distress. The negative appraisals that BDD sufferers have produce negative feedback, fuelling feelings of self-dislike. Constant comparisons between the self and others continue to reinforce these feelings of shame, disgust and hopelessness (Veale, 2004). Links between BDD experiences and experiences categorized as depressive symptoms have been established and, whist they are unlikely to be symptoms of distress diagnosed as depression, they often coexist with a depression diagnosis and may be related to it (Philips, 2005).

Guilt and shame are emotions linked to self-esteem. Feelings of guilt are prominent in emotionally distressed people and this may be because distressed people are often strongly self-critical and self-punishing. Individuals are prone to guilt when they feel they have violated their own values and not lived up to their own standards. We feel guilty when we believe we have done something wrong or think we should have behaved differently. Shame is usually inextricably linked with a negative view of the self and often incorporates secrecy. Unsurprisingly, the source of shame is often hidden and destructive (Padesky & Greenberger, 1995).

1.16. Gender

In one study women were shown to be twice as likely as men to be diagnosed with depression (Gelder, Gath, Mayou & Cowen, 1996). Stressful life events have a substantial causal relationship with the onset of depressive episodes (Kendler et al., 1999) and the quality of experience associated with life events may be a contributing factor to gender differences in such distress. However, the evidence that females might be at higher risk of depression owing to higher rates of adverse life events has been inconsistent (Bebbington, 1996), with some studies demonstrating gender differences in the anticipated direction and others

detecting similar levels of life events in males and females. Nonetheless, the excess of life events in females has not been found to account entirely for their higher frequency of affective disorders (Bebbington, 1996).

Craig (1996) reported that experiences of defeat, humiliation and entrapment were at the heart of depressive diagnoses in males and females, although females were far more likely to report such experiences.

A study of couples reported that the excess of a depression diagnosis onset among females following adverse life events was entirely restricted to crises involving children, housing or reproductive problems. This occurred among those couples with a clear gender difference in the associated roles, resulting in increased responsibility of females in these areas (Nazroo, Edwards & Brown, 1997). These findings suggest that biological sex represents a useful starting point in research on gender differences in distress diagnosed as depression, provided that the observed differences are then related to sociocultural roles and norms by considering an individual's multiple social identities within his or her current and biographical contexts.

Research conducted by Nolen-Hoeksema (1999) found that women reported more chronic strain, a tendency to ruminate and a lower sense of self-mastery than men. Reported chronic strains were bound up with irritants and burdens linked to women's lower social power. Women were found to carry out a greater load of the housework and childcare and to bear more of the strain of parenting than men. It was found that the level of strain was correlated to higher levels of emotional distress categorized as depressive symptoms, suggesting that such factors do contribute to women's greater vulnerability to suffer emotional distress.

Chesler (1972) argues that women do become depressed long before menopausal chemistry becomes a possible explanation and suggests that women may get depressed as they grow older when their already limited opportunities for sexual, emotional and intellectual growth decrease further.

Emslie, Ridge & Ziebland (2007) found that both men and women found it difficult to recognize and articulate mental health problems and this had consequences for their ability to communicate with health professionals. Help-seeking individuals who present their feelings using psychological language and explanations for their symptoms (often women) are more likely to receive psychological diagnosis. Those, mostly men, who adopt normalizing styles of attribution, attributing their symptoms to environment or physical causes are more likely to receive physical diagnosis (Kessler & Mc Leod, 1999) This suggests the possibility of emotional distress subsequently diagnosed as depression being linked to social role and gender.

1.17. Social role theories

When women freely choose a traditional career as a full-time homemaker they often find that this is undervalued, lacks stimulus and is isolating. Such conditions can trigger loss of self-esteem, motivation and subsequent distress. Repetti & Crosby (1984) referred to this as *the noxious nature of the housewife role* theory of depression. Women who are unemployed outside of the home often have limited gratification in their lives. So long as all is well at home, these women are happy; conversely, if there is discord at home, they may have no one or nowhere else to run to. The theory holds that women often experience distress amounting to a diagnosis of depression as they lack multiple roles, which can compensate for each other in difficult times (Hoeksema, 1990).

One might infer from this theory that women could avoid emotional suffering by having both a family life and career outside of the home. However, according to role overload theory (Gove & Tudor, 1973), these women encounter a different set of pressures. Most women who work outside of the home still do most of the cooking, cleaning and caring for children in the home; hence they carry two full-time jobs. They are expected to be unselfish, patient and supportive at home, and at the same time selfish, aggressive and self-sufficient at work. Such pressures alone can lead to role overload and to the despair of

emotional distress (Hoeksema, 1990).

1.18. Victimization and discrimination

Sexual and physical abuse has been identified as a risk factor for emotional distress in women. A large community study found the risk of clinical depression diagnosis among sexually abused women to be 21.9 per cent, as compared to only a 5.5 per cent risk for those without a child sexual abuse history (Stein, Golding, Siegal, Burnam & Sorenson, 1988). Other studies report depression rates from 53 to 56 per cent for sexually abused women (Mullen, Martin & Anderson, 1994).

Another explanation for women's higher rates of emotional distress is domestic violence. Though men are sometimes the victims, men to women most commonly mete out such violence. In a World Health Organization multi-country study of women's health and domestic violence in ten countries, Garcia-Moreno, Jansen, Ellsberg, Heise & Watts (2005) found that rates of severe physical violence against women ranged from 4 per cent in Japan to 49 per cent in Peru. In all the countries surveyed, women who had experienced physical or sexual violence were significantly more likely to report higher levels of crying, inability to enjoy life and tiredness, as well as being significantly more likely to have attempted suicide.

Chronic, blatant and serious victimization such as that experienced by battered wives is the type of experience that creates a sense of helplessness in women. Some women are beaten and threatened with murder on a daily basis and feel they have no means of escaping the situation because their husband threatens to kill her or her children. These situations are more frequent than one imagines (Hoeksema, 1990).

There are also many other ways women are made to feel powerless. For instance, if they raise objection to actions or statements that they experience as

sexist, they may be told they are over sensitive or lacking a sense of humour. Repetition of such experiences and ridicule of attempts to change negative aspects of one's environment can lead to feelings of helplessness for some women (Hoeksema, 1990). Radloff (1975) argued that the constant frustration women face in society could lead to feelings of learned helplessness, a precursor of distress diagnosed as depression (Seligman, 1975). Sexual harassment can also be a problem for women (Hoeksema, 1990) and it is possible that sexual harassment at work may increase the rates of a diagnosis of depression in women too.

The gender gap at work is still alive and well according to Kelan (2009) who found that women working 41 to 44 hours per week earn 84.6 per cent of what men working similar hours do. It was also noted that whilst many female workers acknowledge gender discrimination in the workplace they also claim their workplaces to be gender neutral. This was linked to the concept of gender fatigue where individuals tire of acting upon gender discrimination despite the fact that incidents of gender bias either may have occurred at one time within their organization or could occur again.

A commonly advanced explanation for gender differences is that women are relatively powerless compared with men, and are consequently more likely to suffer from the kind of social deprivation and stress which may lead to a diagnosis of depression (Brown & Harris, 1978, 1989). It was discovered by Jenkins (2008) that divorce makes men richer, particularly fathers, whilst in contrast an average woman's income falls by a fifth and remains low for many years.

It seems the idea that many men are fleeced as a result of their divorces while women get richer and live off the proceeds may be a myth. In reality many women suffer economic hardship when they divorce and this may be exacerbated by the fact that many women do not get paid the same as men for comparable work and some women do not receive child support from their divorced husbands.

The above highlights some of the blatant and subtle forms of discrimination and victimization that women face and which seem to contribute to feelings of helplessness, which feelings are in turn linked to emotional suffering.

1.19. Culture, race and religion

Studies in the US, the UK and elsewhere consistently indicate lower levels of depression among people of African descent (Williams, 2008 & Kessler et al., 1994). Before elaborating on this point it is of significant interest to note that, contrary to this, a number of studies in the UK have shown higher rates of schizophrenia diagnosis in Afro-Caribbean groups (Bhugra, 2000). Several critics have linked this to racism in psychiatry (Fernando, 2003), whilst others have linked this to the effects of migration by first and second generation Afro-Caribbeans migrants (Bental, 2004).

Given the above and the supposed interrelationship between socio-economic deprivations, the relative social positioning of black people in the US and UK and the rates of depression diagnosis, lower rates of it among African individuals presents something of a paradox. Many African Americans living in poverty reside in areas beset by alcohol outlets, open air drug markets, high incarceration rates, significant levels of homelessness and large numbers of children in foster care without permanent homes, all of which have an impact on mental health (Martin, 2002).

This may be because misdiagnosis and under-treatment is common within the African American community. Many African American women do not seek treatment because it is viewed as a personal weakness rather than a health problem. Just 12 per cent of African American women seek help or treatment, while at the same time they are more likely to consider emotions related to a diagnosis of depression as being evil or acting out (Williams, 2008).

In addition, high levels of poverty and marginal incomes just above the poverty line affect many African Americans, making them more likely to delay seeking treatment for mental health needs until they reach a crisis point and emergency intervention is necessary. They often do not have adequate insurance cover or ready access to primary care where mental health problems can be identified and treated in the early stages. Often, family values and traditions are a barrier to seeking help as well. There is a long practice of being stoic and toughing out troubles that implies that seeking mental health services is a sign of weakness (Taylor, 2004).

The prominence of religion in the African American community may also be a factor. Taylor (2004) found some evidence for involvement in religion being a protective factor in African Americans. Other literature suggests that the strength of faith along with support from the church can supplement treatment of emotional suffering and reduce isolation for African Americans. For example, Loewenthal (2007) cites that there is now an enormous scientific literature showing a reliable association between measures of religiosity and well- being, including lower distress diagnosed as depression.

Women have been found to rate higher on religiosity than men (Brown, 1987; Francis, 1993; Beit-Hallahmi & Argyle, 1997). This is widely confirmed, though most reports pertain to Christian cultures. Research conducted by Maltby (2005) indicates that religion makes people feel guiltier and that women are more religious; therefore, women feel guiltier and more depressed. He goes on to say that some forms of religiosity may be linked to a healthy guilt, while other forms may be linked to different types of maladaptive guilt.

Andrews, Qian & Valentine (2002) suggest that it is shame rather than guilt that is linked to depression. It could be that religious factors somehow make people feel not only more anxious and guilty but also ashamed.

However, Pargament (2002) found that particular styles of religious coping are associated with better and worse psychiatric outcomes and concluded that higher

well-being is associated with internalized religion, intrinsically motivated religion and a secure relationship with God. Lower well-being is associated with imposed religion, religious beliefs and behaviour that has not been examined, as well as a tenuous relationship with God and the world.

Religious factors may have both positive and negative effects on mood, and possibly on mood disorders. There are two possible important factors. Firstly, the social structure of religious groups which can offer a cohesive social framework, incorporating rules that may reduce the occurrence of some of the stresses that increase the risk of depression (Loewenthal, 2007). For example, Loewenthal et al., (1997) found that severe stressors such as divorce were less likely to occur within religious groups and that acts of kindness and compassion are considered meritorious. Moreover, cognitive factors that allow people to use religious coping beliefs in times of stress underpinned by automatic thoughts often form a constant backdrop to the lives of religious people. Pargament et al., (1990) identified some of the following religious beliefs that were helpful to individuals: the belief that God is a supportive partner; the belief that one can only control what one can and must leave the rest to God; the belief in a just and benevolent God. Nonetheless, the perception of one's troubles as God's punishment was associated with poorer mental health outcomes, a finding that has been reported repeatedly (Pargament, 2002).

Many people who could benefit from professional mental health care do not, as they are urged to rely on faith and prayer rather than therapy. In many instances, seeking counselling is considered a sign of a lack of faith in God and the healing power of divine intervention (Pargament, 2002). One prospective study by Tix & Frazier (1998) using general religious coping measures did find a positive association between religious coping and positive psychological adjustment; however, subsequent studies have failed to replicate these findings.

In a recent prospective study of female cancer patients, Hebert, Zdaniuk, Schulz & Scheier (2009) found no association between positive religious coping, such as benevolent religious appraisals or religious forgiveness, and measures of

psychological well-being. They did find that negative religious coping, in which individuals feel abandoned or punished by God, was positively associated with experiences of emotional distress, worse mental health and lower life satisfaction. Another recent prospective study of medical transplant patients (Sherman, Plante, Simonton, Latif & Anaisse, 2009) yielded similar results. This study found that negative religious coping was associated with increased experiences of emotional distress, post-transplant worry, lower measures of well-being and transplant concerns, while positive religious coping was unrelated to these variables. These findings are further consistent with those found by Fitchett, Rybarczyk, De Marco & Nicholas (1999), who prospectively studied positive and negative religious coping in medical rehabilitation patients and found support only for the harmful effects of negative religious coping.

A study on tolerance for distress diagnosed as depression conducted by Loewenthal, Mac Leod, Lee, Cook & Goldbatt (2002) discovered that men and women, in a sample of Jews and Protestants, did not differ in their tolerance levels to it. However, it revealed that Jews were more tolerant in their attitude to emotional suffering than Protestants. This research indicates people may have different levels of acceptance and tolerance to their emotional suffering subsequently diagnosed as depression and suggests that there will be a difference in the way people respond to and construe low mood or personal distress. Not only might religious attitudes influence an individual's propensity to or the severity of emotional suffering, they may also have some effect on the way people manage or experience it.

Overall, it is not clear if religious factors play a role in accounting for gender differences in emotional distress but it was concluded that religion probably plays a beneficial role more often than a malign one.

1.20. Media

New research conducted by Kersting (2005) revealed that gender stereotypes interfere with media portrayals of distress categorized as depression. It was

found that the printed news media were more likely to depict women's mental health in relation to gender-stereotyped roles, such as marriage, motherhood and the menopausal female. During this period men's emotional distress was increasingly described in terms of aggression or forms of escapism in relation to over-engagement in work or sport. Although the media is helping to raise the profile of emotional suffering diagnosed as depression, the information disseminated about sufferers' experiences may be biased by preconceived stereotypes.

Numerous online magazines and websites carry stories about celebrities who admit to experiencing emotional distress. A headline on www.dailymail.com in April 2008 read, "'I had post-natal depression' admits Gwyneth Paltrow". According to the English dictionary, the word admits is synonymous with confess. Indeed other celebrities have been described as confessing to suffering from emotional suffering. A headline from Female First magazine in 2007 referred to "Anne Hathway's depression confession".

Words such as admit and confess transmit feelings of shame in relation to depression, and such feelings have been identified as a barrier to treatment (Brown et al., 2010). Whilst it is indeed helpful and beneficial for the public to have access to people's experiences of emotional suffering diagnosed as depression, the stories often seem to be clouded by the vocabulary used by the media. Furthermore, the focus on celebrity experiences may prevent lay people with emotional distress subsequently diagnosed as depression from identifying with these stories.

1.21. Treatment-seeking behaviours

There has also been debate as to whether gender-related differences in rates of diagnosed depression are accurate reflections of actual psychological morbidity rather than being a reflection of gender differences in attribution styles and health-seeking behaviours (Wagber, 1998).

Research suggests that the stigma of mental illness can hinder treatment-seeking and utilization. On account of this perceived public stigma, individuals with mental illness might choose to avoid the public label and stigmatization by not seeking treatment or discontinuing it prematurely. Alternatively, through internalized stigma, individuals with mental illness may avoid the negative feelings of shame and guilt about themselves by not seeking treatment at all. Public and internalized stigma can manifest differently within individuals, as well as influencing each other in their impact on the stigmatized individual. If an individual with mental illness perceives public stigma to be high they may be more likely to internalize these negative stereotypes than if they perceive public stigma about mental illness to be low (Corrigan, 2002). Disparities exist in the utilization of mental health services (Snowden, 2001), with African Americans typically having lower rates of treatment seeking than whites, higher dropout rates from treatment and greater use of emergency care.

1.22. Research aims

This introduction has focused on experiences that are subsequently diagnosed as depression. Although the researcher at times refers to such experiences as pre-diagnosed depression this does not imply that the researcher wishes to understand these experiences in accordance with any existing model of depression. The above introduction considers and reflects on the various theories of emotional distress categorized as depression and their relevant perspectives. It is hoped that these theories may offer valuable insights into those experiences of emotional suffering subsequently diagnosed as depression. Nonetheless it is the experience of emotional suffering prior to the depression diagnosis that is being explored.

The researcher intends is to explore the nature of the participants' distress only in those cases where it is considered worthy of a depression diagnosis by a GP or psychiatrist. She is primarily concerned with understanding how people might experience emotional distress, some of which may not be documented in classification manuals. She is interested in the possibility of discovering new

experiences that may not be documented in the existing literature.

There are a variety of theories explaining emotional distress subsequently diagnosed as depression but the researcher has chosen to focus on life events and how the sufferer interprets these. She will also explore how the experience of emotional distress varies between individuals and the severity of suffering reached prior to the realization that they were in need of professional help.

The researcher has worked with distressed clients who described an insufferable amount of emotional and psychological noise, distraction and intrusion. Some of these clients told her they were troubled by persistent unwanted thoughts and feelings morning, noon and night. Some have described feeling emotionally flat and being so detached from their feelings that they claim to feel nothing at all, experiencing a world of flat greyness in which they prefer to sleep. The common factor in these reported experiences is misery. How did participants interpret and understand this misery that would eventually lead them to seek professional help?

This introduction was written before the researcher began the analysis. Since completing the analysis, the aim of the study has changed a bit and the scope has been reduced.

Originally, the intention was to explore people's experiences of emotional suffering subsequently diagnosed as a first episode of depression. However, it was decided to explore only people's experiences of pre-diagnosed depression and forgo the emphasis on a first episode. This was because much interesting and relevant data was gleaned from some of the participants' accounts of pre depression diagnosis experience that were not limited to first episodes. Further reasons for this change will be elaborated on in the upcoming methodology.

The researcher is interested in this pre-diagnostic period because, working as a counselling psychologist, she has observed how different the experiences of emotional distress can be and how bad it can become before individuals opt for

professional help. Standard symptoms described by DSM-IV-TR (2000) suggest that indicators are recognizable across a population of people. Rigid use of such manuals with their medical approach runs the risk of not understanding why people behave as they do. Psychopathology classifications can never capture the complexity and uniqueness of human experience (Ivey & Ivey, 1998). It seems that DSM-IV-TR (2000) was never intended to concern itself with the individual's phenomenological experience. This is presumably because it is primarily a psychiatric diagnostic tool normally used by clinicians to recognize signs and symptoms of disorders. However, as each person is different and their distress differs in nature and degree, there can be a danger of individual experience getting lost in a pool of theories, symptoms and syndromes (Parpottas, 2012).

Unlike DSM-IV-TR (2000), the Beck Depression Inventory (BDI-II; Beck, 1996) is a self-scoring checklist composed of items relating to symptoms of distress categorised as depression, such as hopelessness and irritability, cognitions such as guilt or feelings and thoughts of being punished and physical symptoms such as fatigue, weight loss and loss of libido. People are asked to rate how much they agree with certain statements, with chosen varying in intensity. Those that score highly on the questionnaire statements also score highly on levels of distress diagnosed as depression. Statements include "I am so worried about my physical problems I cannot think of anything else", "I believe that I look ugly", "I feel irritated all the time", "I have lost all my interest in other people", "I feel tired all the time", "I hate myself" and "I am so sad and unhappy I can't stand it". This study will investigate in depth what people undergo when they experience some of the psychological and emotional background to these statements, how these thoughts and feelings play themselves out in people's lives and the extent to which they believe these feelings are related to events in their life.

It is worth noting how much more descriptive some of the experiences documented as signs and symptoms on the BDI-II (1996) are in comparison to those listed in DSM-IV-TR (2000). DSM-IV-TR (2000) does not tell us how any

of the symptoms it cites such as feelings of worthlessness or inappropriate guilt might show up in an episode of diagnosed depression. BDI-11 (1996) on the other hand provides typical cognitions that feelings such as worthlessness listed in DSM-IV-TR (2000) might translate into, “I feel I am a complete failure as a person’.

This is because experiences of emotional distress documented as symptoms of depression in DSM-IV-TR (2000) do not represent the concrete thoughts in particular subjects. The current National Institute for Clinical Health and Excellence (NICE) guidance uses the DSM-IV-TR (2000) classification to diagnose major depression and requests the presence of at least one of the core symptoms such as persistent sadness or low mood nearly every day or loss of interest or pleasure in most activities.

If an individual had been struggling with the cognition “I feel there are permanent changes to my appearance that make me look unattractive” BDI-11 (1996) or “I have greater difficulty making decisions than I used to” BDI-11 (1996) or “I am disgusted with myself” BDI-II (1996), I am curious as to how they might come to the conclusion they warrant a depression diagnosis according to the criteria of BDI-II (1996) and are in need of professional help. If they suspected they were experiencing emotional suffering worthy of a diagnosis of depression and consulted DSM-IV-TR (2000) as recommended by the the NICE guidelines online, they may not be able to link their distorted thoughts such as those cited above to some of the described symptoms, for example as loss of interest in pleasurable activities or feeling empty.

If they were able to recognise that their distress was indicative of a possible depression diagnosis, they might then approach the health care services. If however they were not able to do this, they may continue suffering emotionally trying to make sense of their personal distress and possibly even feeling guilty about it. The researcher intends to interview people who have battled with unwanted thoughts such as those itemized in the BDI-II (1996) and to understand

how they interpreted them and what the experience may have meant to them before they were diagnosed with depression.

This is of particular interest as the researcher's professional work as a counselling psychologist has revealed that each person is different and their distress differs in nature and degree. In addition to exploring individual experiences of pre-diagnosed depression, she will explore the context of its onset, whether or not it was triggered by a particular life event and the totality of their life at the time.

This research aims to move away from diagnostic medical language in an attempt to understand the participants' experiences of emotional suffering using their own descriptions. An Interpretative Phenomenological Analysis (IPA) is an approach to qualitative analysis with a strong psychological interest into how people make sense of experiences (Harper & Thompson, 2012). As this research will explore how people acknowledge, manage and make sense of pre-diagnosed depression, it seems a suitable method to adopt.

IPA has been specifically developed by Smith, Harré & Van Langenhove (1995) to allow thorough and precise exploration of idiographic subjective experiences and social cognitions. It is now widely used within British psychology (Thompson, Kent, & Smith, 2002; Clare, 2003; Biggerstaff, 2003; French, Maissi, Marteau, 2005). Its philosophical and theoretical roots stem from the phenomenology which originated with Husserl's (1931) attempts to construct a philosophical science of consciousness, from hermeneutics (the theory of interpretation) and from symbolic-interactionism, the theory that the meanings individuals attribute to events are of central interest but are only accessible through an interpretative process. IPA acknowledges that the researcher's engagement with the participant's text has an interpretative element, yet unlike other methods such as discourse analysis (DA) (Potter, 1996), it assumes an epistemological stance whereby, through cautious and explicit interpretative methodology, it becomes possible to access an individual's cognitive inner world.

Moreover, it enables one to examine what people endure when they experience emotional suffering by collecting detailed, retrospective and reflective first person accounts from research participants. The researcher hopes to give voice to those who have suffered from emotional distress. She shall be using a one-to-one, semi-structured interview to generate the data.

A step-by-step methodological approach will be outlined later in the methodology section. By not looking for quantitative data the researcher will focus on the participants' subjective experiences of pre-diagnosed depression by means of a qualitative approach and will have an opportunity to discover whether participants experienced anything other than those symptoms cited in DSM-IV-TR (2000) or the Beck Depression Inventory (1996).

1.23. Study benefits to counselling psychology

It has been stated that although efforts have been made to improve public knowledge of physical disease such as heart disease and cancer, efforts to increase knowledge of psychological disorders have by comparison been somewhat neglected (Jorn, 2000). Research has focused on triggers, causes and treatment-seeking behaviours in distress categorized as depression (Adamson et al., 2010; Lauber et al., 2003) and less so on subjective experiences.

This research project aims to introduce the complexities of emotional suffering subsequently diagnosed as depression to a wider audience. Learning from our clients is something highly valued in counselling psychology where the emphasis is on understanding and working with a client's subjective experience. Counselling psychology as a profession prioritizes the therapeutic treatment of psychological distress and the client's unique system of making sense of what they are experiencing. It is commonly used with people who are intensely worried and extremely sad, otherwise classified in psychiatric terminology as depressed or anxious.

Emotional distress has been notoriously difficult to detect in general practice. Even when the distress diagnosed as depression is severe, half the cases go unrecognized (Montgomery, 1990). The reasons for this are unclear, although lack of insight on the part of the sufferer is undoubtedly a contributory factor as is the failure of sufferers to recognize their own distress subsequently diagnosed as depression. (Montgomery,1990). In primary care practices, up to 80 per cent of depressed patients present exclusively with physical symptoms that can include headache, abdominal pain and musculoskeletal pains in the lower back, joints, neck and body (Stahl, 2004). This inevitably makes it harder to determine whether people are presenting with emotional distress or not.

Early intervention and treatment for emotional distress are important to prevent people's suffering from deteriorating. Effective detection strategies require recognition of this distress at an early stage. It requires recognition from professionals as well as from the sufferer that something is not quite right. If an individual does not think they are in need of help they may be more inclined to suffer in isolation as they try to make sense of their plight. A study conducted by Barney (2009) found that the low visibility of distress diagnosed as depression means it is often not apparent to others. This also suggests that sufferers may have to endure emotional isolation, as people around them may not see their distress.

This research could help counselling psychologists develop their understanding of and familiarity with the breadth of experience people suffer when they experience emotional suffering subsequently diagnosed as depression. It could help them understand the variety of experiences people undergo when they are suffering emotionally.

As this study is concerned with what people experience when they are suffering emotionally before being diagnosed with depression, the emphasis is not on whether they were depressed according to classification systems or not. Rather it is on how they experienced the emotional distress that subsequently led to a depression diagnosis. It can provide counselling psychologists with a deeper

understanding of how distress might manifest when people are emotionally distressed and diagnosed with depression. By bringing this to their attention it is hoped that counselling psychologists will be able to identify the experiences under a broader theme and thereby understand them more.

It may also help counselling psychologists to recognize that some experiences that seem bizarre or unusual may in fact be triggered by emotional suffering that is subsequently diagnosed as depression. It may also point to early signs that someone is suffering emotional distress that may be diagnosed as depression and require certain treatment interventions.

The development of Improving Access to Psychological Therapies (IAPT) in 2010 was an initiative aimed at making psychological therapies more accessible to people facing mental health challenges. A large number of people are seeking, and will continue to seek, psychological help for general feelings of unhappiness or feeling ill at ease.

Since counselling psychologists are amongst the professionals that provide psychological counselling for emotional suffering, any research that can provide more information about people's experiences of personal distress is useful. Counselling psychologists are concerned with engaging with subjectivity and intersubjectivity, values and beliefs. They emphasize empathy and respect for first person valid accounts and do not assume superiority of any one way of experiencing, feeling, valuing or knowing (British Psychological Society, 2005). Gaining information of people's experiences of emotional distress subsequently diagnosed as depression would be of interest because of this.

2

METHODOLOGY

2.1. The research question

The research question this qualitative study explored is "How do people experience emotional suffering subsequently diagnosed as depression?" The research takes the form of an Interpretative Phenomenological Analysis (IPA). The researcher's aim was to engage and empathize with the participants' personal accounts of experience of emotional suffering and to understand how these are experienced. As a qualitative study it did not test a hypothesis with quantitative underpinnings. Neither was it concerned with predictions of outcomes.

2.2. Epistemological position

When applying IPA it is important to consider its epistemological position. Phenomenology pays attention to the individual's particular account of reality rather than the objective reality itself (Smith, 1995). Phenomenology, whilst recognizing the material reality of objects in the world, stresses that our perception of those objects will always remain subjective. Whilst acknowledging the fact that phenomena are always experienced through a personal lens and that any individuals participating in research will always be influenced by their own and the researcher's interpretations of the world, this does not mean that the accounts of these individuals are not relevant to the realities they describe.

As this study will explore people's experiences of emotional distress, the phenomenological approach will enable the researcher to gather and elucidate information about the participants' experiences whilst suspending presuppositions,

assumptions and judgments relating to their stories. It allows for diverse experiences of the same environment or situation. Because phenomenology is always concerned with how the world is experienced by human beings within particular contexts at particular times, it is therefore sensitive to diversity, deviation and difference in human experience (Spinelli, 1989) and is consequently well suited to a study that aims to explore people's potentially diverse experiences and interpretations of emotional distress.

It seems that exploring and categorizing subjective accounts of such experiences is appropriate for a study exploring pre-diagnosed depression experiences. It is because the approach is concerned with meaning and interpretation of human experience that I chose to conduct a phenomenological research approach. Phenomenologists believe that our knowledge and understanding are acquired in our everyday world and that truth and the understanding of life emerge from life experiences. As such it cannot be quantified. A semi-structured interview process seemed an appropriate way to collect data for the study. The results could subsequently be subjected to an IPA where the researcher could generate codes from existing data rather than using a pre-existing theory to identify codes that might subsequently be applied.

The researcher acknowledges that her interpretation of other people's experiences is partly influenced by her own thought processes, assumptions and ideas, and that this could have influenced the results. Equally, without some bedrock of thoughts, assumption and ideas, one would not be able to interpret other people's experiences at all.

2.3. Reflexivity - The researcher's standpoints

Reflexivity requires awareness by the researcher of her contribution to the construction of meanings throughout the research process and an acknowledgement of how difficult it can be to remain objective while conducting research. It encourages the researcher to explore the ways in which her involvement in a particular study influences and informs the research process (Nightingale & Cromby, 1999). As reflexivity is considered an important aspect of a study's transparency, the

following section illustrates as far as possible the researcher's values, interests and assumptions and considers how these might have influenced the research process (Elliott, Fischer & Rennie, 1999).

2.4. Background to study - Researcher's interests and potential biases

The researchers own interests and professional background also need to be made explicit. She is a British white female born in 1974 and grew up in a middle class area of London. She worked as a counselling psychologist in the NHS for six years before setting up her own private practice in London. In total she has amassed a wealth of ten years of experience providing psychological counselling to people presenting with a variety problems including emotional distress.

The researcher has worked in a variety of socio-economic areas in London, from those with high levels of ethnic minority and poverty to other more affluent areas. She feels this has broadened her understanding of different life experiences and the ways in which they can impact on an individual's well being. Overall, the researcher has worked with a diverse clinical population.

When the researcher began training as a counselling psychologist, she assumed that people's experiences of emotional suffering, often subsequently diagnosed by clinicians as depression, would be more or less the same. She was familiar with experiences of distress recorded as symptoms in classification manuals and assumed that they would manifest similarly in different individuals. As her clinical work progressed, she came to realize that this assumption was at odds with what she discovered first hand, namely that individuals' experiences of emotional distress are often very different.

Note only were clients' experiences of distress made up of many elements these elements varied greatly from one client to another. The researcher was interested in exploring these varied experiences in more detail. The idea therefore came to

develop this into a doctoral thesis on how individual's experience episodes of emotional distress subsequently diagnosed as depression.

General Practitioners who have already diagnosed them as suffering from depression refer quite a few of the researchers' clients to her. Similarly, she encounters much emotional distress already classified as depression by the time clients present for psychological counselling. At the same time she is aware that people experience distress differently.

The researcher's intention was to explore in more detail what actually went on for people when they were suffering this kind of emotional distress. She wanted to hear their stories of what the experience was like, how they made sense of it and how they responded to the situations and circumstances in their lives that may have triggered it or been linked to it.

2.5. Rationale for selection of qualitative design

Qualitative research is concerned with meaning. Rather than focusing on an outsider's views of what people do (Fiese & Bickman, 1998), it aims to shed light on how people make sense of experiences and what their behaviour means to themselves and others (Willig, 2012). Its goal is to understand a relatively small number of the participants' own experiences in depth and it does not attempt to test a preconceived hypothesis on a large sample (Smith, 2008). By not looking for quantitative data, the researcher is in a position to emphasize the participants' subjective experiences of emotional distress diagnosed as depression.

The approach appealed to the researcher because it is more holistic. In contrast to quantitative research methods, which place an emphasis on numbers and statistics often at the expense of individuals, a qualitative method allowed a process-orientated approach where she was able to examine how people experienced distress and how they thought, felt and attributed meaning to it. It is also interesting and exciting to be able to conduct research with the freedom a qualitative approach allows one to

explore the researcher/participant relationship whilst taking into account the phenomenon of reflexivity. A qualitative approach was thus considered suitable for this study.

2.6. Rationale for selection of IPA

An Interpretative Phenomenological Analysis (IPA) is an approach to qualitative analysis with a strong psychological interest in to how people make sense of experiences (Larkin & Thompson, 2012). IPA helps to provide new and differing perspectives on a phenomenon by learning from those who are experiencing it, rather than learning from or being biased by old theories or predetermined notions in existing research.

The idiographic nature of IPA therefore fits with the objective of this research. It allows the researcher to focus on a small group of individual experiences, rather than formulating general notions for larger populations (Smith & Osborn, 2008). Indeed, Smith (2004) suggests that this type of analysis can enable us to understand and learn about important generic themes in addition to each participant's individual story. IPA is particularly useful for investigating complexity, process and novelty (Smith & Osborn, 2008). The opportunity to investigate phenomena from a new perspective by learning from those who are experiencing it, rather than from pre-existing theories or knowledge (Shaw, 2001), fits well within the current NHS agenda of taking a patient-centred perspective and listening to the views of service users (Reid, Flowers & Larking, 2005).

Its philosophy is embedded in what has been termed symbolic interactionism, a concern for how meanings are constructed by individuals within both the social and personal world (Smith & Osborn, 2008). IPA views individuals as experts on their own experiences that can offer researchers an understanding of their thoughts, commitments and feelings by telling their own stories, in their own words and in as much detail as possible (Reid et al, 2005).

It is an approach concerned with exploring individuals' experiences and perceptions of an object or event, rather than producing an objective truth about that object or event. It emphasizes that experiences are influenced by perceptions, which are themselves constrained by social constructions.

IPA has proven to be effective in the exploration of sensitive and unexplored topics (Flowers, Mc Gregor, Larkin, Church & Marriot, 2011). Any human experience can be subject to an IPA in so far as it engages with the individual's subjective experience and concerns itself with its diversity and variability. As this research will explore how people manage and make sense of experiences of emotional distress subsequently diagnosed as depression it therefore seems a suitable method to employ. It enables the researcher to examine the suffering people endure when they experience emotional suffering by collecting detailed and reflective first person accounts from research participants. IPA has an established procedure for the analysis of experiential qualitative data (Smith & Osbourne, 2003), allowing space for a wider contextual interpretation (Willig, 2008).

IPA highlights the value of considering a researcher's role in influencing the process (Smith & Osborn, 2008). As her views, assumptions and beliefs will influence an interpretation of a participant's account, it stresses the importance of reflexivity to aid transparency. It recognizes that the production of an interpretative account is a function of the relationship between a researcher and a participant, and is in turn constructed and shaped by this encounter (Larkin, Watts & Clifton, 2006)

It is also an appropriate methodological approach for the researcher who, as a counselling psychologist, has extensive training in gaining empathetic, in-depth and authentic accounts of individual experience and in managing personal accounts of individual distress.

The researcher took a curious and facilitative stance, using a series of one-to-one, semi-structured interviews to generate the data. An interview agenda was devised and explained in the method overview to help prevent her from losing sight of the original research question; nevertheless, she tried not to be controlled too rigidly by

this as potentially rich data could have been lost if she did not follow her participants' accounts. An interpretative engagement within the text is therefore apparent and it is likely that this took the analytic process into a particular direction.

2.7. Limitations of IPA

Although IPA recognizes the importance of the researcher's perspective, it has been criticized for not providing guidelines on how to incorporate reflexivity into the research process and for not specifying how the researcher's preconceptions influence analysis. Willig (2001) suggests therefore that findings invoke a sense of discovery rather than construction, although Smith & Osborn (2008) argue that IPA is an approach rather than a rigid methodology, allowing flexibility to meet the researcher's need and context.

The role of language can be problematic in IPA. Social constructionists argue that language constructs rather than describes reality. It could be said, therefore, that an interview transcript tells us more about the way in which an individual talks about a particular experience, within a particular context, than about the experience itself (Willig, 2001). The ability of participants to communicate the rich texture of their experience successfully is a question that has been often asked of IPA. It is possible then that this study could potentially yield information about how participants talk about their experiences of distress rather than about the experience itself. This may be exacerbated if participants struggle to communicate their thoughts and feelings with words.

The phenomenological approach may not always be suitable for people who are less able to articulate their experiences through words. In answer to this, IPA acknowledges the role of social constructionism and the fact that pure experience is never accessible. It recognizes the action-orientated nature of language yet challenges the narrow view of people only as discursive agents (Eatough & Smith, 2006). Individuals can struggle to use language in a way that accurately conveys the subtleties and nuances of their experience (Willig, 2001). However, Smith & Osborn (2008) accept that whilst people often struggle to express what they are thinking and

feeling, their emotional state can be interpreted by a researcher as a result of analyzing what they say and, importantly, by asking critical questions about what is not said. It has therefore been assumed that language is a representative and valid tool for communicating experience (Willig, 2012).

A potential disadvantage of using a semi-structured interview is that participants may be inclined to adopt the stance of an interviewee. In this case, the result may be that they say more about their experience and reaction to being interviewed than the experience the research is attempting to explore. This is always the possibility of interference within interview-driven qualitative research.

This approach was suitable for this research, however, because it enabled the researcher to describe and record the lived experiences of the participants. Nevertheless, it must be acknowledged that it does not, in itself, explain them. Any insight gained from analysis of text is only the product of interpretation. Furthermore, it is recognized that the researcher will be implicated in the analysis one way or another and that her conceptions will influence the analysis. The researcher has therefore disclosed her values and assumptions to help the reader interpret the analysis. In addition the researcher's demographics have been declared to facilitate the detection of any possible influences on the data collection and analysis.

As mentioned earlier, IPA depends on both the participants' ability to communicate their experiences in a relatively articulate and comprehensive manner and the researcher's capacity to understand and process the participants' accounts of their experiences. There is further potential for ethical dilemmas arising from the close supportive relationships that can arise as a result of exploring people's personal experiences and handling personal and sensitive participant data (McLeod, 2003). However, it has been recognized by McLeod (2003) that ethical research problems often arise in everyday clinical work and this is part of the research process. He recommends that the researcher strike a balance between good and harm when conducting research. Possible examples include whether or not a researcher should give or withhold treatment, or whether to conduct research in natural or artificial

settings.

2.8. IPA as opposed to other qualitative methodologies

In deciding on this study's methodology, Grounded Theory was ruled out notwithstanding its similarities to IPA. It has been suggested that Grounded Theory is best suited to address sociological research questions, as it focuses on theory construction and social processes that account for phenomena, whereas IPA adopts a more psychological approach focused on gaining a detailed understanding of the quality and texture of individual experiences (Willig, 2001).

Discourse analysis (DA) was also felt inappropriate due to its focus on the role of language in the construction of social reality (Willig, 2008). Its goal of understanding how people use language to create and enact identities and activities contrasts with IPA's focus on the detailed understanding of a particular lived experience (Starks & Brown Trinidad, 2007).

2.9. Reliability

The issue of reliability is less important in qualitative research as it does not investigate large numbers of people. However, Silverman (2000) emphasized that qualitative research ought to generate reliable results. Hammersey (1992) stated that reliability in qualitative research refers to the consistency with which experiences are assigned to the same category by different observers or by the same observers on different occasions. Having an independent co-rater can aid the control for bias in qualitative research whereby the observer unconsciously seeks out particular categories to support a desired outcome (Coolican, 1999).

Alternative procedural suggestions to improve reliability in qualitative research include: the documentation of methodology and research procedure (Kirk & Miller, 1986; Silverman, 2000); the availability of interview recordings and transcripts to examiners (Bryman, 1988); and, the use of the participants' own language in the

coding process (Glassner & Loughlin, 1987). In the present study these were addressed through an emphasis on transparency in the methodology and the availability of a section of the transcript for review.

2.10. Validity

Problems with validity can arise within qualitative and quantitative research. Potential concerns are managed in various ways. For example, much qualitative research is conducted in real-life places as opposed to artificial settings such as laboratories where one has to extrapolate findings to the real world. This means qualitative studies have higher ecological validity. Moreover, the process of reflexivity means the researcher is continuously reviewing his or her own role in the research, thus increasing validity and discouraging the imposition of meaning on the part of the researcher (Willig, 2008).

2.11. Ethical considerations

Throughout this study, the researcher aimed to remain ethically sensitive as such issues and dilemmas can arise at any point throughout the research. Participants were informed that the research would not be of direct benefit to them and that the researcher would not provide a professional opinion or intervention.

In addition, the researcher adopted interventions to maintain personal safety and self-care. Participants were asked to attend her private practice for interviews where there were other practitioners and a reception service. This addressed personal care and safety by eliminating any potential problems that could arise if the researcher was alone and interviewing a stranger in an unfamiliar environment. As this was not always convenient for participants, some were interviewed at [redacted]) in a hired, private and quiet room and two were interviewed in their own home. These two people were acquaintances, so concerns of the researcher visiting a stranger in an unfamiliar and unprotected environment were significantly reduced.

This study endeavors to be transparent and reflexive, placing value on interaction and sharing. Explicit permission was gained for the recording of interviews. The aim of the research was explained and made clear. Conducting interviews about experiences of emotional suffering is likely to stimulate participant's self-reflection, thoughts and feelings, which they may not have experienced otherwise.

Though it has been stated by Thompson & Chambers (2012) that there is substantial evidence that emotional disclosure across a wide range of settings has the potential to be beneficial, there is always a chance this may affect a participant in a non-desirable way. For example it may highlight beliefs and values the participant had been unaware of previously. It may promote focus on or the recall of unwanted memories, raise divisions between attitudes and behaviours and trigger feelings of remorse, resentment or regret.

Though the researcher adopted responsibility for the research effects on the participants, she could not guarantee being able to deal with them. She therefore ensured that participants had space at the end of the interview during which reflection on the process could occur (Fossey, Epstein, Findlay, Plant & Harvey, 2002) and any interview-engendered emotional distress could be dealt with. She was also able to raise the participants' awareness of other support sources such as counselling services or support groups.

The following standard ethical considerations were applied (Elmes, Kantowitz & Roediger, 1995) and the research adhered to the ethical principles of the British Psychological Society (2005):

1. **Informed consent**: participants were told exactly what the researcher was exploring and were asked for consent to participate in the study.
2. **No deception**: participants were not deceived at any point in the study.
3. **Right to withdraw**: participants were able to withdraw from the research at any time.

4. **Debriefing**: participants were informed about the full aims of the research and were informed that they would have access to any publications arising from it.

5. **Confidentiality**: complete confidentiality regarding any information about participants was maintained. No names or participant descriptions were attached to the study; moreover, all recordings of interviews will be destroyed a year after the study is completed.

Furthermore, all comments in the study are presented anonymously and all participants were made aware of all these conditions before signing the consent form.

The study proposal was supported by the Ethical Committee of City University London (see Appendix A).

2.12. Purposive sampling and participants

Ten participants were interviewed:

- Eight participants were born and brought up in England, one was born in Denmark and moved to England as a child and another was born in Africa and also moved to England when she was a child.
- Ethnicity: White 7, White and Black Caribbean 1, British Asian 1 and Black African 1
- The age range was 21 to 42 years.
- Two participants were male and eight were female.

The occupation status of the participants varied greatly. One was unemployed and on benefits, one a housewife, two lived on family generated private income, three were students, one was self-employed and two were in full time employment.

- Seven described themselves as of middle class and three as working class status.
- Four participants were educated to degree level, three were studying

for a degree and three were educated up to GCSE level.

All of the participants gave the researcher consent prior to being interviewed. Participants were selected using purposive sampling based on a number of criteria and were recruited to represent the research question and illustrate the phenomena under investigation. In this case, this included adults between the ages of 18 and 65 who had been diagnosed with depression by a GP or psychiatrist within the previous three years as well as being treated for said condition within the previous three months.

2.13. Changes made to the study

Originally the researcher set out to out to explore experiences of emotional suffering subsequently diagnosed as a first episode of depression. The aim was to interview people who had been i) diagnosed with depression for the first time in the previous three years and ii) treated within the previous three months. This three-year cut-off point aimed to reduce the risk of interviewing participants who may have had subsequent episodes of emotional distress diagnosed as depression and who might consequently have found it hard to distinguish these later episodes from the initial one that the research intended to focus on. Interviewing participants who had been treated at least three months prior to taking part in the study was intended to significantly reduce the risk of participants still suffering emotionally when they took part in the research.

However, whist conducting the interviews it became clear that some participants had not been diagnosed for the first time in the last three years despite having said that this was the case prior to the interview. Whilst being interviewed, some participants started talking about previous experiences of distress subsequently diagnosed as depression as opposed to a more recent first experience that my research intended to focus on. The researcher thinks this was because whilst being interviewed, participants began to reflect on past experiences they may have forgotten, repressed or even denied. They said things like “Actually, now I think about it I was depressed back in 1999 when I saw that counsellor”. As participants

are humans it is difficult to be sure that their disclosed histories will tally with what they tell the researcher before the interview takes place.

Having reflected on this with her supervisor and the course director of the counselling psychology top-up doctorate, it was agreed that the study would be improved if the researcher did not restrict herself to exploring a first time diagnosis only. This was because some very interesting data was generated by a couple of participants who had been diagnosed with depression more than three years before and had been diagnosed with it more than once. The researcher decided she did not want to reject this data just because it did not reflect their first time experiences of diagnosed depression. As the essence of the study explores experiences of emotional suffering subsequently diagnosed as depression, it seemed it would have been a shame to eliminate interesting data on experiences of a diagnosis of depression gleaned from such participants.

It also seems an ethical concern would only have arisen if a decision had been made to abandon the second condition of interviewing people who had been treated for emotional distress diagnosed as depression within the previous three months as there would have been the problem of them still being distressed when they participated in the research. All the participants had received treatment in the previous three months so the procedure was still in line with the researcher's primary ethical safeguard, that of not interviewing people who had not received treatment for their diagnosis of depression.

It was ensured that all participants had recovered from their diagnosis of depression by taking the extra precaution of administering the CORE-10 (Clinical Outcomes in Routine Evaluation), a client self-report questionnaire where the client is asked to respond to ten questions about how they have been feeling over the past week (see Appendix B). It is used as a screening tool and outcome measure of worry categorised as anxiety, distress categorised as depression, trauma, physical problems, day-to-day close and social relationships and risk to self. A score of above 25 would indicate that an individual was experiencing clinical levels of any of the items measured and would not be deemed suitable for interview. All the participants

scored well below this number except for one who scored 25. We discussed that his score was borderline and he explained that he was happy to continue with the interview bearing in mind the possibility that there would be potentially rich data for me. As he did not score above 25 on the core form the researcher deemed it safe and ethical to continue. She did however inform him of possible services where he could get further support and treatment were he to need it. However, he explained he did not believe this would be the case.

2.14. Recruitment strategy

An email with a letter was sent out to undergraduate psychology students at one university asking them if they would be interested in participating in the research (a copy of this letter is attached in Appendix C).

Other participants were recruited through word of mouth where the aim was to recruit people adhering to the sample characteristics described above (see Purposive sampling and participants 2.12.) Friends and colleagues were opportunely approached with the aim of them passing on a request for participation in the study. The interviews with my ten participants generated data relevant to this research project and made possible the exploration and examination of the conversations that ensued.

2.15. Recruitment response

In total ten people agreed to participate in the study. Three of the participants had responded to the email sent out to psychology students at [redacted] and seven participants responded by way of word of mouth.

All participants were keen to tell their stories and told me they had found it a cathartic experience describing in detail their pre-diagnosed depression experience.

2.16. The interviews

Smith & Osborn (2008) recommend the use of semi-structured interviews for an IPA study. This facilitates a more informal, flexible conversation, enabling the interviewer to probe particular areas of interest that arise or follow novel areas pertinent to the research question. IPA often incorporates a verbatim transcript of a first person account generated by the research participant in response to questions from a researcher (Larkin & Thompson, 2012). This usually manifests in the form of a one-to-one, semi-structured interview (Smith, Flowers & Larkin, 2009).

The interviews in this research followed a semi-structured interview format (see Appendix D), although it was decided that if conversations became restricted or compromised because of this, the researcher would not be too rigid about adhering to the format in order to avoid the loss of potentially rich data.

The researcher began by introducing herself and telling the participants a bit about the work and the study. They were informed that they were welcome to ask questions at any point during the process. Explicit consent was gained for the recording of the interviews (see Appendix E).

The style of interviewing was designed to allow the participants maximum freedom to describe their personal experiences of emotional distress. Open-ended questions were formulated beginning with words like "what", "how", "when" and "is there" to encourage and evoke thought, memory and contemplation in the participants. Questions were also devised that would prompt-them to elaborate at certain points.

The researcher began with more public questions and moved on to more personal matters once a rapport had been established. She then asked questions that she had devised for the interview. Throughout the interview participants' comments were noted and often incorporated into further questions. The researcher referred to Spradley's guide (1979) in order to formulate different types of questions that were meaningful to the participants.

The interviews were conducted and transcribed using principles of interpretive phenomenological analysis. A conversational style was adopted to diffuse power imbalances and a counsellor-client dynamic. Transcripts were subject to individual analysis and emerging themes were identified which would then be reduced to further subcategories. The ultimate aim was to identify shared themes that captured the essence of the participants' experience of emotional suffering subsequently diagnosed as depression.

Interviews were conducted and recorded (with a Sony Minidiscs recorder) at a booked room at LSBU, at the participants' homes and at the researcher's private practice where she conducts psychological counselling and where a receptionist and other therapists were present. For those interviewed at the private practice and LSBU, the locations gave a sense of credibility to the research. There was great assurance of personal safety for both researcher and participant. As those that were interviewed in their homes were acquaintances, this eliminated the concern of the researcher visiting a stranger in an unfamiliar environment. However, there was also an increased sense that the balance of power was shifting towards the participant as the researcher was entering their territory. It was also harder to end the interviews on time as there were not other participants or clients arriving and consequently there was no need to vacate a hired room. However, this had its advantages, as the researcher felt more relaxed about letting the participants take their time, as it was not essential to finish on the exact hour.

All participants were given ten pounds for their time and travel. Informed consent was sought on the day of the scheduled interview. Upon meeting participants were asked if they had any questions. Participants were not asked to sign the consent form until they had been given adequate information about the study, had read the participant information form and had had time to consider their decision. The researcher talked through all aspects of the study and responded to the participants' queries to check their understanding of what was involved in the study prior to gaining consent.

Participants told their own stories and the transcripts were analyzed in accordance

with the principles of IPA. Emerging themes from the text were identified and examined in detail. Relationships between themes were detected and interrelationships established. Since this study was interested in the participants' experience of emotional suffering, the content of their reported experiences provided the analytical focus of this study.

2.17. Confidentiality and consent

Participants were given the choice to sign the consent form just with their first names. Before signing the consent form they were made aware of the following points:

1. The interviews were to be recorded for transcription purposes only and would be seen only by the researcher and their research supervisor. The recorded interviews were to be destroyed a year after completion of the research.
2. All data would be treated in the strictest confidence and kept in a locked cabinet to which only the researcher had access.
3. The names or any descriptions of the participants would not be attached to the study. Any personal details about the participants were to be changed so that they would be unidentifiable.
4. Comments used in the study were to be presented anonymously.
5. All participants would have the right to withdraw from the study at any time without having to give a reason for doing so.

The consent forms were signed by all participants and the researcher prior to the start of each interview and this intended to deal with some of the possible ethical dilemmas that can arise with psychological research on humans. Participants were debriefed on the nature, purpose and consequence of the research as recommended by Thompson & Chambers (2012) and given the opportunity to discuss it. They were also able to request a copy of the transcript afterwards as well as a final copy of the report.

2.18. Information given to participants

Information sheets were sent to participants by email before the interview took place (see Appendix F). This provided them with time to read a bit about the research and what would be expected. It also gave them an opportunity to further consider if they wished to partake after reading the information sheet. In some cases the interview questions were sent out to participants before the interview so they could prepare accordingly. This was requested by four of the participants.

On arrival, it was explained to participants that they should raise their arm at any point if they decided they no longer wished to continue with the interview due to the sensitive nature of the subject. The researcher also confirmed that the interview would last one hour if they were happy to complete it. It was important to establish a time boundary due to the sensitive nature of the subject. She did not want to find herself in a situation where the participant felt cut off and asked to end abruptly in the middle of discussing something that was emotionally distressing.

2.19. Transcription

The researcher transcribed four of the transcripts from the recorded interviews and this proved to be of enormous value as it allowed her to engage with the data in a way she had not previously done. The researcher found that she paid more attention to some things when hearing them for a second time and began detecting themes in the participants' interviews as they were typed up. This was before beginning the analysis.

As it took on average three hours to transcribe each interview it was becoming time consuming and preventing progress with the analysis. An arrangement was therefore agreed with a professional typist who signed an agreement of confidentiality and typed up the six remaining interviews anonymously. All transcripts were transcribed using intelligent verbatim. The transcripts were then

analyzed using IPA (Smith, 1997). See Appendix G.

2.20. The procedure used for analyzing transcripts

Data was analyzed using IPA, as detailed by Smith & Osborn (2008) and discussed above. The analysis was also guided by documentation on quality in qualitative research (Elliot, Fischer & Rennie, 1999; Spencer, Ritchie, Lewis & Dillon, 2003; Yardley, 2008) and through research supervision. A procedure for analyzing the transcripts outlined by Willig (2008) was followed. The researcher began by reading and re-reading the transcripts, scrutinizing them line by line, as this enabled her to remain open to the data and to continue to notice new nuances and subtleties (Charmaz, 2006). Ideas were able to arise in ways they may not have done had she merely been listening to the texts or transcribing them in larger chunks.

Broad and somewhat unfocused notes were made in the left margin, reflecting the researchers observations and thoughts about the texts (see Appendix H). These notes included summaries of what was said, as well as comments on connections, similarities, differences, contradictions, associations, questions, interpretations, absences, descriptive labels and preliminary interpretations.

The emerging data was then clustered into themes and analyzed using IPA. The aim was to remain as close as possible to the original data and its meaning whilst simultaneously attempting to unearth the key experiential themes in each participant's accounts.

2.21. The process of identifying and labelling themes

The emergent themes were then listed in order of appearance and attempts were made to look for and make sense of connections between them, creating theme clusters. Smith & Osborn (2008: pp70) suggest imagining a magnet, "with some themes pulling others in, helping to make sense of them" (see Appendix I).

These clusters were then titled, creating superordinate themes. It was essential to keep returning to the transcripts throughout this process, in order to verify that the superordinate themes still reflected what the participant had actually said. A spreadsheet of superordinate themes, together with associated subordinate themes and supporting verbatim text extracts was then produced.

This process was repeated for all ten interviews, each time putting the previous interview to one side and working on the next one from scratch. Although commonalities in themes began to be identified, care was taken to acknowledge new issues emerging from each transcript, thus paying attention to ways in which accounts from participants were similar but also different (Smith & Osborn, 2008).

When all ten interviews had been analyzed, the superordinate and subordinate theme clusters for all interviews were examined and clustered together to create a master list of superordinate themes and component subordinate themes for all participants. The superordinate theme titles provided a coherent framework to understand the participants' experiences of emotional suffering subsequently diagnosed as depression.

2.23. The production of a summary table

Identified themes were reflected upon and then considered in relation to one another. The researcher oscillated between the list of themes she wanted to structure and the text that initially generated them as suggested by Willig (2008). Many of the themes shared meanings and references with one another and others were distinguished by hierarchical relationships with one another.

A spreadsheet summary table (see Appendix J) was then produced for the first participant with the structured themes together with quotations that illustrated them. The original participant summary of identified themes was then used to code the other transcripts in the same manner, elaborating and adding themes in the process. A cyclical process was adopted so that later emerging themes could be verified

against earlier transcripts to acknowledge whether new themes were genuine new concepts. As a result of this process an integrated list of themes developed and this reached completion on the analysis of the final transcript.

2.24. Integration

The researcher then continued to generate a list of superordinate themes that encapsulated the quality and nature of the participants' shared themes. The analysis continued until full integration of themes was achieved. The list of superordinate themes reflected the data from the subordinate themes from which they were derived and reflected the experiences of the group as a whole.

3

RESULTS

3.1. Results

All participants generated rich and interesting material and the total accumulation of themes was higher than that presented for this study. As this study set out to explore experiences of emotional suffering subsequently diagnosed as depression only, themes that were not directly linked to this were omitted.

There was considerable overlap and interrelatedness between themes and this is apparent throughout the analysis. The researcher chose to focus on themes that conveyed the rich and penetrating experiences participants described throughout their emotional distress subsequently diagnosed as depression. Many of the themes were either not documented in the classification manuals or not systematically discussed in the literature of counselling psychology. A decision was made to focus on these themes as the researcher felt this brought something new to the literature.

3.2. Introduction to superordinate themes

Eight superordinate themes were presented in the analysis and identified as

being most relevant. This was because they arose most frequently amongst participants and together conveyed the depth and complexity of their experiences.

In answer to the research question enquiring how the participants experienced emotional suffering subsequently diagnosed as depression, accounts clustered around these eight themes. The following table itemizes these and their related subordinate themes.

(Table 1)

Superordinate theme	**Subordinate themes**
A) Totality of life at the time	i. Change and loss ii. Lack of space and the need to escape iii. Feeling trapped by responsibility/obligations iv. Feeling directionless
B) Embodied distress	i. Somatization ii. Physical manifestations of self loathing iii. Discomfort in one's own skin iv. Feeling catatonic
C) Trapped in the head	i. Overthinking and overanalysing/noise in the head ii. Worry
D) Severed social and emotional connections	i. Mistrust and persecution ii. Troubled relationships iii. Feeling misunderstood and rejected iv. A need to belong
E) Transformation of identity	i. Social comparisons ii. Changed identity iii. Multiple identities and masking iv. Lost identity v. Fixed identity
F) Dissociation	i. Disengagement and alienation ii. Chosen detachment
G) Belief in a higher force	i. Destiny ii. Deserving of punishment iii. Superstition iv. Spirituality
H) Disciplining the self	i. Finding control ii. Application of acceptance and patience

The themes identified are discussed using relevant passages from the

participants' accounts of their experiences. Individual identities have been changed in all the accounts to maintain anonymity.

The identified themes are discussed in three different sections. In the first section (3.3.1.) attention is focused on possible triggers and maintaining factors (A). In 3.3.2. the focus shifts onto how emotional distress was itself experienced (B & C). Finally in 3.3.3., I consider those aspects of this experience, which, through the participants' interpretations, sometimes led to the development of coping strategies (D, E, F, G and H).

3.3. Discussion of themes

3.3.1. Life situations as a possible trigger and maintaining factor at the time of the participants' emotional suffering

Whilst this research set out to explore experiences of emotional suffering subsequently diagnosed as depression, it also considered some of the life events and situations participants experienced both before and during the time of their initial distress. In order to understand the participants' accounts it was considered necessary to situate them in the context of their lives.

The researcher was motivated by the belief that experiences of distress generally do not arise out of nowhere and are often responses to situations in life. Cromby, Harper & Reavey (2013) use the term distress to characterise experiences that are sometimes referred to as mental illness or symptoms of psychopathology. They argue that distress can be part of everyday life and is bound up in social and material conditions, personal biographies, life events and relationships. They believe that in psychiatric settings these experiences are often matched all too easily with pre-defined diagnostic categories and that, as a result, difficulties in their lives that are linked to their distress can be missed.

Most of the participants in this study were able to speculate about causal and

maintenance factors related to their emotional distress in ways that were of significant interest to the researcher. Some suggested that their difficulties were with their life at the time. This is in contrast to those who felt that they had fallen victim to the sudden onset and sudden development of a psychological or emotional disorder often classified in clinical manuals and psychological literature as depression. Hence, the following theme emerged:

A) Totality of life at the time

This superordinate theme was linked to circumstances and situations generated by the subordinate themes change and loss, lack of space/the need to escape, feeling trapped by responsibility/obligations and feeling directionless.

i. Change and loss

The diathesis-stress model unites biology, in the form of an organic vulnerability or diathesis, with the psychological and social influences that cause stress. If the combination of a person's predisposition and stress exceeds a certain threshold, the person may go on to develop a disorder (Ingram & Luxton, 2005). Vulnerable people can thus develop a diagnosis of depression in response to life events that disrupt the equilibrium of their lives.

Below Adrian describes how facing change in his life was unsettling for him because of new experiences:

"I'd had my first son, I had a lot of stress at work and there were new experiences, perhaps in similar ways to when I first went to college. I just didn't know who I was. I was in a new environment, with new stresses, and didn't really know who I was, I felt out of control." (Adrian, p6, 19-22)

Adrian discloses how he felt thrown by new situations in his life and that consequently he felt out of control. He did not feel equipped to tackle or deal with the new demands placed upon him at that time and this appeared to trigger

his feelings of distress. He later acknowledged that change was not something he dealt with well.

"Periods of change. I am not very good at those." (Adrian, p17, 17)

These changes in life situations were often described by participants as triggers to their emotional distress and as being negative experiences often linked to loss.

Tania refers to the time her parents divorced as a difficult period for her that precipitated her emotional distress:

"My parents divorced which is something I completely blocked out. All my security, everything I had known, had suddenly gone, like the rug had been pulled quickly from under my feet, but I detached myself from it and just thought it is for the best and did not allow myself to get *emotionally involved in it." (Tania, p3, 17-20)*

Later, she adds:

"My old family home was no more. I remember when my sister was my age and she would come home at weekends and have both parents there and have this security but for me I had my grandma's house but it was not quite the same. It was not as I knew it. My parents were different people. It was very unsettling." (Tania, p4, 17-21)

Tania describes feelings of change and loss at the root and core of her family life and how related feelings of unfamiliarity led her to feel insecure. She was able to establish clear links between this and the commencement of her emotional distress.

Another participant mentions her experience of loss. She was able to link the onset of her emotional distress to the painful experience of being left by her

partner of many years and communicates how she struggled with feeling rejected.

"I was in a very long term relationship with someone I loved dearly and we grew apart. He ended up leaving and I was totally floored by it.' (Kate, p3, 1-2)

Jane also points to an experience of loss as triggering her misery, although in her case it was loss experienced through death:

"Well, I think it was a combination of factors. There was the death of a very close friend and I think that had a big impact on me emotionally." (Jane, p1, 30)

Jane's emotional suffering subsequently diagnosed as depression is interpreted partly as a response to her friend's death, and can be interpreted as a normal reaction to a traumatic even that triggered great sadness and distress.

DSM-IV-TR (2000) states that feelings of grief and sadness that do not exceed two months may not be signs of distress diagnosed as depression if they can be better accounted for by bereavement. Jane's emotional suffering went on for a lot longer than two months. Two months seems a surprisingly short time for someone to recover from the loss of a loved one or a best friend and perhaps DSM-IV-TR (2000) is wrong to state that grieving beyond two months is a sign of a depressive illness. Could it not rather be the ongoing emotional suffering linked to bereavement?

It is of course possible that Jane's emotional suffering was triggered by bereavement and that this continuing despair manifested as a further distress that was later diagnosed as depression. It has been noted (Frances, 2013) that someone who is typically grieving focuses their thoughts on the person who has passed away and experiences waves of pain rather than the constant pain of someone suffering from distress categorised as depression, similar to the constant distress that Jane described throughout her interview. It is possible then that in the later stages of her emotional suffering Jane may not have been suffering from

bereavement alone. The experiences of distress that mimic 'depression symptoms' associated with grief tend to lessen over time with the help of family and friends (Frances, 2013). The opposite seemed to happen with Jane whose distress seemed to intensify over time, suggesting her grief may have spiralled into a deeper form of emotional distress subsequently considered worthy of a depression diagnosis by a healthcare professional. However it is possible she was experiencing grief in addition to other emotional distress that may not have been linked.

Ella also reflected on a difficult time of both loss and change when she had a young child and a new baby. She explained that her husband became addicted to gambling triggering a temporary break-up of their marriage and a related loss of income. This resulted in her having to move out of her home. She established a link between her living conditions and emotional distress. The theme lack of space emerges

ii. Lack of space and the need to escape

"I kind of felt like it was circumstance. I was living in a room that was smaller than this with my two sons. My step mum did not want me to be there. All my boxes were around. We were living in a damp room and because of the severity of my circumstances I had gone right into the worst part of my psyche." (Ella, p7, 24-30)

Another participant also describes returning to her childhood home at the peak of her emotional suffering and explains that, while her parents were helpful and supportive, the situation eventually became counterproductive. She too described feeling the need for space and the need to escape:

"I realized at that point I really needed to leave my parents' house. They were very loving and supportive but their anxiety and fear about my state was becoming counterproductive." (Jane, p12, 16-18)

Like Ella, Kate explained that at the time of her pre-diagnosed depression she had to move back home due to her circumstances; whilst it was clear in the interviews that this served a purpose and was helpful to some extent, related difficulties linked to lack of space appeared to exacerbate her distress.

"For a period of time the only thing that got me out of bed was the idea of getting out of my mother's house. I think there was a lot of pressure with that because I had come from being this big shot from New York and then I had to move back home to London to my mother's house, which I'd left when I was 17." (Kate, p11, 5-9)

Kate's account suggests she felt she had taken one step forward and two steps back with her life. She felt she had regressed by moving back to her childhood home and it seems that this may have had a negative impact on her confidence and self-esteem.

iii. Feeling trapped by responsibility/obligations

"My mum - who I was closest to - in a way I felt imprisoned by her because she'd asked me to move in and take care of her while she was disabled. I was stuck with her and she was not letting me be depressed. She was not letting me feel low and she just thought it was all nonsense." (Kate, p11, 31 & p12, 2)

As we have seen, Ella also moved in with her mother. Although the change was helpful in many ways, like Kate she found it hard as it exacerbated her sense of duty and responsibility, as she too felt obliged to look after her mother.

"I felt like my mother wanted me there to look after her so I suddenly felt very stressed that I had another person to look after." (Ella, p19, 3-5)

"I felt like I was looking after her and my children." (Ella, p19, 7-8)

iv. Feeling directionless

Jane disclosed how she struggled to have a normal life and romantic relationships. She described her needs and choices as incompatible with what she felt she could achieve. She confessed to feeling directionless in life at the time of her emotional distress and this too might have been a causative factor in her emotional suffering.

"I felt desperate, isolated. I also could not imagine how I was going to have a normal life in the world. I just could not see how I was going to have a relationship. I felt like I couldn't have a relationship. Up until that point I'd wanted to be an actress but then when I considered the realities of life as an actress, I suddenly thought 'I am not sure that I would be able to handle that', so I didn't really have a direction." (Jane, p7, 1-6)

These participants seem to have understandable reasons for suffering emotionally. It is easy for the reader to empathise and sympathise with these participants' descriptions of their lives and agree that they are distressing. These participants felt powerless to alter the negative events in their lives that triggered their emotional distress.

3.3.2. How emotional suffering subsequently diagnosed as depression was experienced

This second chapter explores the content of the participants' experiences of emotional suffering subsequently diagnosed as depression. Their accounts reflect how they felt at the time of their distress and what went on within them. Two super-ordinate themes were generated by six sub-ordinate themes that emerged from the data and these are discussed in the next two sections (B & C).

<u>B) Embodied distress</u>

The superordinate theme embodied distress was generated by the subordinate themes somatization, physical manifestations of self-loathing, discomfort in one's own skin and feeling catatonic. Whilst acknowledging that DSM-IV-TR (2000) points to physical symptoms of emotional distress diagnosed as depression such as weight changes, insomnia, lack of appetite and psychomotor agitation or retardation, and the BDI-II (1996) to somatic preoccupation, the participants in this study also revealed some different bodily experiences at the time of their emotional distress.

i. Somatization

The most prevalent subordinate theme of embodied distress was somatization where participants described feeling their emotional distress in their bodies. There are three theories of somatization, the oldest of which, holds that symptoms represent the body's own defence against psychological stress. This theory suggests that the mind's capacity to tolerate stress and strain is limited and, consequently, social or emotional stresses beyond a certain point become experienced as physical symptoms (Pribor, Yutzy, Dean & Wetzel, 1993). This theory can help explain links between distress and somatization, indicating that when emotional suffering reaches certain intensity the person can no longer endure the distress will manifest itself physically.

The second theory postulates that it is triggered and maintained by heightened sensitivity to internal physical sensations. Some individuals feel the slightest amount of discomfort or pain in their bodies. Hypersensitive people can experience bodily events such as minor changes in heartbeat that the brain normally would not register in the average person. Studies have shown that people with panic disorder are particularly sensitive to internal sensations such as breathing and heart rates, which may lead them to react with intense fear to minor internal changes. The physiological or psychological origins of this hypersensitivity to internal sensations and their relevance to somatization disorder are still not well understood (Allen, Woolfolk, Escobar, Gara & Hamer, 2006).

The third theory claims that somatization is caused by one's own negative thoughts and overemphasized fears. For example, interpreting slight ailments such as headaches to be brain tumours, or equating shortness of breath to asthma could lead those who have somatization problems to actually worsen their symptoms (Stein & Muller, 2008). A somatic preoccupation indicative of worry diagnosed as health anxiety has been cited as a symptom of a diagnosis of depression in the BDI-II (1996). However, the following somatic experiences described by participants did not seem to convey only this.

Below, some participants describe how they felt physically at the time of their emotional distress. In particular they reported head, heart and stomach experiences.

"The only way I can describe it is like there's a feeling like there's a death in your head and your heart. If I shut my eyes and think about what it looks like inside it's just dark." (Joe, p7, 11-13)

"I think when I was 17 I did not really know anything about the concept of depression. I didn't know that you could interpret things in this way or that way. I had a blank mind. Everything was just like a feeling. No thoughts." (Joe, p4, 24-27)

Jumania also describes times during which she experienced no thoughts at all, only bodily experiences:

"I used to have no thoughts. There was no particular thought that was causing it." (Jumania, p2, 8-10)

Joe and Jumania's accounts of emotional suffering subsequently diagnosed as depression sit uncomfortably with the CBT theory of depression as a thinking disorder (Beck, 1979). Interestingly, both make reference to the heart in

describing their experience: Joe feels his heart has died whilst Jumania states that her heart feels heavy.

"I just started to feel ever so down. My heart used to feel really heavy and I used to feel just something pulling me down." (Jumania, p8, 11-12)

Participants also alluded to a feeing of dread in their stomach that accompanied them most of the time.

"How did you make sense of everything and what did you think was going on? What kind of things went through your mind?" (Researcher, p4, 10-11)

"Just a negative, crippling and dead feeling in my stomach. It's a sick feeling as if something has died." (Tallulah, p4, 14-15)

Jane echoes this:

"Well, it was just really hard to describe. I just felt one thing all the time and there was this sort of pain. If I can talk about it in a physical way, it was a pain in my solar plexus… and a feeling of complete emptiness - that's all I ever felt." (Jane, p8, 19-24)

This stomach discomfort that some participants describe resembles the familiar butterflies in the stomach that children sometimes allude to when they are feeling nervous or stressed. What is striking about these accounts is that participants described the stomach pain as constant, suggesting they may have been experiencing a perpetual degree of fear in their emotional distress subsequently diagnosed as depression. This would be supported by previous links between worry and low mood already alluded to in the introduction.

Below Joe and Adrian explain their experience of embodied failure:

"How does it manifest for you when you feel like a failure?" (Researcher asks Joe, p18, 7-9)

"It's a very palpable feeling. It's strong. It's inside, in my chest and then up to my head… It's a bodily feeling, then you feel exhausted." (Joe, p18, 10)

"It won't go away, just the feeling of unhappiness, the feeling of dread, the feeling of self loathing, the desire to try to kill yourself." (Adrian, p7, 8-10)

He also refers to this state of dread that Tallulah and Jane described but does not give it a precise location in the same way the others did. It would have been interesting if the researcher had enquired as to where in his body this feeling of dread had manifested. Was it in the stomach?

ii. Physical manifestations of self-loathing

Adrian mentions self-loathing and this leads us into the next theme, namely physical manifestations of self-loathing. This description of embodied distress can be linked to those depression symptoms as documented in the BDI-II (1996) such as "feeling ugly and unattractive". Cheryl elaborates on the theme of self loathing and feeling ugly and unattractive:

"*I used to have a real problem with the way I looked and thought I was really ugly and really fat." (Cheryl, p3, 8-9)*

She adds later:

"Every time I look in the mirror I just think 'Oh really, is that what I look like?' I can't do anything to change it. I do what I can." (Cheryl, p4, 3-4)

Researcher continues to ask:

"So you are not happy with what you see and there is a sense of powerlessness as you can't change what you see?" (Researcher, p4, 5-6)

Cheryl replies:

"It makes me feel miserable, it makes me hate myself. I don't like looking in the mirror. And then it makes me question why my fiancé is with me even though he says I look beautiful" (Cheryl, p4, 7-9)

And:

"I just hate myself completely and utterly and that is why." (Cheryl, p4, 18-19)

It seems that Cheryl does not like herself and is looking for reasons to validate how she feels. She possibly hated the person she felt she had become when she was emotionally distressed and consistently felt she looked ugly; perhaps she believed this is how others saw her too, hence her disbelief that her boyfriend could be attracted to her. Anna's account conveys a strong dissatisfaction with her appearance at the time of her emotional suffering too as well as an uncertainty and incomprehension as to why her husband wanted to be with her.

"I don't feel like a woman. I just wondered why he would want to be with me. I had some issues with trust when he went out. I was not able to trust him. I could not be the woman I was when I first me him. I was slim, beautiful and motivated. Things just spiralled from there." (Anna, p5, 20-24)

iii. Discomfort in one's own skin

Below, Cheryl describes-feelings of intense body discomfort including feeling a lack of familiarity in her own body. It seems as if she feels she might be able to expel some of her emotional pain by transferring it into physical pain and scratching it away.

"I say to Adam sometimes that I feel like scratching my skin off as I don't feel it is mine. In the same way, I have those moments when I don't want him touching me. It's the same thing, like my skin is crawling. Like it's not mine and I need to remove it and he is looking at me saying 'Are you alright, what are you doing?' But I just feel so uncomfortable, my body feels all weird, like it's not mine." (Cheryl p10, 1-5)

And:

"I just do not want to be in it [my skin] any more as it is so uncomfortable." (Cheryl, p10, 8)

She describes feeling as if her skin is crawling which conveys intense discomfort and perhaps a feeling of tension combined with disgust. She later elaborates on this, saying she feels she is squirming:

"I sit there and squirm. Usually I get in the shower, that helps and cools me down and when the shower hits my head it drowns out all the noise - I can't hear anything else." (Cheryl, p10, 13-15)

Jumania also points to feeling uncomfortable in the extreme:

"I was crying about how uncomfortable I felt and I just wanted it to go. Like, I was crying because I was in an uncomfortable sate." (Jumania, p3, 22-23)

Some of the following physical descriptions of embodied distress can be linked to those depression symptoms as documented in DSM-IV-TR (2000) such as loss of appetite. However, in this study the theme feeling catatonic emerged.

iv. Feeling catatonic

"Everything becomes negative and then it got to the point that I stopped eating and then, by that stopping, not going to the loo and finally I felt that I couldn't even move." (Kate, p6, 6-7)

Whilst Kate's description fits the DSM-IV-TR (2000) symptoms of loss of appetite, she goes on to say she did not even go to the toilet any more, something not documented in DSM-IV-TR (2000) or the BDI-II (1996).

"The loss of appetite and not eating or drinking anything. I stopped going to the loo and I just sat on the floor in my bedroom in a heap and just did not move." (Kate, p6, 30-31)

This section covers the variety of embodied experiences participants felt at the time of their emotional suffering subsequently diagnosed as depression. It reveals individual aspects of their experiences in detail and also highlights physical experiences people feel when they are distressed some of which are not documented in classification manuals on depression.

C) Trapped in the head

The following responses from participants convey a sense of being mentally trapped by their distress. Cheryl describes her emotional distress as an internal experience that exists within her. She does not link her distress to her experience of life circumstances. Rather she suggests her experiences of distress are internally generated.

"It's me; it's in my head." (Cheryl, p5, 17)

Whilst Tania, Tallulah and Ella were able to link their emotional distress to circumstances in their lives, at other times in their interview they also described emotional distress as this intrusive, cognitive turmoil. In response to the question "How would you describe your emotional suffering subsequently diagnosed as depression?" they replied:

"A manifestation of thoughts and feelings." (Tania, p13, 24)

"A mental feeling." (Tallulah, p, 10, 21)

"*Being swamped with thoughts that make you feel like you are shit or a failure, that life is hopeless and that you're worthless and not being able to get out of it, like buckling legs." (Ella p 20, 30-33)*

Ella describes, "not being able to get out of it", indicating she has no control over the thoughts of worthlessness and failure she describes. Jumania also describes it as a mental experience in the way that Tallulah does.

"I think all your problems are in your mind. It's basically like a disabling of your mind in your brain rather than your physical being." (Jumania, p16, 30-32)

Jane describes how throughout her pre-diagnosed depression she existed in her mind only:

"I withdrew entirely into a mental world where I was absolutely in a sort of fantasy world. I was in my mind constantly. I was entirely in a world of thoughts. I don't know how to explain it really, always in the future, in the past: I was always in my mind." (Jane, p8, 35-38)

The subordinate themes overthinking and overanalyzing, noise in the head and worry contributed to the superordinate theme trapped in the head.

i. Overthinking and overanalysing – noise in the head

Many participants explained feeling that they couldn't think properly, feeling lost in rumination and being stuck in an endless loop of worry and negativity. Descriptions of relentless overthinking and overanalysing featured strongly in

some of the participants' accounts. This is in contrast to those who emphasized embodied distress or interpersonal distress as the central ingredient to their emotional distress.

Anna alludes to this relentless thinking and there is a sense that she is struggling to live in the present as she is constantly distracted by the contents of her mind.

"In my mind it was too much. I had too much going on. Constant thinking…." (Anna p3, 4)

"It feels like noise, just the same old conversations and trying to analyse people…" (Anna, p3, 7)

"Obsessing about people's intentions and other things." (Anna, p3, 9)

Anna's reference to noise is suggestive. It is an image echoed by Cheryl:

"I have that noise going through my head all the time. I do not know what it is like to be relaxed any more." (Cheryl, p1, 1-2)

"It is constant. I think that is why I have trouble sleeping because I close my eyes but my brain still works. I have to go to bed at least two hours before I sleep." (Cheryl, p11, 13)

Cheryl describes being kept awake at night by intrusive thoughts as well. There is a sense her brain is working overtime and she cannot switch off. She describes the contents of her mind as a consistent noise and distraction that she cannot ignore.

ii. Worry

Tallulah disclosed how she dwelt on the possibility of accidents. There is a sense she was powerless to stop these thoughts that engulfed and preoccupied her:

"It's difficult. I got the anxiety, the thoughts were crippling and since my child was born I had a fear of something happening, worrying about safety. I would remain awake at night touching wood." (Tallulah, p2, 2-3)

The striking thing about this theme is the participants' descriptions of feeling unable to dismiss the constant thoughts they describe. They are unable to ignore the troublesome contents of their minds.

The theme C), trapped in the head complements theme A), totality of life, which links the participants' experiences of emotional suffering subsequently diagnosed as depression to unwanted difficult and challenging life circumstances. As some participants describe experiences of both unwanted, difficult life events and unwanted, cognitive intrusion, one can conclude that pre-diagnosed depression may be a response to both the totality of life and a response to the contents of one's mind, with retained insight.

It seems that for many participants these two factors may be causally linked, as many participants who experienced difficult life events went on to develop what they would probably describe as intrusive mental distress that amounted to intense emotional suffering, usually incorporating many other unwanted experiences.

3.3.3. Aspects of distress experiences, which, through the participants' interpretations, may lead to various coping strategies

D. Severed social and emotional connections

The superordinate theme severed social and emotional connections was generated from the subordinate themes mistrust and persecution, troubled

relationships, feeling misunderstood and rejected and a need to belong.

i. Mistrust and persecution

Below, Anna talks about feeling she can no longer trust people. She describes questioning everyone's intentions and her attempts to cope with this:

"I used to try and stop thinking and tried to convince myself that actually I should not be questioning things as much as I did because it is not real. It's mainly about other people's mistrust so I try and think of positive things or I try and think of my mistakes, or *think about how I felt at some point and wonder if the other person may have felt that way too." (Anna, p4, 3-7)*

This issue of mistrusting others developed further into a general mistrust of everyone, including a mistrust of friends. Allied to this mistrust were feelings of persecution:

"I think I became very wary of people. I trusted no one." (Jumania, p10, 3)

"I didn't even trust my own friends. I felt so alone and had a complete lack of trust. I just felt so let down that I could not depend on anyone." (Kate, p3, 13-14)

"I started to get paranoid about people. I have always been quite sceptical of people but I actually started thinking everyone was against me and it just got too much for me." (Anna, p2, 4-6)

"I just didn't like people." (Anna, p2, 14)

When emotionally distressed one may feel vulnerable and different to other people and this may be a key factor in the generation of suspicious or paranoid thoughts. Freeman & Garety (2006) point out that when people are feeling low, they may feel guilty or ashamed and believe that other people not only see this

but also may treat them accordingly. This belief only fuels the suspicion and paranoia about others.

ii. Troubled relationships

The comments below reveal some of the struggles participants experienced in their relationships at the time of their emotional suffering. Anna described how she withdrew from her husband and reflected on the negative impact this had on their relationship and how consequently they grew apart.

"*I just did not like people. That was my reaction. I did not say that but inside that is what I was thinking. Even my partner: it affected our relationship a lot; we were not intimate at all. I just withdrew from him." (Anna, p2, 14-16)*

Joe explained how he struggled to feel fulfilled in his relationships when he was suffering emotionally and this may well have been a maintaining factor in his distress:

"I tried huge friendship groups, long-term relationships, short-term relationships, casual relationships, one-night stands - everything. Nothing really fulfilled me." (Joe, p6, 14-17)

He discloses that he felt unable to get close to anyone and that, despite having intimate relationships with others, he could not escape the painful feeling of emptiness he alludes to so often throughout his interview.

Adrian talks about finding relationships chaotic and how, as a coping strategy, he found solace in avoiding them all together:

"*Well, if I completely become a hermit I wouldn't have to have these chaotic relationships." (Adrian, p19, 1-2)*

iii. Feeling misunderstood and rejected

Many participants felt that others did not understand their experience of emotional suffering in pre-diagnosed depression. Kate said of her mother:

"She was not letting me feel low and she just thought it was all nonsense." (Kate, p11, 31)

Kate describes further how she felt misunderstood by her family:

"I didn't feel they understood or knew me at all and they didn't really care as long as I was the sweet Kate who was always there to help. Compared to my sister, they were bowled over if she actually even answered the phone or spoke with them and everything she did was so wonderful. In fact, she did jack shit for them and only ever took care of herself and I felt dreadfully hard done by [laughs] because it is really unfair." (Kate, p12, 14-19)

She laughs when talking about feeling hard done by, perhaps trying to make light of how she feels, as she may feel uncomfortable about her disclosure. She talks earlier about the importance of being seen as someone who can cope and perhaps it was hard to for her to acknowledge that other people's demands and expectations, at that time, were too much for her.

Other participants described feeling misunderstood by others. This was linked to reactive feelings of disengagement and isolation from people.

"I would make excuses not to see people. I felt very uncomfortable around people. I could not talk, I was just there and felt raw the whole time and felt alone like no one understood me." (Anna, p2, 8-10)

"One time someone said 'Are you all right? I am saying hello to you' and I had not even noticed they were there." (Anna, p3, 12-13)

When talking about her friends, Jumania says:

"They never used to understand. Like, when I used to say I m feeling really down or feeing quite depressed they used to just say 'You don't know the meaning of it. You don't know what you're talking about'. It was like, come on, pick yourself up and get on with it. Yeah, I used to hear that quite a lot." (Jumania, p1, 29-32)

"I used to feel that nobody really got me." (Jumania, p1, 34)

Jane echoes Jumania's comment:

"There were some people initially that were understanding because they'd experienced a few things like that but there were other people who really weren't understanding at all. I think what happened was as a result of me not knowing how to manage what was happening to me, as well as not understanding what was happening to me." (Jane, p4, 2-5)

Jane not only felt misunderstood by others, she said that she herself did not understand what was happening to her and acknowledges that this exacerbated her distress all the more. She elaborates as to why she struggled to be around those who did not understand her. It is clear from her quotes that feeling understood by others would have helped her re-connect to people, making her feel less isolated and perhaps less worried.

"When I am suffering I want to find someone who can understand. I don't want to be around normal friends who really have never suffered because they don't understand and that just increases the sense of isolation." (Jane, p17, 8-12)

"I actually tried a couple of different therapies at the time. There were a few

different people around. I went to a few more traditional therapists but when I started to talk about my experiences in the spiritual dimension I felt they did not understand." (Jane, p5, 22-25)

iv. A need to belong

A need to belong seemed to arise often in those interviews where participants described feeling detached, dissociated or disconnected from others. It also appeared to be linked to feeling lost and directionless in life. Anna describes an overwhelming sense of needing to belong:

"I always have this overwhelming sense of wanting to be part of something and belonging because I do not feel like I am. That is why I have things inside me." (Anna p4, 9-11)

Here she refers to her feelings of distress as "things inside me*"* and links them to not being part of something and not belonging, therefore implying that she would have felt better had she been.

In a more positive manifestation of the need to belong, Jane makes reference to feeling connected to others in a way she had never experienced before. At this point, her experience was a positive one that she described as spiritual. It seemed that a sense of belonging was key in her experience at this time.

"*I went on holiday to Ireland with some friends who were interested in spirituality and that was the first time I'd ever really heard about spiritual things and I think I became interested then. Also, they were very creative people, one of them was a poet and I felt I was suddenly amongst kindred spirits." (Jane, p2, 9-13)*

The need to belong bore fruit in a coping strategy with a positive outcome, reaffirming the significance of her social and emotional connections at this time.

In the following passage, Tania talks about feeling completely lost in her distress around the time her parents got divorced and not knowing where she belonged any more. She describes how she lost a sense of herself and how this could only be regained by identifying with a new crowd of people with who she felt she belonged. Her wanting to belong is prominent here and her coping behaviour is a response to it.

"I think I completely lost myself. My identity was immature. It took me a long time to grow up. I loved being with the family and in the family home and all that was so important to me so I think when all this happened I did not know who I was so I tried to carve out a new identity by doing all this stuff, self destructive behaviour, hanging around with people from different worlds to me… I even adopted a new accent, not my middle class accent; it was all unconscious but I was longing to be accepted. The new people I was hanging around with were working class Afro-Caribbean and some had grown up in awful circumstances. I wanted to belong and felt I had a connection with them. I changed everything about me to suit my new life." (Tania, p8, 16-22 & 27-31)

There is a sense here that Tania had to develop a new identity to survive her emotional suffering in an interpersonal world where fitting in with others seemed her only option.

E) Transformation of Identity

A prominent superordinate theme that emerged was transformation of identity. It was evident from the data collected by interview that emotional suffering had the ability to transform a participant's sense of identity either as a result of their emotional distress or as a way of managing it. Subordinate themes were social comparisons, changed identity, multiple identities and masking, lost identity and fixed identity.

i. Social comparisons

Some participants descended into tremendous depths of self-doubt and self-dissatisfaction as a result of comparing themselves with others and validating their identity in relation to them. They tended to engage in upward comparisons, measuring themselves against people who appeared or were more skilled or fortunate than they were (Festinger, 1954).

The following quotes illustrate some of the ways in which the participants' sense of self was interpreted in terms of, and influenced by, their relations with others. The comparisons generally led participants to view themselves in unfavourable and self-deprecating ways.

"When I would socially interact I'd spend ages scrutinizing it and just loathed it. I guess I kind of looked at myself in the third person and thought: I am not like one of these people; everything seems a real breeze for them. They can go down the pub and have a laugh and make friendships. Everything's very kind of straightforward, which of course is an enormous assumption but that's the way I felt about other people." (Adrian, p2, 32-36)

Adrian articulated thoughts and feelings to the effect that these other people were managing better and enjoying life more than he was; there is a sense of me versus them. When comparing himself to these others, he concludes that he must be different in some way. This sense of difference is felt in relation to how he views himself in comparison to the people he is around.

Like Adrian, Jumania arrived at the conclusion she is different when comparing herself to her friends. At the time of her emotional suffering she felt different to her friends, indicating that her sense of identity as a different person was triggered and maintained by the comparisons between herself and the company she kept.

"I felt alone as a person, feelings, everything, like me as a whole I felt alone and that was not necessarily a bad thing but I just thought you're different. I'm

different from all the people I see." (Jumania, p4, 6-8)

Other participants described a similar and somewhat exaggerated tendency to identify themselves in relation to the people around them. Ella's identity is framed in relation to how she feels when she compares herself to her friends whose more affluent lives make her feel socially inferior.

"I think I'm living in a flat whereas they've got a house. Friends of mine would have their houses done up or they'd buy houses and I'd think I haven't got that. I haven't got a garden I am not a proper family." (Ella, p4, 25-28)

Later, she says she feels:

"Like I have failed, like I'm not where they are. I'm not clever. I remember standing outside someone's house that I knew…. they had limitless money that they could spend on doing it up and I just remember looking through the window and being crushed." (Ella, p4, 37*-40)*

She confesses to feelings of jealousy brought on by the belief that other people's lives were better than hers. She describes this as a change in her personality, reflecting a transformation of her identity:

"I felt jealous of people… It took away the softness and my acceptance of everybody, which I was *like when I grew up. I was a pleaser really and loved people. Instead, having all these thoughts created jealousy and bitchiness as every time I heard someone have a success story I would get crushed and feel jealous, which I am not doing so much now, so I am very grateful and that was a really good indicator for me that things were not right". (Ella, p6, 17-25)*

Kate on the other hand discloses that she feels shame and a negative sense of self when she compares herself to her peers:

"I wasn't being productive. I wasn't here. There was nothing positive coming out of me so I felt very much ashamed. Comparing myself to anyone else and trying to analyse things and really I should have been fine. I had a roof over my head. I had the ability to eat every day. I didn't have dependants so really I was quite lucky yet I wasn't able to function properly." (Kate, p8, 15-19)

Shame is usually connected to a highly negative view of oneself (Padesky, 1995). It involves the feeling that we have done something wrong. When people feel shame they may assume they are flawed or no good.

The participants' indulgence in social comparisons reveals how their identities, at the time of their emotional suffering, were created, maintained and transformed in relation to the people around them. Their social surroundings provided a framework through which they created an identity for themselves. Further exploration of the theme transformation of identity shows the ways in which participants presented differently with different groups of people and how the ways in which they compared themselves to others affected the way they projected themselves on to others.

ii. Changed identity

Social comparisons were seen to bring about a change due to negative self-appraisal. However, some participants said that their identity had actually changed, though not as a result of such comparisons.

Adrian explains how he feels his major episode of distress diagnosed as depression changed him into a different person as a result of having to modify his behaviour to accommodate his emotional distress:

"I'm a different person *now than I was ten years ago, before this major episode. There are things I deliberately know I am doing now and deliberately avoid, so I will avoid situations because they depress me" (Adrian, p8, 34-36)*

Others had made a specific decision to change their identity as a result of their emotional suffering, thereby creating a coping strategy. Tania describes feeling as if she had to become someone else to save herself from her emotional distress. The sense of agency in relation to this project is clear.

"It must have felt like I had to get away from my old world as it was the only way I could detach myself from my old self and my old world. I had to become someone else*." (Tania, p8, 21)*

It seems that with her emotional distress she entered uncharted territory in her life and felt she had to become a new person to manage it. For these participants a change of identity had enabled them to cope with their distress.

iii. Multiple identities and masking

Some participants employed masking and the adoption of multiple identities as a way of coping with other people in the course of their emotional distress.

"It's *only in the last three years that I have thought enough is enough. I want a life where I am free of having to hide." (Joe, p4, 4)*

"I felt I did not know myself any more. I had to drop that front that I put across that everything is fine, that I am happy and can be dependable and I can pick the mood up. All of a sudden I had to drop that." (Joe, p14, 27-29)

"I went to college and all of a sudden within two months I became the centre of a group of about 20 friends who organized everything and people would say the party didn't start until I'd turned up." (Joe, p4, 9-13)

The experience and pressure of putting on a jolly façade is also familiar for Adrian who describes reaching a point where he was no longer able to keep wearing the mask:

"You big yourself up and go out of the door and you are fine and everything's a laugh and everything's going to be okay and then you just kind of crumble when you come back through the door." (Adrian, p8, 1-4)

It is noticeable that only the male participants describe a mask of laughter in which they are having fun and everything is fine. There seems to be some counter-attack or overcompensation strategy at play, masking the fact they are actually suffering emotionally and in reality not enjoying the company of others at all. Perhaps they were attempting to make light of their situation in addition to trying to convince others they were well and happy.

Talking about his emotional distress, Adrian also says that though he went to lengths to hide or mask his inner self it may have been visible to others anyway.

"*I spent years sweeping it under the carpet, hiding it. I think the people around me knew because a lot of things went along with the depression, like being antisocial or introverted." (Adrian, p1, 14-16)*

Again he reaffirms his need to veil his distress. He was concerned about others knowing how he felt:

"I do remember cutting myself on the chest and having absolutely no idea why, and this had been going on for a year on and off. I didn't even notice it going on because I didn't want anybody to know that I was going through so I kind of blocked it out, that kind of stuff." (Adrian, p5, 8-11)

Kate also makes reference to her desire to withdraw from others and this seems to originate in her fear that her emotional suffering may have been visible and may have resulted in her becoming a burden to others.

"I did not want to be around anyone and maybe that's because I didn't want anyone to see me like that because I always identified myself as being quite bubbly and energetic and a helper, so I didn't want to burden anyone." (Kate,

p10, 26-30)

"It's also really interesting because I think that a lot of the time - and I noticed this myself - I have tried to cover up my feelings or tried to pretend that things are okay because you get to a point where you feel 'I can't keep telling my friends that I am feeling this way because I am going to become boring for people'." (Jane, p16, 26-30)

Jane's hiding of her pain is linked to a fear of rejection from others unlike Kate who fears being a burden to others and Adrian who fears disapproval from others. Though the theme masking was consistent across these participants, it appeared that the motivations behind each one differed. Nonetheless, common to them all was fear of being perceived and evaluated negatively by others.

This fear echoes some of the symptoms cited in a diagnosis of social phobia where people experience dread in relation to how they will be perceived or judged by others, usually involving a fear of embarrassment or humiliation. Extensive co-morbidity between a diagnosis of social anxiety and major depression has been established, though social worry has also been known to have an earlier age of onset than distress categorised as depression. Less is known however about the relationship between them (Chavira, Stein & Bailey, 2004). Whilst it is clear that in the above instances participants were talking about wanting to hide their emotional suffering, their concerns about how others would perceive them also seemed to reflect those experiences commonly associated with a diagnosis of social anxiety

"I was a failure because I was depressed. There was no way I wanted people to know" (Adrian, p7, 25-17)

iv. Lost identity

The following comments indicate a sense of lost self that some participants alluded to when disclosing their experiences of pre-diagnosed depression. Here,

Kate describes feeling that she no longer knows herself and almost sees herself as a stranger:

"So, it was complete loss of self in a way. Of thinking, just who is this person that's emerged?" (Kate, p9, 23-24)

Jane also articulates feelings of disconnection linked to a lost self:

"I mean, I was in such a state there was no sense of identity or self, really. I didn't communicate at all. Really, I withdrew entirely in to a mental world where I was absolutely in a sort of fantasy world." (Jane, p8, 34-36)

Ella elaborates on her feelings of lost self in response to the researcher's question:

"Did you experience any changes to your self identity at the time and your perception of yourself?" (Researcher, p5, 24)

"Yeah, [I felt like] a non-entity" (Ella, p5, 25)

This quote indicates that the participant's sense of self has dissolved, possibly in response to the ongoing distraction and immersion of her emotional distress.

v. Fixed identity

Some participants described feeling that their emotional suffering was a manifestation of who they were and what they had become, thereby linking it more directly to their identity or sense of self. Tania describes feeling that her emotional suffering subsequently diagnosed as depression was just a part of who she was:

"*I thought, this is not a real problem. This is something I am faking. I was*

making a big deal of it because I just thought it was part of my character." (Tania, p11, 18-20)

She communicates a belief that her emotional suffering is not related to anything in the material world or to any particular living difficulty or circumstance. Instead, she sees it as being merely the product of experiences created and maintained by her personality alone. A sense of powerlessness comes through here; if her distress diagnosed as depression is part of who she is then it may be something she has no control over and will never escape. This may be a manifestation of the feeling of helplessness recognized in the psychological literature on depression (Seligman, 1975).

Jumania also explained that she felt her unwanted thoughts were just part of who she was:

"When you were depressed did you still have those thoughts about cleanliness and germs?" (Researcher, p8, 19-20)

"Yeah, it's kind of like become installed in me. That is part of me." (Jumania, p8, 22)

Jumania sees herself as the totality of her obsessive thoughts linked to her emotional distress, again attributing them to her personality. She believed the thoughts were part of her rather than cognitive intrusions triggered and maintained by her emotional distress. Her belief that her obsessions were ingrained in her identity and life experience run counter to mindfulness theories which suggest intrusive and obsessive thoughts are uncomfortable experiences that are transitory and inevitable aspects of human life (Gilbert, 2009).

Anna, too, explains that she had not considered her experience of emotional distress to be the depression it was diagnosed as. She perceived her distress to be part of her personality and identity, attributing her emotional suffering to who she was:

"I did not think mine was depression, I just thought 'Help, I cannot cope'. I thought it was just what I was…" (Anna, p8, 6-7)

Finally, the identification of the self with a diagnosis of depression sometimes leads to reluctance to let go:

"This is another thing about the way I've experienced depression, that it's something I've kind of enjoyed as well. It's the sort of thing that is a real part of me and I haven't wanted to give it up." (Adrian, p10, 31-33)

Adrian indicates that his emotional suffering had almost become like his friend. He does not want to reject it and it is possible this is linked to feelings of fear about the unknown, of living his life without it.

F) Dissociation

Related subordinate themes of dissociation were disengagement and alienation and chosen detachment, the latter being a coping strategy.

The researcher will begin by looking at the participants' navigation through already existing feelings of dissociation, which exacerbated feelings of personal distress in pre-diagnosed depression. She will elaborate and examine in more detail the participants' descriptions of a peculiar inability to feel connected to the world.

Whilst this research set out to explore experiences of distress diagnosed as depression, it was interesting to discover that, for some, emotional suffering involved an absence of experiencing any emotions at all. Participants portrayed this as flatness, indifference and even a living death.

i. Disengagement and alienation

This profound feeling of being cut off from others was both distressing and isolating. It goes beyond the BDI-II (1996) reference of social withdrawal. Participants often described this feeling of being disconnected and cut off from other people as feeling alienated.

Jumania describes being with her friends and at the same time feeling as though she is not really there with them. She seems to experience these situations more in the role of observer rather than as a social participant. The term *depersonalization* refers to feeling cut off from both the world and even one's own self. People with depersonalization complain of feeling like a robot or an automatic pilot and feeling like an observer of oneself (Barker, Hunter, Lawrence & David, 2007).

"I felt like I was an onlooker on myself. It's as if I'd been recorded on CCTV or whatever and I was just watching myself." (Jumania, p5, 4-6)

She goes on to describe a sense of disconnection between herself and others, a sense of feeling different to everyone else. She describes this experience as alienating:

"I would see people laughing and joking and just getting on with their normal lives around me and I would feel like they were in a different world to me." (Jumania, p3, 30-31)

"It's like I felt detached and they weren't aware of this. They would include me in their jokes and everything but I felt like we were in different places in our lives." (Jumania, p9, 33-35)

"I felt like I was in my own world. I was experiencing different things." (Jumania, p4, 10-11)

"I was going to say 'alienated'." (Jumania, p4, 15)

Similarly Jane,

"There was just a sense of being somehow outside of the normal world. Also what I found was that I was unable to communicate with a lot of my friends and I felt very alienated from them." (Jane, p3, 38-40)

Adrian refers to feeling alien around others:

"I didn't want to be with them, I did not want to be there. I wanted to hide away, I felt that I was sort of slightly alien to these people." (Adrian, p2, 28-29)

Joe also alludes to a feeling of separateness from his friends when he describes this surreal experience of feeling as if he is watching them and himself from a distance, removed and detached from them:

"*People would say 'The party does not start till you turn up' - the classic - but it was like I was watching. I would feel like I was in a theatre, in the stalls, watching the play on the stage and having no connection to it other than just observing." (Joe, p4, 11-14)*

Cheryl affirms her inability to feel connected to her friends:

"*It's like total emptiness, like most of the time even when I am with friends, I just feel numb and detached and everything feels cold and distant even though I am in the moment." (Cheryl, p9, 18-19)*

Given that a lack of support is a recognized trigger and compounder of emotional distress (Hammen, 1998), it seems a cruel twist of fate that these participants were unable to connect with people in a meaningful way that might have supported them in their time of personal distress. Unsurprisingly this

incongruity intensified their emotional suffering all the more.

"There was a feeling of intense loneliness in me. The more it went on, the less able I felt to actually find a way in to the world." (Jane, p4, 32)

This feeling of utter disconnection is not something that is overly acknowledged in popular cognitive theories of emotional distress categorised as depression. Yet it seems the ways people connect or disconnect from the material world and why is of great significance to the experiences of emotional suffering subsequently diagnosed as depression.

Jane discloses an absence of feeling, which contributed to her interpersonal difficulties at the time:

"I lost my ability to feel people. I had uncomfortable interactions with people because I couldn't sense what was going on for them at all, so I would sometimes ask questions that they were obviously uncomfortable with and I wouldn't even realize. I would just suddenly read it from their faces, I had to learn to read faces." (Jane, p9, 27-30)

"It was very strange, feeling that cut off from people and talking to them or interacting with them but not having any sense of them emotionally at all. I started to understand how people could sort of view each other as objects of curiosity. I really did not have any empathy at all and it suddenly all made sense that people could do awful things to each other and have no feelings about doing so." (Jane, p10, 3-10)

Tania reaffirms her experience of having no feelings at all and the resulting sense of detachment when she describes how she feels like she is talking about someone else:

"Because I internalize everything I did not get angry. There were no related emotions. Even now it is like I am talking about someone else but I think what

happened was I repressed it all and went about my day." (Tania, p6, 1-3)

Adrian talks about loss of feeling giving rise to feelings of indifference:

"You could come up to me and say 'Well done, you've won the lottery' and I'd go 'That's fine'." (Adrian, p14, 6-7)

Perhaps the most prominent aspect of this subordinate theme was an experience of dissociation and detachment triggered and maintained by a profound loss of feeling and a consequent emptiness.

Kate describes this feeling of total emptiness below:

"I just surpassed it all. You surpass being scared or you surpass almost feeling nauseous with depression because you feel so sad or so low or so panicked. You surpass all of that and you're an empty shell and I would have not been able to get myself up off the floor. Someone else did." (Kate, p7, 18-21)

When reflecting on her experience of feeling cut off from the rest of the world, Cheryl concludes that ultimately she feels empty and different as mentioned previously in the theme severed connections.

"You don't feel like you are really there somehow, so it's like separateness between you and other people. Not even other people, just the world, buildings and tables seem lifeless and empty." (Cheryl, p9, 22)

"Sounds like a jigsaw puzzle and you are the bit that won't go in." (Researcher, p9, 23)

"Yeah, good, ha!" (Cheryl, p9, 24)

Kate also refers to this sense of a mere existence or living death. The following

extract illustrates the experience of feeling there was nothing left of life at all:

"I was not eating or drinking anything, stopped going to the loo and I just sat on the floor in my bedroom in a heap and just didn't move." (Kate, p6, 30-31)

"Why? What was stopping you from moving?" (Researcher, p6, 32)

"There was just nothing left." (Kate, p6, 33)

The depersonalization already mentioned also encompasses feeling emotionally numb and detached from the world around you, lacking empathy towards other people and the world around you appearing artificial and less colourful than it really is (Barker et al., 2007). These are all experiences described by the participants, although, interestingly the literature says that people with distress diagnosed as depression only report depersonalization from time to time and that it is generally confined to emotional blunting or deadness of feeling (Barker et al., 2007).

ii. Chosen detachment

This section will look at how some participants appeared to use dissociation as a coping mechanism to aid them through and detach them from their emotional suffering.

Some participants described escaping by retreating into imaginary situations, on occasion even fantasizing about death as the ultimate escape:

"*I would fantasize about being in a car crash." (Ella, p8, 30)*

Although Ella entertained thoughts of death, the concept of taking her own life was unthinkable to her at the time. She was separated from her husband because of his gambling problems and had young children who were dependent solely on

her.

Jane elaborated on her complete avoidance of others by retreating to a fantasy world devoid of any interaction with the outside world.

"I mean, I was in such a state, there was no sense of identity or self, really. I didn't communicate at all. I withdrew entirely into a mental world where I was absolutely in a sort of fantasy world." (Jane, p8, 34-36)

Her comment suggests she feels that in the absence of any social interaction she experienced a complete loss of self where she no longer felt she existed in the material world. However she continues to describe her experience as somewhat detached and possibly destructive. She revealed that her emotional suffering intensified around this time and it sounded as if losing touch with reality was pivotal in exacerbating her distress.

"This is my understanding of it: I felt opened up on some level to something I'd not experienced before and I think I also somehow started to lose touch with normal life." (Jane, p3, 29)

It is important to note that she says she didn't communicate at all and withdrew to a mental world. It seems an element of choice influenced this process. This is in contrast to cases in which she and other participants describe strong feelings of disconnection and detachment that did not arise through choice and caused them dreadful suffering and related anxiety. In the case of Jane, this decision to withdraw from others into a mental world was the beginning of something more sinister that was soon to overpower her and deny her of any connection with the external world.

Tania also describes retreating to a chosen place of fantasy to avoid and escape from her life as it is.

"I fantasized about the past a lot." (Tania, p10, 4)

"I would also have fantasies about climbing through the TV into my old family life." (Tania, p10, 6-7)

This preference for fantasy suggests that these participants were not happy with their real worlds at the time and were escaping into fantasies that could make them feel better and perhaps more in control. It seemed that reality was a zone they chose not to be in.

Cheryl also discloses a sense of chosen detachment and dissociation and indicates that it served a purpose in the form allowing her to escape difficult feelings and situations.

"Well, I like my bubble. I do not like people in my personal space and even when I'm not in a depressed mood, I still feel like that a lot." (Cheryl, p7, 10-11)

The borders between reality and fantasy appear to have blurred in some of the participants' descriptions of their pre-diagnosed depression experiences. It seems that in the above cases participants have chosen to dissociate as this provides a better alternative to a world that had for them become meaningless, grey and miserable.

The fantasies of fantasy prone people often include dissociation and a high correlation between dissociation and fantasy proneness has been identified (Dalenberg, 2012). Both Jane and Tania describe fantasizing and they both reported high levels of chosen and unwanted detachment and dissociation throughout their emotional suffering.

A link has been established between the fantasy-prone personality and paranormal and intense religious experiences (Wilson & Barber, 1983). Jane describes both spiritual and religious experiences, as recorded in the theme belief in a higher force to be discussed next, and retreating into a fantasy world throughout the course of her emotional suffering.

G) Belief in a higher force

Belief in a higher force refers to the participants' understanding and interpretation of their emotional suffering within a supernatural or spiritual framework, characterized by the belief that a higher force or stronger power is controlling their experience of emotional suffering subsequently diagnosed as depression.

Subordinate themes that generated this superordinate theme were destiny, deserving of punishment, superstition and spirituality. This theme is also reflected in some of the participants' various coping strategies.

i. Destiny

The subordinate theme destiny was a term some participants used to describe a sense of fate and determinism, which they believed to be in control of their emotional suffering. The following passage illustrates how these concepts and beliefs manifested:

"It's too much effort in the end. It's too hard. It's like you're changing the flipping curtains when the whole house is falling down around you, trying to keep things under control and then in the end you just think, right, I'll just leave it to fate." (Joe, p8, 8-11)

Here Joe expresses his inability to maintain the battle against his emotional suffering and describes feeling despondent. He communicates his desire to "throw the towel in" (Joe, p28, 15) and just give up altogether; with a mixture of despondency and relief, he places his future in the hands of a stronger power he calls fate.

Other participants pointed to a more punitive sense of feeling damned.

"I felt like I was doomed, like I was not going to get better." (Jumania, p3, 28-29)

ii. Deserving of punishment

"I just wanted to be dead. I just thought 'What's the point of being alive when you have been afflicted with so much crap?' It's cruel. I used to think, 'What did I do to deserve this life?'" (Anna, p2, 21)

Anna's account reflects a sense of being punished by a higher force that's beyond her control. She describes feeling that she deserves her emotional distress and talks about being afflicted, suggesting that bad things in life just happen to her combined with the belief that they may have happened for a reason, such as to punish her. She goes on to say:

"I did not think mine was depression, I just thought 'Help, I cannot cope'. I thought it was just what I was and just what I deserved." (Anna, p8, 6-7)

She suggests that she is somehow blameworthy of emotional and psychological punishment and one might suspect that this would further compound her suffering and reinforce her feelings of low self esteem and self doubt.

Cheryl describes an uncertainty about her spiritual beliefs, claiming she is divided on whether she believes in God or not. Though she says she is an atheist, she feels God is punishing her, as this is the only way she can make sense of her suffering and discomfort of her existence.

"My head was wrong, my life was wrong. I should not be here. I am an atheist, I don't believe in God but if there is one, it would be like he has put me on this Earth and I should not be here. He has made a mistake and now he is trying to

punish me for it for being here." (Cheryl, p12, 8-11)

Later she elaborates, indicating that she is being controlled and possessed by a higher force. She does not describe this as God but as "something coming over me", perhaps leaning towards something more sinister.

"I was crying once, as usual in the evening, and something came over me and I felt possessed. It sounds really weird but I had this overwhelming feeling of dread and fear and I was writing stuff and did not know what; it felt like it wasn't me doing it but I have never been so scared in my life. It was terrifying. I don't think anyone really believes me." (Cheryl, p12, 13-18)

iii. Superstition

Some participant's were more superstitious than others and in some cases this subordinate theme was linked to anxiety and obsessive behaviours, as may be seen in the following passage:

"I had a fear of becoming something I didn't want to become. I had obsessive thoughts for three or four years about becoming a devil worshipper. I have never wanted to be a devil worshipper but I had non-stop thoughts about becoming one, to the point where I used to pray constantly." (Jumania, p15, 2-5)

Here, the participant feels she is losing control to supernatural forces and is afraid of this. She adopts safety behaviour, praying in an attempt to ward this off and regain some control over her life and future. The cited links between worry and despair have been mentioned in the introduction and it is evident that this participant's emotional suffering incorporated feelings of fear and worry.

This supernatural - or superstitious - perspective is also apparent in Joe's attempt to overcome his suffering:

"It was like I was exorcising some sort of demon." (Joe, p9, 8)

It is as if, feeling that something or someone has taken control over him, he is commanding it to depart in the name of a higher power.

iv. Spirituality

Some participants referred to the discovery of spirituality at the time of their emotional distress and saw their distress as a transformative experience from one stage of their life to another. Spiritual interpretations sometimes seemed to make possible a positive reconstruction of the participant's experience and to help some participants to regain control of their lives.

Jane makes reference to her emotional suffering subsequently diagnosed as depression as a spiritually transformative period in her life. She explains having met a psychic healer who she believes understood her plight by saying:

"I can see that you have gone through some sort of spiritual awakening." (Jane, p3, 8-10)

This same participant also refers to a newly developed belief in God:

"Suddenly, for the first time, I believed in what people would call God, probably because I suddenly felt aware of something else, of another dimension of existence that I had not been aware of or at all interested in up until that point." (Jane, p2 38-41)

As she describes her experience as profoundly empowering, this resort to spirituality may be viewed as a coping strategy.

H) Disciplining the self

Another superordinate theme that arose was disciplining the self. This need for discipline found particular expression in the subordinate themes finding control and application of acceptance and patience.

i. Finding control

Throughout the interviews many participants described a need to feel in control and this was often a response to feeling out of control. Adrian explains how he felt he had lost control and describes his attempts to regain a sense of control in his life:

"I just wasn't coping with large groups of people really. I was fine one-to-one but felt incredibly out of control as soon as I was in a group." (Adrian, p2, 21-23)

"I was in a new environment, new stresses, didn't really know who I was, felt out of control. There you go, felt completely out of control. The whole food thing was about, I think, in it's varying guises about control. I had a need to punish myself around food so I could be binge eating, putting on tons of weight and then starving and then the whole bulimic thing." (Adrian, p6, 22-30)

Reflecting on his need to have things in order Adrian says,

"It became obsessive." (Adrian, *p18, 33)*

"The washing up has got to be done and the clothes have got to be put away and all the toys have got to be in their baskets. Yes, and that goes along with so many different things and as soon as it's not, you are out of control and even when you are out of control emotionally, if you go into a room and everything is tidy, that's alright. It looks in control. It's part of that façade. It's like I'm saying that I am not depressed, I haven't got any problems - look at it, everything is tidy." (Adrian, p18, 9-12)

Jumania also discloses that she felt out of control at the time of her pre-diagnosed depression and it is evident in her description that she felt able to overcome this experience by controlling and disciplining her thought processes:

"I remember going to my job and not being able to control myself and just crying." (Jumania, p3, 19)

"I feel that if I think I am down, I am down, and if I think in my head that I can enjoy myself today, despite how bad I was feeling an hour ago, I am able to enjoy myself today." (Jumania, p9, 18-20)

ii. Application of acceptance and patience

Ella describes how the discipline of a steady mechanism within her enabled her to control herself and not spiral into a breakdown. She was able to retain some stability throughout her emotional distress with the application of acceptance and patience, and there is a sense she is in charge of her emotions.

"I knew something was not right but then I knew I would not have a breakdown." (Ella, p3, 28-29)

"I felt very strong as well so even though I was crumbling there was something in me that I felt I could cope with it and it wasn't a fake cope, it was just a steady mechanism that I had in my head which I feel like has always been there, of just sailing and just biding." (Ella, p3, 30-34)

Whether Ella and Jumania are aware of it or not, they both appear to be cultivating aspects of mindfulness with the application of patience, acceptance and the focusing and discipline of their attention and awareness. Mindfulness involves understanding attention and learning how not to be caught in the automatic-ness of our thoughts and taking control over what we attend to rather

than allowing our attention to be directed by whatever emotions happen to be activated at the time (Gilbert, 2009).

4

DISCUSSION

4.1. Discussion

The terms ‘symptoms’ and ‘depression’ arise throughout this study. This is not because the researcher believes that classification manuals and their terminology have an authority in relation to experiences diagnosed as depression. Rather it is because it is important to understand how emotional distress diagnosed as depression is understood and discussed in the existing literature. Once the researcher had completed this research and analysed the generated themes, it became apparent that the word ‘depression’ functions as an umbrella term for an array of experiences that people struggle to make sense of when they are emotionally distressed.

This thesis attempts to flesh out the clinical term depression by revealing how some of these distressing experiences are much more complex and heterogeneous than is suggested in the classification manuals. Indeed the results of this study show that the diagnostic term ‘depression’ failed to apply to some of my participants’ experiences of emotional distress and that it might be preferable if this term were used in a less rigidly diagnostic manner. Emotional distress has been found to manifest in difficult relationships, bodily experiences, spiritual experiences, mental distress and challenged and fractured sense of the self.

This research hopes to make a contribution to the understanding of people’s

experience of emotional suffering by giving voice to the participants' experiences and illustrating both how emotional distress manifests for individuals and how it impacts on their day-to-day living experiences. It charts the journey people undergo from the moment they feel something is not quite right up until the time they are diagnosed with depression by a GP or a psychiatrist.

4.2. Summary of findings

The results section reveals the prominent experiences that arose for participants and documents them in the form of superordinate and related subordinate themes. This discussion will consider how the documented themes revealed in this study relate to the relevant literature in the field of counselling psychology and psychology in more general terms.

Some of the generated themes, for example, deserving of punishment and physical manifestations of self-loathing, have already been documented in established classification manuals. However, the researcher doubts whether symptoms listed in this way can adequately capture and incorporate the experiences of those who suffer emotional distress subsequently diagnosed as depression. Symptoms and signs are often described using words such as psychomotor retardation or indecisiveness. Nothing further is conveyed as to what the contents of these experiences are. Consequently, describing what they actually felt like expands on themes formed in this study, such as feeling deserving of punishment.

Some of the themes have not been noted in classification manuals and it is to be hoped that this study provides some interesting and original data. For example, the theme belief in a higher force documents the participants' experiences of spirituality. However, it must be acknowledged that those experiences which are not documented as symptoms in classification manuals such as DSM-IV-TR (2000) and the Beck

Depression Inventory (BDI-II (1996) may be acknowledged and reflected in more general psychological literature. Such themes will be discussed in relation to the existing literature available on them.

There was considerable overlap between the themes generated in this research and the existing literature. This is not fully alluded to in the results section due to both restrictions on word limits and the fact that the primary purpose was to discuss themes that arose rather than how they overlapped.

4.3. Links between themes and existing literature

4.3.1. Totality of life

One of the themes discussed in the results section was totality of life at the time. This captured possible links between life events and the onset and maintenance of experiences of emotional distress. Some participants were able to say that their distress was caused by life events at the time. For example, one participant explained that her distress had been caused by the stress of having to move out of her home into a box room with two young children due to her husband's gambling problems. She said the stress of her circumstances had pushed her into the "worst part of her psyche".

Another participant disclosed how difficult her life was as a single mother on benefits. Although she had a boyfriend at the time, the responsibility of raising and financially supporting her child was largely down to her. She described feeling directionless and hopeless and, due to her commitments as a mother, was unable to escape from being financially dependent on the welfare system.

Population studies have shown that poor mental health is strongly associated with low income and material deprivation (Fryers, Melzer, Jenkins & Brugha, 2005). People

on lower than average income are twice as likely to develop mental health problems (Social Exclusion Unit, 2004). Pickett & Wilkinson (2010) have gathered substantial evidence, through long-term population studies, that the bigger the gap between the richest and poorest members of a society, the worse said society performs on measures such as mental and physical health, violence, crime, obesity, education and community life. Cromby et al. (2013) state that restricted income, resources and opportunities enable distress to arise more often and more severely and that those in disadvantaged situations will have fewer resources to buffer their experience of distress.

Some participants linked the onset of their emotional suffering to life events such as loss of a relationship, death of a friend or the divorce of their parents. Kendler, Hettema, Butera, Gardner & Prescott (2003) found that experiences of loss or humiliation made people more likely to suffer from distress diagnosed as major depression whilst experiences of loss and danger rendered people more likely to suffer from worry categorized as generalized anxiety disorder. In this study it was found in the participants' accounts of their experiences, experiences of loss were pervasive.

The foregoing is in contrast to explanations that are inclined to attribute emotional distress to the person than a response to their surrounding world. For example (Weekes, 1977) in her book Self Help For Your Nerves writes "above all, remember that depression is you, and it is not the world that is so terrible. Depression is an illness, just as influenza is an illness". This book was written some time ago and it is interesting to note how emotional suffering is not considered to be linked to the nature of people's lives.

4.3.2. Trapped in the head

The theme trapped in the head, does not relate so much to the specific content of thinking as to the experience of being overwhelmed by the presence of thoughts and by

an inability to escape them. When describing experiences of worry, overthinking, over analysing and noise in the head, participants alluded to an experience of being locked in by their thoughts. Whilst there is much literature acknowledging dysfunctional thought processes in emotional distress categorized as depression, the researcher was not able to find any material that focused on this sense of being locked in by thoughts.

As the results section conveys, some participants describe their experience of emotional suffering as a heady manifestation of thoughts. Beck (1979), in describing emotional distress as a thinking disorder, emphasizes their negative, dysfunctional and intrusive character. However he omits any reference to their claustrophobic and constant locked-in-ness.

The closest example in the literature the researcher could find was in Trapnell & Campbell's (1999) differentiation between motivated attention on the self, such as the enjoyment of trying to understand oneself through reflection, and a tendency to be constantly analysing why one does things. This latter sense of endless inner reflection has something though not everything in common with what participants in this study communicated as a feeling of being locked in by their thought processes.

Hoeksema's theory on overthinking also links in to this feeling of being locked in by cognitions. Hoeksema (2003) describes overthinking as going over and over negative thoughts and feelings, examining them, questioning them and kneading them like dough. She outlines three possible types of overthinking: rant and rave overthinking centring around some wrong we believe has been done to us; life of its own overthinking where one entertains possible causes for their feelings and accepts all the explanations we generate, especially the most dramatic ones; and, lastly, chaotic overthinking, where we don't move in a straight line from one problem to another and all kinds of concerns flood our minds at the same time. Chaotic overthinking can be especially overwhelming as people can't identify what they feel or think very clearly and become overwhelmed

with feelings and thoughts that disorientate them, causing them to shut down or run away (Hoeksema, 2003). Chaotic thinking captures what many of the participants in this study described as persisting throughout the time of their emotional distress, a constant intrusion of thoughts and worries, linked to their life and world experiences at the time which they could not expel from their minds.

For example, they might feel overwhelmed with self-deprecating thoughts that are set off and maintained by constant social comparisons; these in turn may cause people to feel inferior to more affluent and seemingly respectable others. Hoeksema (2003) cites the different ways in which happy and unhappy people engage in social comparisons suggesting that unhappy people engage in social comparisons a lot as they are more attuned to their status compared to others. Unhappy people worry more about how they are doing. Their moods are more affected by thoughts about relative status, with the result that how they measure up against others ends up being more important to them than how they actually perform. In contrast, happy people generally ignore social comparison as their identity is based on more stable internal standards. In this case if they meet their own standards, then they are happy (Hoeksema, 2003).

Whilst this rings true for this research, it should be acknowledged that participants felt socially inferior to their peers due to deterioration in status and lifestyle. Their intrusive and overwhelming thoughts are a manifestation of distress with life at the time. The mind becomes fixated with this and struggles to think about anything else. There seems then to be an interaction between unhappiness in life and a related obsession with the explanation of this unhappiness. This is re-affirmed by Teasedale & Green (2004) who describe a mode of responding to distress that involves repetitively and passively focusing on experiences of distress and on the possible causes and consequences of it.

4.3.3. A need to belong

This tendency to compare the self with others shares elements of another theme discussed in the results section, namely a need to belong. In social psychology the need to belong is an intrinsic motivation to affiliate with others and be socially accepted (Zimbardo & Formica, 1963). This need plays a role in a number of social phenomena such as self-presentation and social comparison. Our need to belong is what drives us to seek out stable, long-lasting relationships with other people. It also motivates us to participate in social activities such as clubs, sporting, religious and community activities. By belonging to a group, we feel we are a part of something bigger and more important than ourselves.

It has also been noted by Shachter (1959) that contact with other people is often an antidote to loneliness as it reduces anxiety. Simply put, there is safety in numbers and the presence of others can distract people from their concerns. The reactions of others can provide information about our situations and other people. They provide the means by which we evaluate ourselves.

In The Theory of Human Motivation (1943), Abraham Maslow identifies the human need for affiliation. The hierarchy is usually portrayed as a pyramid, with more basic needs at the base and more complex ones near the summit. The need for love and belonging lies at the centre of the pyramid as part of the social needs. While Maslow suggested that these needs were less important than the physiological and safety needs, he believed that the need for belonging helped people to experience companionship and acceptance through family, friends and other relationships (Maslow, 1943).

It was evident in this research that some participants who felt misunderstood, lost, detached or isolated were longing to experience a feeling of connection with others. The theme a need to belong was a subordinate theme of severed social and emotional connections and it seemed some participants who did not feel connected to others expressed a yearning to belong to a group or crowd where they felt accepted and

understood.

4.3.4. Dissociation

Dissociation has been described as a partial or complete disruption of the normal integration of a person's consciousness or psychological functioning. It is a common response to trauma as it allows people to distance themselves from experiences that are too much for them to cope with by spacing out or switching off (Dell & Neil, 2009). Dissociation was one of the most prominent themes that emerged in the participants' experiences of emotional distress. The term dissociation captures a sense of being detached and cut off from the world. However, the term depersonalization seems to be more suggestive of the depth of the experiences participants described when reflecting on their varied experiences of dissociation.

The following have been associated with the experience of depersonalization; feeling cut off or detached from the word around you, being emotionally numb, lacking empathy towards other people, feeling in a dreamlike state, feeling isolated from the world around you, feeling like an observer of yourself with the world around you appearing artificial and less colourful than it really is (Barker et al., 2007). Such experiences appear to mirror what some participants in this study were experiencing in their emotional distress. They are not documented in depression classification manuals.

Participants described feeling as if they were observers of themselves. They reported feeling as if they were watching themselves on CCTV or watching themselves perform in a play when they were socializing at parties. There is a distinction to be drawn here between dissociation from the self and dissociation from others and the surrounding world. Some participants described feeling dissociated from themselves whilst others described feeling dissociated and detached from others.

Feelings were disclosed of intense detachment from the surrounding world, feeling completely cut off from people and having no empathy or sense of them emotionally. Some participants also conveyed an emotional indifference to the things that would normally arouse excitement and emotion such as winning the lottery.

When experiencing depersonalization participants also described changes in the way they experienced their surrounding world visually at the time of their emotional distress. They explained that chairs and tables seemed somehow empty and lifeless. It seems this particular experience might be better described by the term *derealisation* which is defined as an alteration in the perception or experience of the external world so that it appears strange or unreal (Baker et al., 2007).

4.3.5. Belief in a higher force/spirituality

Links between dissociation and spirituality have been established by Loewenthal (2007). She claims that in certain societies, what we might consider to be dissociation may in fact be connected to culturally or religiously specific states. Participants disclosed having spiritual experiences at the time of their emotional suffering during which they felt possessed, as if in some kind of trance. Case studies from Singapore (Ng, 2000), Colombia (Pineros, Rosselli & Calderon, 1998), Senegal (Bullard, 2005) and other African societies (Helman, 2000) have shown possession and trance states to share certain features with dissociative states, such as amnesia, multiplicity and a loss of touch with reality. It has also been noted that feeling possessed may result from personally stressful and traumatic experiences and **is** often more connected to religion, such as the belief in reincarnation and spirits (Cromby et al., 2013).

Chen (2006) states that striving for meaning is considered to be at the core of an individual's being and the driving force behind intellect and emotion. These understandings can be incorporated within religious perspectives of life and in

humanistic and existential thinking as discussed in the introduction. Spirituality has been conceptualized as a broader search for meaning in life, involving a universal power as a guide (Koenig, 2001,Canda & Furman, 1999; Underwood, Powe, Canales, Meade & Im, 2006). The concept of spirituality is found in all cultures and is often considered to encompass a search for ultimate meaning through religion. Both religious and spiritual beliefs offer a foundation from which understanding, insight and meaningful life experiences may be recognized by providing feelings of comfort, peace, faith and hope. These concepts may be linked to the generation of the theme belief in a higher force. Although none of the classifications manuals for depression document spiritual experiences as a possible component of emotional distress categorized as depression, the relationship between spirituality, religion and health is now a focal point of interest in mainstream health psychology and psychiatry (Culliford, 2002; Miller & Thoresen, 2003). There is substantial empirical evidence highlighting the important role of spiritual practice for mental health (Koenig, McCullough & Larson, 2001;Weaver & Koenig, 2006). Similarly, a robust and vast body of empirical research demonstrates the positive effects of mind-body practices, which are often associated within, or practiced as part of, a spiritual belief system for well-being and health (Khols, Walach & Gander, 2009).

From an existentialist perspective, a longing for truth and orientation in life forces us to ask questions about the ultimate meaning of life. It has been argued by Dysen, Cobb & Forman (1997) that if an individual is unable to find this meaning, all domains of life may be affected and spiritual distress will be experienced. This concept echoes the experience of one participant who believed her emotional suffering was some sort of wake-up call for a need to create a more spiritual existence and find an alternative meaning in her life that would be more fulfilling. Her understanding of her emotional distress was that she was undergoing a spiritual transformation that was purposeful rather than pathological.

A study conducted by Diaz et al. (2011) exploring the relationship between spirituality and diagnostic depressive symptoms among in-patient individuals who abuse substances lends further support to the idea that spirituality may play a purposeful and protective role in relation to mental and emotional distress. It found that individuals who abused substances and reported higher levels of spirituality were more likely to report lower levels of depressive symptoms. Given that spirituality involves meaning and purpose in life linked to a sense of belonging, which may minimize loneliness and despair thereby cultivating feelings of optimism, hope and a sense of well-being, this is not surprising (Diarmuid, 1994).

Whilst there is evidence that spiritual belief and practice can play a supportive role in emotional suffering, there is also some evidence that it may be a contributing factor to the development of distress.

In this study both positive and negative aspects of spirituality were associated with distress. Whilst some participants believed they were deserving of their emotional suffering and were damned, others described intense emotional distress at the time their search for and involvement and engagement in spirituality began. It has been suggested that breakdowns or mental distress may occur after intense periods of spiritual exploration and attempts at self-realization, as people endeavor to acquire meaning in their lives (Clay, 1996). It is however possible that emotional distress labeled as anxiety and depression may cause spiritual distress. Smucker (1996) argues that physical and emotional distresses are defining characteristics of spiritual distress, as they are accompanied by feelings of disharmony, disconnectedness and a loss of meaning.

Swinton & Kettles (1997) identify a model whereby spirituality already present is affected when subsequent distress is experienced. For example, they suggest that when someone experiences distress diagnosed as depression, their spirituality becomes contaminated by hopelessness, purposelessness and a loss of meaning in life.

4.3.6. Disengagement and alienation

A person with anxiety may experience alienation in relationships, which are central to a person's well-being (Polner, 1989). The theme disengagement and alienation was prominent in the participants' experiences of emotional suffering subsequently diagnosed as depression. Whilst the term was often used to denote feelings of difference and apartness from others and was strongly linked to experiences of dissociation and detachment, it also seemed to convey a feeling of being an outsider, sometimes in the most literal sense of the term. Some participants not only described moments of feeling alienated from others but also complained of feeling like an alien, a sense of feeling somehow foreign to the rest of the human race. Such an experience seems to go beyond the loss of interest in other people mentioned in the BDI-II (1996). It is one thing to feel detached and apart from people around you, as people do when they feel dissociated or depersonalized as mentioned earlier, and quite another to experience feeling foreign to the human race. This is something that could be explored more as it seems it may be a more prominent experience in emotional distress than is currently acknowledged.

4.3.7. Severed social and emotional connections/troubled relationships

Another theme that arose in relation to feeling alienated from others was troubled relationships. It has been recognized that people diagnosed with depression often have limited social support and this may be due in part to emotionally distressed individuals alienating those close to them on account of their excessive demands for support, a process that elicits rejection and in turn serves to intensify or maintain distress diagnosed as depression (Coyne et al., 1987). However, according to participants in this study, problems arose within the existing relationships rather than on account of the lack of them. Interestingly, Hammen (1991b) observed that women with recurrent depression diagnosis experienced significantly more interpersonal negative events during a one-

year period than groups of women with bipolar or medical disorders or non-psychotic controls. Those distressed women diagnosed with unipolar depression were particularly likely to have experienced conflict events and interpersonal difficulties with friends, spouses, family, employers and teachers.

This tendency for emotionally distressed women to contribute to the occurrence of more interpersonal and conflict stressors was also found in another sample of young women (Daley et al., 1997). It was not always clear in this research whether troubled relationships were identified by the participants as being a causative factor in their experiences of pre-diagnosed depression or a consequence of it. Nevertheless, interpersonal difficulties featured in the participants' accounts of their emotional distress.

It is indeed widely recognized that distress can result from and create difficulties in interpersonal relationships. IPT therefore attempts to alleviate experiences of emotional distress improving interpersonal functioning by clarifying, refocusing and renegotiating the interpersonal context associated with the onset of depression (Weiss & Kleinman, 1998). This lends support to the findings in this research that troubled relationships as well as lack of social support are something individuals experience at times of emotional distress.

4.3.8. Mistrust and persecution

One of the things that seemed to interfere with some of the participants' relationships was the issue of mistrust and persecution. Bentall et al. (2009) described paranoia as the excessive estimation of personal threat and stated that paranoid beliefs are more likely to emerge in those individuals who have experienced victimization and powerlessness (Janssen et al., 2003; Mirowsky & Ross, 1983).

Interestingly some participants in this study described traumatic childhood experiences of neglect from both family and those who fostered them in the care system. Whilst this study did not set out to focus on or establish links between a persons past and present emotional suffering, it is noteworthy that the participants' experience of pre-diagnosed depression does match what the above literature suggests. This gives the researcher a clue as to where these experiences of mistrust and paranoia may have originated. Traditionally, psychiatric theorizing assumes that experiences of paranoia are simply irrational and false, a sign of pathology whose context and content are meaningless (Harper, 1996, 2004). Whilst this may sometimes be the case it is perhaps no surprise that if one has been excluded, marginalized, discriminated against or have faced victimization, you may start to experience the world as a fearful place (Cromby & Harper, 2005).

4.3.9. Transformation of identity

Another key theme that arose was transformation of identity, reflecting changes the participants' self-identity underwent at the time of their emotional suffering. The concept of personal identity refers to an inner sense of wholeness and security, which is achieved when there is congruence between the individual's perception of self and others' perceptions of him/her (Erikson, 1968).

Many participants described feelings of uncertainty and discomfort in relation to their assumptions as to how other people might perceive them at the time of their pre-diagnosed depression. It seemed their sense of self was unstable. It was as if they were mere reflections of what they assumed other people thought they were and that their own negative thoughts about themselves at the time influenced what they saw themselves to be. Erikson (1968) described identity as a subjective sense and an observable quality of personal sameness and continuity, and it seems this core sense of self was disrupted and sabotaged in the participants' experiences of pre-diagnosed

depression.

One could argue that at the time of their pre-diagnosed depression some of these participants experienced an identity crisis. Erikson (1968) stated that when an adolescent has an identity crisis, they might have no idea as to who or what they are, where they belong or where they want to go. He further described patterns of withdrawal from normal life and the turning to negative activities, such as crime or drugs, as a way of dealing with identity crisis, stating that to someone having an identity crisis, it is more acceptable to have a negative identity than none at all. This theory would fit with the participant's accounts of masking, whereby they created a new identity to fit in with and please the people around them. Whilst Erikson applied this theory to adolescents, he also stated that an identity crisis might occur at any time in adult years when one is faced with a challenge to their sense of self. This is what the participants' accounts reflected.

4.3.10. Embodied distress

Feeling unhappy with appearance was another form of distress participants described. Some participants described feeling ugly and unattractive as part of their experience of emotional suffering. This form of embodied distress is something that is documented in the BDI-II (1996) as mentioned in the introduction and it was something the researcher was able to explore further with those participant's who felt it. Participants described feeling that they hated themselves when they were emotionally distressed and, when they talked about their suffering; they related their despair to their appearance. Some disclosed that self-hatred manifested in feeling ugly and not being able to understand why their boyfriends or husbands were with them. This can be seen as an example of negative attitude towards one's own body, experiences commonly associated with a diagnosis of Body dysmorphic disorder (BDD). This is defined in DSM-IV-TR (2000) as a condition marked by excessive preoccupation with an imaginary or minor defect in

a facial feature or a localized part of the body. A common feature of a BDD diagnosis is the fundamental belief that the self is defective due to flawed appearance (Corrove & Gleaves, 2001; Phillips, 2005; Veale, 2004b). Negative perception of self in individuals diagnosed with BDD has been specifically linked to the particular association of appearance with self worth (Silver & Reavey, 2010). The importance of examining selfhood in relation to embodiment is now well established across the social sciences and feeling good about oneself is thus intimately tied to the widely available discourses on what constitutes the ideal body/self and is not necessarily confined to specific diagnostic categories (Silver & Reavey, 2010).

As this research has demonstrated, emotional distress is not only a matter of the mind but also of the body, affecting both the patient's bodily functions and his or her attitude towards their own body. It is a common experience from physiotherapeutic practice in psychiatry that emotionally distressed patients tend to have somatic complaints and difficulties, such as pain and ache from muscles and joints, disturbed body awareness, general bodily tension and anxiety, restlessness, slowness and lack of coordination of movements, disturbances in posture, restricted breathing and negative feelings and attitudes towards their own body (Stahl, 2004).

As the term 'depression' has been primarily used as a name for an illness and the experiences of those who suffer from it have been described in terms of 'symptoms', such as anxiety and vegetative symptoms such as sleep disturbance, it is therefore not surprising that a great deal of emphasis is placed on the recognition and treatment of such experiences. On the other hand, according to Stahl (2004) distress categorized as depression is an illness that frequently presents with a large number of unexplained physical symptoms and such symptoms are frequently excluded from diagnostic criteria for major depressive disorder. Some of the physical symptoms that arose in this study are not mentioned in DSM-IV-TR (2000) or BDI-II (1996). For example, some participants in this research described a constant feeling of dread in their stomachs,

sometimes referred to as pain in the solar plexus, a description that may be more easily identified within new age literature.

Participants also described feeling an intense discomfort in their body that made them want to scratch their skin off. This description calls to mind the colloquial expression "feeling so comfortable in one's own skin", meaning that one is relaxed and happy with oneself. However, one participant's comment describes the opposite, an extreme discomfort both with herself and inside her body.

The experience conveys this similar sense of being locked in that some participants described when disclosing experiences that reflected the theme trapped in the head. There is a sense that intense physical discomfort is overwhelming and cannot be escaped. This is not something that is documented under cited physical symptoms of depression.

4.3.11. Disciplining the self

Some participants described disciplining themselves with rigid eating habits and even starvation, whilst others did so through obsessive rituals. It has been argued that what individuals share in weight loss is not so much a desire to be thin as a desire to exert control over lives that are often beset by family conflict, abuse and oppression (Lee, 2001). It seems that the participants' experiences of rigid eating and starvation in this study may be linked to emotional distress linked to life difficulties that are in turn managed by trying to control the self and manage mood.

Malson & Ussher (1996) noted that in a sample of women diagnosed with anorexia, starving oneself was related to refusal to be associated with some of the negative aspects of femininity, such as "highly emotional, sexual, vulnerable and out of control". This reinforces the view that starvation can be used as a means to develop and maintain a

sense of control in an individual who is feeling out of control. Participants who described interpersonal difficulties and troubled relationships at the time of emotional suffering also described starving themselves and bingeing. Cooper, Todd & Wells (2005) found that triggers for bingeing included low mood, anger and interpersonal distress. Participants described attempting to avoid unwanted emotions and exerting control in their life through habits of chosen starvation and bingeing. Some participants described enduring emotional suffering with a self induced steadying mechanism, a process of self-discipline that enabled them to bide their time.

Feeling out of control was an experience participants described in relation to their emotional suffering. Attempts to regain control included the adoption of obsessive order, tidying and routine rituals. Participants described imposing structure on their lives as a way of coping with feeling chaotic and out of control and many disclosed that their lives were lacking structure at the time of their emotional suffering. This was noteworthy and not sufficiently common to be elaborated into a theme.

Overall, participants described an on-going struggle reflecting problems around management of the self in relation to others. The subordinate theme, troubled relationships that contributed to the generation of the superordinate theme severed social and emotional connections focused on the difficulties participants were having in managing their relationships with others at the time of their emotional distress. This was not the only superordinate theme that had to do with the relational difficulties participants were undergoing. Many of the identified themes in this study indicate a certain level of interpersonal distress.

For example, the theme severed social and emotional connections incorporates the subordinate themes mistrust and persecution, troubled relationships, feeling misunderstood and rejected and a need to belong. As acknowledged by the superordinate theme severed connections, these themes all reflect experiences

participants were having with other people. It encapsulates the relational struggles participants were enduring at the time of their pre-diagnosed depression.

Similarly, the superordinate theme transformation of identity incorporates the subordinate themes social comparisons, lost identity and multiple identities and masking. In times of emotional distress, participants were constantly adjusting their identity to fit in with their surroundings adapting their behaviour around different people as a way of managing other people's expectations and experiences of them. This seemed to be experienced as a pressure for some of those who otherwise felt unable to manage their relationships with others. Participants appeared to be transforming their identity depending not only on whom they were with, but also in response to what was going on in their relationships at the time. The superordinate theme transformation of identity is concerned with the participants' movements through different forms of identity at different times, which movements depend on the relationships they found themselves in.

The superordinate theme dissociation also revealed some of the difficulties people were having maintaining their relationships with other people. Ultimately, it was about people switching off from those around them, presumably because they found it too difficult to maintain relations in the way people do when they are not suffering emotionally. This gave rise to feelings of detachment and alienation, the feeling that they were no longer the same as others or not existing in the same world.

The totality of life at the time theme revealed how some participants struggled with the basic demands of work and family life. Again, this reflects aspects of relational dynamics suggesting misery may not just be about the individual, it can encompass the relationships they are in too. This study suggests that emotional suffering subsequently diagnosed as depression is an experience that is deeply embedded in peoples' relationships, how those relationships are managed alongside their distress and how others' responses to the emotional distress are experienced and managed by sufferers.

It appears that many of the themes, amongst them severed social and emotional connections, troubled relationships, a need to belong, multiple identities and masking, feeling misunderstood and rejected and dissociation, are incorporated into this thing called depression and are largely about relationships and how individuals manage themselves in relation to others; they are about what it is like to deal with people who do not understand what the emotionally distressed person is enduring. They highlight the stress individuals can feel when demands are placed upon them they don't feel they can fulfill. This was evident in the examples on the theme totality of life at the time where participants, particularly females, described feeling unable to cope with the pressures and demands linked to other people's needs. This may have been linked to gender. It has been stated by Hoeksema (1999) that women report higher levels of chronic strain as they carry a greater load of the housework and childcare and more of the strain of parenting than men do.

The participants' experiences in this research also highlighted the difficulties people feel in not being able to escape when they feel emotionally distressed and have to fit into a world that does not necessarily support, understand or accommodate their emotional suffering. This difficulty is well documented by Smail (1993) who has long maintained that not many of the experiences of psychological and emotional distress may correctly be seen as medical matters. Smail maintains that the so-called psychiatric disorders are a construct of the social world in which we live.

Overall, emotional suffering in this study seems to incorporate a variety of experiences, some of which are documented in well-known classification manuals and many that are not. It is interesting that some of the reported experiences correlated with experiences described as symptoms in other psychological disorders.

The results of this study reveal that there may be considerable overlap in experiences

of emotional distress as described by participants on the one hand, and symptoms that diagnostic psychological disorders cite on the other. Some of the participants' distress experiences correlated with symptoms described in the accounts of various psychological disorders. Feeling uncomfortable and worried about how one is being perceived by others and adopting related coping strategies, prevalent in the generated theme transformation of identity, mirrored experiences described as social anxiety in classification manuals, in which a person in a social situation is overly concerned about being judged or evaluated by others and has an intense fear about what others they may be thinking about them (Adelman, 2007).

As mentioned earlier, feelings of detachment and dissociation seemed to mirror experiences of depersonalization and derealisation. Worry, overthinking, overanalysing and noise in the head seemed to reflect some of the cognitive obsessions as documented in the diagnosis of obsessive-compulsive disorder (OCD). Hatred of one's body and appearance also occurred and seems to mimic experiences cited as symptoms in the diagnostic manuals of Body dysmorphic disorder (BDD), while the interpersonal difficulties that many participants described have been documented as symptoms of a borderline personality disorder (Padesky, 1995).

One could argue that if an individual is undergoing such a variety of experiences, it could be difficult for them to make sense of what is going on and they may be inclined to believe they are suffering from a variety of psychological disorders in an attempt to make sense of the multitude of their experiences. The researcher feels that the situation of the sufferer may not be unlike that of the astrological enthusiast who finds it all too easy to identify with the wide and overlapping characteristics the various star signs represent.

Exploration of how individuals suffering from emotional distress come to understand their suffering in relation to various classification systems of psychological disorders

would be interesting as it might shed some light on how helpful classification systems actually are to individuals undergoing such experiences. Whilst we know that those who work in the field of mental health are aware that worry diagnosed as anxiety and distress diagnosed as depression often occur simultaneously (Beck, 1979)-the layperson might not equate worry with unhappiness. Because of this, they may become confused as to what exactly they are suffering from when they try to make sense of their experiences using classification manuals. It can indeed be misleading when symptoms in such manuals overlap. For instance, the documented symptoms of depersonalization may describe some participants' experiences well, yet they are not to be found in those classification manuals that categorize emotional suffering as depression.

This may be a problem inherent in classification manuals. It is improbable that participants in this study were suffering multiple disorders simultaneously. Perhaps their emotional suffering subsequently diagnosed as depression incorporated experiences that mimicked some symptoms cited in other disorders. It seems the experience of emotional suffering subsequently diagnosed as depression may be vastly more complex than which the depression classification systems describe.

4.4. Undocumented experiences and classification problems

Not only did this research reveal distressing experiences that were reflected in the symptoms of the disorder commonly diagnosed as depression. As we have seen, it also brought to light experiences not documented in depression classification manuals. This suggests that classification systems can be problematic and may not work as well as some might think.

In this research, emotionally distressing experiences displayed heterogeneous trajectories that were different for all participants. This was in stark contrast to the more homogeneous type of distress, which standard diagnostic criteria suggest. Whilst the

researcher acknowledges that diagnostic categories and classification manuals can be helpful in indicating treatment, enabling prognosis, providing a basis for research, enabling professionals to communicate with each other, giving patients access to services and in some cases even providing relief to patients and carers (Cromby et al., 2013), it is worth noting that they also provide much benefit to current categorization systems. Psychiatric diagnosis is deeply embedded in the criminal justice system, in medical insurance, in government treatment guidelines and in pharmaceutical companies' development of new medications (Cromby et al., 2013). It is clear, then, that diagnostic categories have many advantages. However, the advantages may be more objectively beneficial than subjectively helpful.

It can be argued that the medical language of psychiatry (diagnosis, illness and symptoms) hides the fact that the course of psychiatric diagnosis is essentially unlike medicine on account of the lack of signs similar to those that confirm the presence of a biological disease. We are still not able to understand why people have the emotional and psychological experiences they do in the same way that we are able to understand why people suffering from diabetes show signs of low blood sugar due to rises in insulin.

Further problems arise with diagnostic categories when one considers that medical diagnosis should be stable across cultures. If one has HIV in the USA they will still be recognizable as having that illness wherever they are, whether that be in Africa, Denmark, Japan or anywhere else. However, as Cromby et al. (2013) point out, someone who experiences hearing voices in UK may consider themselves cured when they arrive in a country where hearing voices in normal, which can be the case in countries where it is not unusual to believe you can communicate with spirits or ancestors. If certain experiences are recognised as pathological in one culture and healthy and acceptable in another, it suggests that not only are people's experiences of distress very different but their interpretations of them are too.

This study also highlights some of the reasons why people tend to develop emotional suffering subsequently diagnosed as depression. As Cromby et al. (2013) state, the reasons why people break down psychologically and emotionally are very complex. Classification manuals do tend to suggest that people are suffering from an illness rather than responding to difficult life situations.

As this research has revealed, some participants, at the time of their emotional distress, were undergoing extreme stress in their lives due to social deprivation, troubled relationships and various other life-related circumstances and their thoughts, behaviours and feelings at the time seemed to reflect this. The current dominant paradigm is to view this type of emotional distress as depression, a psychological disorder, although one could argue that misery is a natural and understandable response to the difficulties listed above. This raises the question: does diagnosing life-related emotional distress as symptoms and illness have the unintended consequence that people's experiences may be misunderstood or framed in a way that is unlikely to lead to them receiving the help they need?

As a counselling psychologist, the researcher works with formulations as opposed to diagnosis and conducting this research has reinforced the importance of this. A formulation can be described as a hypothesis about a person's difficulties, which draws from psychological theory (Johnstone & Dallas, 2013). It is an individual summary of a person's problems, which reflects on all aspects of his/her life in an endeavor to explain how and why their problems arose and what therapeutic interventions might be useful (Cromby et al., 2013). Formulations in clinical practice reflect a desire to understand individuals from a psychological perspective, to recognise the complexity and heterogeneity of the clinical presentations together with the specific problems of individuals sometimes collectively diagnosed as depression.

When considering this research in relation to counselling psychology, the researcher reflected on how much it really helps to label certain kinds of emotional distress as depression. When a client is referred for treatment for distress diagnosed as depression, it signifies that they may be, and usually are, suffering from a range of symptoms, which are recognised and documented in classification manuals. This may be helpful and unhelpful. It may help psychologists to consider some appropriate interventions to help emotionally distressed people manage and overcome some of the experiences documented in this research. However, there is a danger it can encourage the psychologist to attribute an individual's experiences to a disorder and merely attempt to treat the symptoms rather than to explore their problems in the context of their lives and to help them make sense of them.

Regarding a client as depressed has not influenced the way the researcher works with them therapeutically. Within the psychological process, the client and the psychologist unearth the client's experiences collaboratively to seek and identify what it is that needs acknowledging and addressing. When this is done sensitively and adequately, it usually enables the client to recognize, manage and overcome their difficulties, thus releasing them from the prison of their emotional distress subsequently diagnosed as depression.

4.5. Limitations

The findings of this study provide insight into the salient themes of participants' experiences in this particular study. The participants have been investigated primarily as a group of individuals who had been diagnosed with depression. As the participant demographics show, the group featured a range of ethnicity, gender, employment status, income and educational background. Nevertheless, there were four times as many women in the study as there were men and only one unemployed person on benefits.

It would have been be of interest to explore differences in between the distressed

experiences of men and women, those on unemployment benefits and the employed. It would also be of interest to explore whether there might be differences in experiences of pre diagnosed depression from a wider range of socio-economic, cultural and racial backgrounds. Differences connected with gender and sexuality might also be worth exploring.

A further factor to consider is the potential selection bias amongst those choosing to participate. It could be that the experiences of those choosing not to participate may have been quite different to those taking part.

A final consideration is the use of member validation. There is debate in the literature regarding its usefulness as a method of establishing the credibility of findings (Angen, 2000). It is suggested that it is a useful method to check the researcher's understanding and to ensure that the participants' views are not misrepresented (Elliott et al., 1999; Yardley, 2008). However, it can be argued that this may lead to confusion, as participants may have changed their minds about an issue, may not understand the interpretations made and may not feel comfortable commenting on the researcher's interpretations (Angen, 2000; Yardley, 2008). Moreover, it relies on the presumption that there is a fixed truth or reality against which accounts can be measured, continuing the positivist assumption of an external foundational reality (Angen, 2000). The researcher therefore decided that use of member validation would be inappropriate for this research, as the interpretative element of analysis may have made it difficult for participants to relate to the analysis. In any case, every effort was made to be rigorous and transparent in the analytical process and recommendations for ensuring the credibility of results were adhered to (Yardley, 2008), as discussed earlier in the methodology section.

4.6. Researcher application and reflexivity

In increasing the integrity and evaluation of qualitative research, researchers need to evaluate how inter-subjective elements influence data collection and analysis (Finlay, 2002). This is thought to involve a thoughtful, conscious self-awareness that further helps to acknowledge that we actively construct the knowledge that we produce as researchers and is therefore integral to any conclusions that are made throughout the research process. Thus it is important to explore the dynamics of the researcher-researched relationship as this plays a fundamental role in shaping the research findings and data collection (Banister, 1994). Acknowledging the researcher's impact on the research in allowing readers to assess the validity of her presented findings is also to acknowledges that a different researcher may have responded differently within the research context, with the potential to create a different relationship with participants by asking different questions (Finlay, 2002).

Although every attempt was made to be rigorous and transparent throughout the analysis and interpretation of the interviews, the researcher recognizes that what is presented is the researcher's interpretation. Other researchers may have highlighted different aspects of the participants' pre-diagnosed depression experiences and generated different themes in relation to them. Given the researcher's background as a counselling psychologist who provides psychological counselling to people experiencing emotional distress, she may have been more likely to focus and explore those experiences she felt she understood or recognised. However a conscious effort was made to follow and explore exactly what it was the client was communicating in an agenda free way.

It is likely that the researcher's experience as an integrative counselling psychologist enabled her to tune in to a wide range of pre-diagnosed depression experiences without focusing more specifically on cognitive ones, which she may have been more inclined to do if she were a CBT therapist. Furthermore, as a counselling psychologist the researcher is aware of how external stressors of various kinds may affect mood,

behaviour and the view of the self. It is likely that she would have been particularly mindful of the possible links between the participants' life situations and their emotional distress at the time.

Some participants were interviewed in their own home, some at university and some at the researcher's clinical practice. It seems that those participants who were interviewed in their home communicated their stories slightly differently. They were more inclined to tell their experience in the form of a story about what had happened to them. This may have had something to do with the fact that they had not travelled to meet the researcher. They would have had time to reflect and gather their thoughts before she arrived, thereby feeling more comfortable, relaxed and open.

The researcher's interests and potential biases have been documented in the methodology section to enable the reader to consider how the researcher's background and interests might have influenced the results of this research. For example, having been referred many clients diagnosed with depression there was sometimes a sense that such clients might require similar interventions to manage and overcome their emotional suffering. However, during the process of conducting this research and analyzing the data it became apparent that experiences subsequently diagnosed as depression go beyond symptoms described in classification manuals. It seems that the term depression does not accurately capture the complexity of experiences of emotional distress subsequently diagnosed as depression that the participants described.

4.7. Conclusions and suggestions for further research

This study attempts to make a contribution to the knowledge of how people experience emotional distress subsequently diagnosed as depression. It also provides examples of some of the coping strategies people adopt as a way of managing this emotional distress so they can try to continue with their everyday lives.-It also shows how this emotional

distress may sometimes be seen as an understandable response to life and some of its difficulties, thereby calling into question whether these responses and experiences need to be understood as psychological disorders. Developing further understanding of those experiences not recognised in classification manuals could help counselling psychology to consider further useful therapeutic interventions. It could also help counselling psychologists to identify possible behaviours clients might be adopting as strategies to cope with their emotional distress.

Further studies can use the information gleaned for the development of theory in the area of emotional distress. More in-depth understanding of the experiences people endure when they are suffering emotionally or diagnosed with depression could help counselling psychologists to recognise that if people are distressed, they may need therapeutic attention in the hitherto unidentified areas this study has generated. Moreover, if the experiences people undergo prior to being diagnosed with depression are more widely recognised it is possible that early therapeutic interventions could be developed.

One avenue for further research might be exploration of the role of embodiment in emotional distress. Another might be the role relationships play in distress. It was clear in this study that embodiment and relational dynamics were central to emotional distress subsequently diagnosed as depression. Looking further into how people manage their relations with others when, for example, they feel dead inside or a changed person would be a potentially fruitful avenue for further research.

It would be interesting in a further study to enquire how people experienced their depression diagnosis and whether they agreed with it or not. What was striking about this research was that all the participants arrived at these experiences of despair in such different ways. Some appeared to have agency over their experiences while others did not, and this too would be an area for further qualitative exploration.

PART D: LITERATURE REVIEW

HOW HELPFUL IS MINDFULNESS-BASED THERAPY FOR OBSESSIVE-COMPULSIVE DISORDER? A SYSTEMATIC REVIEW OF THE LITERATURE

Introduction

Obsessive-compulsive disorder (OCD) is marked by obsession and compulsions DSM-IV-TR (2000). An obsession is defined as a persistent thought, image or urge that forces its way into the mind and causes distress. Such obsessions are frequent, unwanted and difficult to expel from the mind.

Examples of the most common obsessions are: excessive concern with exactness, order or symmetry; fear of contamination dirt, germs and bodily fluids; doubts about harm occurring; urge to hoard useless or worn out possessions; obsessions with the body or physical symptoms; religious and sacrilegious thoughts; inappropriate sexual thoughts; images and thoughts or images of violence and aggression (Veale & Willson, 2005).

Compulsions, otherwise described as irresistible impulses to act, on the other hand occur in response to obsessions with the aim of reducing distress and may consist of repetitive behaviours such as washing, checking or counting. The National Institute of Health and Clinical Excellence in the UK (NICE, 2005) recommended that adults with mild to moderate OCD should be offered a choice of Cognitive Behavioural Therapy (CBT) or SRRI medication given their comparable effectiveness and suggested a combination of the two for more severe symptoms.

Contemporary treatment of OCD has developed over time and now has some

overarching elements. The different elements of treatment involve: i) exposure, facing your fears in a prolonged period of contact until associated anxiety reduces; ii) response prevention, not responding to your urges to ritualize or use a safety-seeking behaviour; and, iii) graded exposure, facing your fears in a graded manner with a planned hierarchy (Veale & Wilson, 2005). These treatment interventions derive from the behavioural model of OCD suggesting that OCD is maintained through negative reinforcement where behaviours aimed at avoiding feared objects or events are successful at reducing anxiety in the short term (Abramowitz, 1996).

In contrast to behavioural theories, cognitive theory focuses on the meaning one attaches to events, thoughts and images. Cognitive therapy reduces OCD thinking by helping individuals understand some of the thinking styles and philosophies that make one vulnerable to the problem (Veale & Wilson, 2005). It aims to identify and challenge beliefs linked to OCD, for example the importance of controlling thoughts and beliefs about personal responsibility for causing or preventing harm, or beliefs involving thought-action fusion (TAF) whereby one believes that having an unwanted and unacceptable intrusive thought increases the likelihood that a specific event will occur (Coughtrey, 2012).

In contrast to CBT the emphasis of mindfulness therapy is on developing the skill of non-judgmental awareness and acceptance of present-moment experience, including all of the unwanted thoughts, feelings, sensations, and urges that are at the heart of these conditions. What this means is that, from a mindfulness perspective, the individual's primary agenda ought not be to change or eliminate their unwanted thoughts, feelings, sensations, and urges, but rather to fully acknowledge and accept them.

Background to review

So what is the rationale behind mindfulness interventions for OCD for those

therapists that endorse its use? Studies have shown that mindfulness based therapies halve the risk of relapse for people with a history of recurrent major depression (Ma & Teasdale, 2004) and reduced symptoms of depression for people currently depressed (Barnhofer et al., 2009).

It has been noted that drop out rates from mindfulness therapy are low. In the Ma & Teasdale (2004) study only three of the 72 participants dropped out (4%) and only two of the 16 participants (13%) who began a group in the Barnhofer et al., study (2009), cited above, withdrew. A drop out rate of 26% was reported by Aderka et al. (2011) for exposure response prevention (ERP) and cognitive therapy for OCD. It appears mindfulness based therapy may have reduced drop out rates though there are other reasons as to why it may be effective for OCD.

From a behavioural perspective mindfulness based therapy encourages individuals to observe unwanted and unpleasant thoughts and experiences as opposed to engaging with them (Baer, 2003). It facilitates meta cognitive change by encouraging clients to accept thoughts such as "thoughts are not facts" which are of particular importance in OCD (Fairfax, 2008). It encourages individuals to notice urges and compulsions and to choose to react and behave in different ways. The purpose of this review is to constructively address the empirical evidence for the effectiveness of mindfulness-based therapy for OCD. In doing so the review will identify and critically evaluate studies of mindfulness-based therapies for OCD with a view to assessing whether it is an effective intervention for OCD.

The subject matter of this review was influenced by my clinical work as a counselling psychologist. I have found that my own clients experiencing OCD have not always benefited from the CBT approach; generally, this lack of success has been restricted to cases where the OCD has been deeply entrenched in the client for some time. In such cases clients have expressed the view that whilst the CBT model makes sense and helps explain why they are experiencing distressing thoughts, beliefs and behaviours it does not necessarily eradicate the their suffering. Although

CBT with exposure and response prevention (EPR) is the first line of treatment for individuals with OCD, not all of them achieve remission on a long-term basis (Hertenstein et al., 2012).

Having reached a point where I was beginning to question the effectiveness of CBT for OCD, I decided to try some mindfulness interventions on a recent client of mine who was suffering from OCD experiences. Surprisingly, after only two sessions of mindfulness intervention this client reported not only a reduction in intrusive obsessive thoughts but also increased control over his urges to indulge in related reassurance seeking behaviours. Whilst there may have been all sorts of other factors that may have contributed to his response, it nevertheless inspired me to explore the recent available literature.

Retrieved studies on the effects of mindfulness-based therapy for OCD

An electronic literature search was conducted using the following databases, PsychINFO, PsychARTICLES, Psychology and Behavioural Sciences Collection, Medline and Emabse, with a view to identifying studies on the effects of mindfulness-based therapy for OCD. The searches covered the most recent five-year period from 2007 to 2013 and included papers generated by the above electronic databases as well as relevant papers in the reference lists. The descriptors in the search included the terms mindfulness therapy paired with ocd, obsessions and intrusive thoughts.

The search results generated a range of papers from various journals including Clinical Psychology And Psychotherapy, Journal Of Nervous And Mental Disease, Psychotherapy And Psychotherapeutic Counselling and Cogntive And Behavioural Practice. Upon closer inspection many of the studies failed to directly address the subject matter, general and specific to this review. For example, some of the studies

investigated acceptance and commitment therapy (ACT) as opposed to mindfulness therapy. Once studies focusing more on peripheral aspects of the subject matter were discarded nine remained.

Summary of retrieved articles (Table 2)

Title	Written By	Publication	Date
The effectiveness and acceptability of mindfulness-based therapy for obsessive compulsive disorder: A review of the literature	Hale, L., Strauss, C., & Lever Taylor, B.	Mindfulness	Aug 2012
The effects of a mindfulness intervention on obsessive- compulsive symptoms in a non-clinical student population	Hanstede M., Gidron Y., Nyklícek I.	Journal of Nervous and Mental Disease. Vol., 196 (10): 776-779	2008
Adapting mindfulness-based stress reduction for the treatment of obsessive-compulsive disorder. A case report	Patel, S., Carmody, J. & Simpson B.	Science direct, vol 14: pages 375-380	2007
The use of mindfulness in obsessive compulsive disorder: Suggestions for its application and integration in existing treatment	Fairfax, H	Clinical Psychology and psychotherapy. Vol, 15: 53-59	2008
Effectiveness of detached mindfulness techniques in treating a case of obsessive compulsive disorder	Firouzabadi, A & Hossein, S	Advances in cognitive science. Vol, 11 (2): 1-7	2009
Mindfulness-based cognitive therapy in obsessive-compulsive disorder. A qualitative study on patients experiences	Hertenstein, E., Rose, N., Voderholzer, U., Heidenreich, T., Nissen, C., Thiel, N & Herbst, N	BMC Psychiatry. Vol, 12:185	2012

Is mindfulness-based therapy an effective intervention for obsessive-intrusive thoughts: a case series	Wilkinson-Tough M, Bocci L, Thorne K, Herlihy J	Clinical Psychology and Psychotherapy. Vol, 17 (3): 250-68	2010
Effectiveness of mindfulness-based cognitive behavioural therapy on patients with obsessive-compulsive disorder	Liu, X, Han, K & Xu, W	Chinese Mental Health Journal. Vol 25 (12): 915-920	2011
Managing Obsessive Thoughts During Brief Exposure: An Experimental Study Comparing Mindfulness-Based Strategies and Distraction in Obsessive–Compulsive Disorder	Wahl, K, Huelle, J, Zurowski, B & Kordon, A	Cognitive therapy and research Vol, 37, (4): 752-761	2013

Nine research papers in total were reviewed. One was a review itself on the effectiveness and acceptability of mindfulness-based therapy for OCD. This paper summarized four studies conducted between the years of 2004 and 2012. The remaining eight studies consisted of: an analogue quantitative case control study, the only study reviewed that had a case control group; a quantitative randomized control condition study; a qualitative and quantitative mixed methods A-B-C replication series study; a single-subject A-B type experimental trial study; a non experimental case study generating both qualitative and quantitative data; a qualitative and quantitative non experimental follow up study; a non experimental qualitative exploration of individuals; a single case multiple baseline design generating quantitative data.

Research conducted on the effects of mindfulness therapy for OCD seems to incorporate varied methodologies. Sample size was generally small with the largest sample of participants being 30.

Hale, Strauss & Taylor (2012) carried out a literature review of the effectiveness and acceptability of mindfulness-based therapy for OCD. The central purpose of

Hale's review was to establish a rationale for using mindfulness-based approaches for OCD, to establish whether it was effective in reducing symptoms, whether is was a therapy that was acceptable to people diagnosed with OCD and to identify the mechanisms of change in mindfulness based therapy.

After a comprehensive literature search four empirical research papers were reviewed and it was concluded that all the studies showed positive effects of mindfulness therapy for symptoms of OCD. Three of these four studies were conducted between 2007 and 2010 so will also be critically examined. This review will however not review anything before 2007, as Hale's did, and will also review an additional five studies including a review of the most up to date study on the effects of mindfulness-based therapy for OCD conducted in 2013.

This literature review will start with the oldest of the journals and finish with the most up to date one.

A case study conducted by Patel, Carmody, & Simpsom (2007) presented a 25-year-old white male with severe OCD and no psychiatric comorbidity. He refused treatment with medication, due to previous experience of SRIs that he had not found particularly helpful for intrusive thoughts. He found exposure and ritual prevention a distressing prospect and refused that as well. He was therefore treated with the application of an Adapted Mindfulness Based Stress Reduction (MBSR) program.

Before beginning the program he had drawn upon various coping strategies such as rationalizing or suppressing thoughts, which had proved to be slightly helpful in the short term. His treatment amounted to an eight-week program of weekly 70-minute one-to-one mindfulness sessions and a follow-up session three months later. In line with the approach of MBCT (Segal, Teasdale & Williams, 2002) the client was encouraged to view his obsessive thoughts as mental events, adopting a decentered perspective on his intrusive thoughts in order to remind him that he is not his thoughts and his thoughts are not facts. In addition, a deliteralization exercise

was borrowed from Acceptance Commitment Therapy (ACT) to decrease the role of evaluation and encourage the client to adopt a nonjudgmental, observer stance in relation to the distressing and disturbing intrusive thoughts he struggled with.

At pre-treatment assessment, his YBOCS score was 22 indicating a moderate level of OCD. Halfway through his treatment his score decreased to 17 and at post treatment his score was 13 indicating a mild level of OCD. On the Toronto Mindfulness Scale (TMS; Bishop et al., 2006) he indicated an increase in score from 18 to 27 in his capacity to evoke a state of mindfulness. His self-report measures reflected perceived benefits as well as areas where his mindfulness practice could be developed. He explained that he felt more grounded after mindfulness practice and better able to detach from his intrusive thoughts.

At a three-month follow-up interview he explained that he was continuing with his mindfulness practice at least two or three times a week. He reported less distress in relation to his OCD, an improvement in symptoms and an increase in awareness of symptom patterns and fluctuation in intensity. He did however say that he needed to develop his ability to bring mindfulness to everyday OCD. Nevertheless he was able to return to full time work. Overall, the client reported that mindfulness practice has improved his ability to tolerate and manage his OCD.

There were several limitations in this study. Firstly, being a case study, the sample size was restricted to one participant. Secondly, experiential session practice of MBSR and discussion of practice and assessment of treatment fidelity are scarce (Patel et al., 2007) making it hard to identify the extent to which the intervention was faithful to the main elements of MBSR. It was mentioned in the study that some of the sessions were adapted to incorporate psycho education about OCD and knowledge about ways to cope with it so it is possible that these interventions were more effective than the mindfulness ones. Finally, the independent evaluator who assessed the outcome for this case was not blind to treatment condition.

There has only been one case control study of mindfulness therapy for OCD published to date. This was a quantitative controlled pilot study conducted by Handstede, Gidron & Nyklicek (2008) among a non clinical sample of seventeen Dutch students who scored much or very much on at least one item of the obsessive-compulsive inventory-revised (OCI-R; Foa et al., 2002). Anyone scoring above 32 on the OCI-R was excluded.

Participants with OCD symptoms, 12 women and five men, received either mindfulness training or formed a waiting-list control group. The mindfulness intervention included eight one-hour group sessions which incorporated training in meditative breathing, a four-step sequence for responding to psychological experiences, body scan (Miller, Fletcher & Kabat-Zinn, 1995) and mindful daily living, applied to OCD. The intervention was found to have a large significant reduction on the participants' OCD symptoms after the treatment (as measured by the OCI-R) in comparison to the control group. Furthermore, those participants in the mindfulness intervention group showed significant improvement in mindfulness (as measured by the letting go subscale of the SMQ; Chadwick et al., 2008) and thought-action fusion (as measured by the TAF scale; Shafran et al., 1996) compared to participants in the control group. This may be the first controlled study demonstrating that a mindfulness intervention reduces OCD symptoms.

However, there were study limitations. Firstly, of the ten participants who began the mindfulness training, two discontinued, representing 20 per cent of the total. It is possible that attrition rates for mindfulness therapy for OCD may be higher than for other mental health conditions. The participants in the mindfulness intervention group had higher levels of OCD before treatment, as reflected by the OCI-R, than the control group, though this was not significant (Hale, Strauss & Taylor, 2012). According to Burns, Formea, Keortge & Sternberger (1995) it is of value and importance to use analogue OCD samples when attempting to explore and understand OCD. This study would be strengthened if replicated in a larger analogous clinical sample combined with a follow-up period to explore participant-

maintained psychological gains.

That aside, it seems that if the findings of this study were to be replicated in larger and clinical samples, mindfulness training might prove to be an alternative therapy for OCD.

Fairfax (2008) explored the use of mindfulness in OCD and its application and integration into existing treatment. The initial rationale to integrate mindfulness into the treatment of OCD with CBT was founded on the assumption that it could encourage a way of sitting with obsessional thoughts. It was also hypothesized that it would provide a way to identify thoughts for what they are. For instance, using mindfulness of breath the individual notices then describes the thought, such as "I am having an obsessive thought that the tap is not turned off" or "I am having a compulsion to put all my shoes in a straight line".

By not engaging with it he is able to return his attention to the breath. Though people with OCD may continue to think things or perform rituals they learn to accept this and not judge themselves because of it. It was hypothesized that mindfulness could complement CBT for OCD in some of the following ways: teaching different ways to relate to thoughts; helping to sever the link with conditioned behaviour and automatic thoughts; providing a method to challenge TAF; breaking reliance on having to think or act one's way out of it; and, enabling the client to feel in control of thinking and behaviour.

The application of the mindfulness-based approach was explored within a set of OCD groups. The first three weeks were devoted to understanding and challenging thoughts and several sessions were also dedicated to managing moods. In the following week clients were given a brief description of mindfulness and were invited to join a five-minute mindfulness-of-breath exercise. The group then discussed this with an emphasis on acknowledging reflections about the nature of thoughts, control of attention and awareness of state in general. Clients were also

given related homework.

A qualitative outcome measure was completed at a three-month follow- up review meeting of OCD groups run by a local Community Health Team (CMHT). This outcome measure, which was designed by the researcher, asked clients to describe what it was they found most useful from the group, what they found helpful when challenging OCD and how they did it. Mindfulness was a significant feature in the clients' evaluation of the group. The clients also scored the various interventions on a five-point Likert scale. When ranked on an individual basis, mindfulness was consistently in the top three preferences out of 14. When ranked on a group basis it was second. Similar results were obtained in two other OCD groups (Fairfax et al., 2008). It was concluded that if applied correctly, mindfulness not only complements traditional CBT interventions but also could increase its efficacy and maybe prevent relapse.

It was hypothesized that integrating mindfulness-interventions to CBT would help individuals challenge TAF. Although TAF has some empirical support, it is still a hypothetical model of how OCD may occur in some individuals (Fairfax, 2008). More studies need to be conducted investigating the role of TAF in OCD. A randomized control trial could have compared mindfulness alone and CBT with controls.

A second case study conducted by Firouzabadi and Shareh (2009) used a single-subject experimental trial of A-B type conditions to explore the effectiveness of detached mindfulness techniques in the treatment of a particular case of obsessive-compulsive disorder (OCD). Detached mindfulness techniques were conducted on a participant with OCD who was assessed at both stage A (baseline) and stage B (final session) by the Y-BOCS scale, Thought Control Questionnaire (TCQ) (Goodman et al., 1989), Metacognitions Questionnaire (MCQ) (Wells & Cartwright-Hatton, 2004), Depression Anxiety Stress Scale (DASS-21) (Lovibond, 1995) and General Self Efficacy Scale (GSES) (Schwarzer & Jerusalem, 1995). The Y-BOCS and

DASS-21 were completed at the end of the treatment sessions and also at a follow-up session. The participant's Y-BOCS score decreased from 36 in stage A to 12 at the end of the treatment sessions and to ten in the follow-up session. The participant's TCQ score indicated a significant reduction in punishment and worry subscales, score reduction in subscales of the MCQ, DASS-21 and score increases in the GSES. It appears that the detached mindfulness techniques were effective for this participant.

A mixed methods A-B-C replication case series design was conducted by Wilkinson-Tough, Bocci, Thorne & Herlihy (2010) to investigate whether mindfulness-based therapy was beneficial for individuals experiencing obsessive intrusive thoughts. Five participants began treatment though two dropped out leaving a sample size of three white participants, two male and one female, aged between 30 and 48. The participants had undergone previous CBT therapy for their OCD.

They underwent a two-week no-intervention monitoring phase, a subsequent two to three week relaxation control intervention phase followed by six sessions of mindfulness-based intervention emphasizing daily practice. The mindfulness intervention incorporated a focus on bodily sensations, otherwise known as body scan, combined with thought observation exercises (Linehan, 1993).

Following therapy all three participants demonstrated reductions in Y-BOCS scores to below clinical levels. Two also demonstrated a reliable change in their Y-BOCS scores from the end of the relaxation phase to the completion of the mindfulness intervention phase. This indicates that the effects of mindfulness training were over and above the benefits of simple relaxation and two participants maintained their improvement at a two-month follow-up. Qualitative analysis of post therapy feedback suggested that mindfulness skills such as observation, awareness and acceptance were seen as helping in the management of thought-action fusion and suppression.

The study was not without methodological limitations however. Though the use of a relaxation control condition was beneficial and helped to strengthen the findings, the order of presentation - relaxation followed by mindfulness - could not be counterbalanced, as participants would not have been able to unlearn their knowledge and experience of mindfulness. Furthermore, the mindfulness intervention phase was longer than the control phase, which may have also contributed to the benefits of the mindfulness intervention.

As we have seen, the study was conducted on a small sample. One participant dropped out after two sessions as they found it hard to engage with mindfulness, and another had withdrawn because he found the time commitment of the mindfulness intervention too challenging. These two explanations for participant withdrawal from the study indicate that mindfulness based therapy may not suit everyone with OCD. Finally, it is possible that the use of alternative measures might have yielded different results.

Though the participants' mindfulness skills appeared to increase with the mindfulness intervention, as measured by the Kentucky inventory of mindfulness skills assessment (KIMS) (Baer, Smith & Allen, 2004) the use of different measures may have generated different results. The KIMS measures four different components of mindfulness compared to measures that provide a uni-dimensional score such as the Mindful Awareness Attention Scale (MAAS) (Brown & Ryan, 2003) and the Freiburg Mindfulness Inventory (FMI) (Walach, Buchheld, Buttenmüller, Kleinknecht & Schmidt, 2006). The KIMS has been criticized for not representing all facets of mindfulness (Walach, Buchheld, Buttenmüller, Kleinknecht & Schmidt, 2006) and it is possible changes in mindfulness skill may have been more or less evident with the MAAS or FMI.

Overall, despite the documented methodological limitations, results of this study do provide some preliminary quantitative and qualitative evidence that mindfulness

therapy for intrusive thoughts may be valuable.

Another study was conducted by Liu, Han & Xu (2011). Their aim was to investigate the effectiveness of mindfulness-based cognitive-behavioural therapy (MBCBT) on six clients with OCD. In a single-case multiple-baseline design six OCD clients received MBCBT. The Y-BOCS and the Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietemeyer & Toney, 2006) were used as measurements. Results revealed that there was a decrease in OCD symptoms that was maintained at follow-up. It was concluded that mindfulness-based cognitive-therapy might be effective in OCD but that further investigations with randomized and controlled conditions are needed.

Hertenstein et al. (2012) used a qualitative approach to assess the subjective experiences of clients with OCD who participated in mindfulness-based cognitive therapy (MBCT) in obsessive-compulsive disorder (OCD). The aim of the study was to investigate whether MBCT represents a feasible and effective complementary treatment option for clients with OCD who are familiar with the principles of OCD including ERP. They set out to explore: i) subjective changes of experience and behaviour within an eight-week period; ii) helpful and problematic aspects of MBCT; and, iii) suggestions for the adaptation of the program to the specific needs of clients with OCD.

Sixteen participants who met the DSM-IV-TR (2000) criteria for OCD and had completed a behavioural therapy with ERP within a two-year period prior to the study were included. Four dropped out during the first three treatment sessions. Of the remaining twelve, six were on medication; these were mainly selective serotonin re-uptake inhibitors and the participants' medication status had been stable for at least ten months prior to inclusion. Three participants fulfilled criteria for avoidant, histrionic and paranoid personality disorder.

The intervention program was adapted from MBCT for depression as described by

Segal, Williams & Teasdale (2002). Cognitive elements of the manual were adapted for OCD with the objective of providing a preferably disorder-specific treatment. Mindfulness elements were adapted from the original MBCT manual. MBCT was delivered in eight two-hour sessions once a week, each session including a brief report of the previous week, a review of weekly homework, guided in-session mindfulness practice and exchange within the group as well as a preview of the homework for the following week. Participants were also given session handouts and instructions for mindfulness exercises to practice at home. All MBCT practitioners were experienced cognitive behavioural therapists with several years' expertise in mindfulness practice.

As there is a lack of literature available on the subjective experiences of people with OCD undergoing mindfulness training, an interview schedule was used to structure conversations. An inductive data-driven approach was adopted for data analysis and subsequently a system of five categories and two sub-categories drawn up. In addition the researchers collected some quantitative data by administering their self-developed questionnaire with a five-point Likert scale, assessing the frequency of mindfulness practice and the participants' satisfaction with the individual mindfulness exercises.

All 12 participants completed the eight-week program and claimed it had enriched their lives. Nine participants stated that during the time of the MBCT they had developed a new way of managing their OCD, reporting an increased willingness to tolerate even unpleasant emotions when performing mindfulness meditation. Three participants, who reported that feelings such as sadness and pain occurred during the body scan, said they had been able to accept these feeling without trying to dispel or change them. Four claimed MBCT had helped them to live more actively in the present moment. They also described a reduction in their tendency to worry and ruminate with an increased ability to engage in and value pleasant activities and experiences. Some even reported improved sleep.

Nevertheless, four out of 12 participants reported that they did not observe any improvement of OCD symptoms after MBCT, with three reporting that OCD symptoms significantly interfered with their mindfulness practice during and beyond sessions. One reported finding it almost intolerable sitting in a room with other participants and described feeling suffocated by participant OCD. However, by the end of the therapy she noticed less compulsion to count during the sessions and found it easier to restrain herself from engaging in rituals during the eights weeks, though she continued to suffer with some obsessive concerns.

Another participant struggled with a compulsion to repeat the trainer's instruction over and over again during the mindfulness exercises. Other struggles were also reported such as mismatch between their wish to override their OCD as quickly as possible and mindfulness being a long-term, non-goal orientated therapy.

Concerning helpful elements of MBCT, patient reports indicated that the three-minute breathing space, a mini-meditation which can help those practicing it to reconnect with the present moment, might be a particularly helpful element of MBCT in OCD, at least short-term.

One participant repeatedly became aware of unpleasant emotional and physical states during the body scan. However, as he stated, this was not a purely undesired outcome, as he tried to embrace these states as opportunities to relate differently to unpleasant feelings and sensations. He reported that the body scan sometimes even brought to light inner struggles that had been rather unconscious. This helped him clarify problems he was currently dealing with.

Another component of MBCT that participants perceived as helpful was the acceptance of private experiences and self-acceptance. The patients reported that after MBCT, they were able to handle their emotions more flexibly and with an increased willingness to experience unpleasant states. This seems especially relevant for patients with OCD since obsessive-compulsive symptoms frequently serve as

processes that regulate unpleasant emotions (Veale & Wilson, 2005). The accepting attitude did not exclusively relate to emotions; some participants also reported that they had learned to relate to their obsessions in a different way, e.g. recognizing them as fluctuating events of their mind and letting them pass by without devaluing themselves

Qualitative methodology remains a rather subjective approach, reflecting, as it does, the experiences of the studied subjects only. It is also prone to researcher bias. Interpretability and generalizability of the reported findings were further limited by the lack of a control group, the small sample size and the unbalanced gender ratio. Furthermore, the patients' reports may have been inflated by a tendency to answer in a socially desired manner. The fact that interviews were conducted directly after the course limits the statements to a short-term perspective, lacking information about long-lasting effects of mindfulness training in OCD. However, scheduling interviews directly after the course probably precluded memory bias.

In the most recent study conducted on mindfulness for OCD, Wahl, Huelle, Zurowski & Kordon (2013) used an experimental study to test the efficacy of a mindfulness-based instruction compared to distraction during brief exposure to obsessive thoughts in obsessive-compulsive clients.

Thirty-six participants diagnosed with OCD were recruited at an inpatient clinic specializing in Cognitive Behavioural Therapy (CBT) for OCD. Four of the recruited participants did not meet the inclusion criteria and two did not complete the experimental procedure satisfactorily. There were no significant differences in any of the participants' characteristics between the experimental and control group.

The participants were asked to listen to their own obsessive thoughts through headphones during three stages: baseline, during an experimental condition and during a return to baseline.

During the experimental condition they were told to tackle their obsessive thoughts using either a mindfulness-based strategy or a randomly allocated distraction strategy. Mindfulness-based coping and distraction instructions were presented on a series of presentation slides. Instruction for the mindfulness coping strategy consisted in three-statements, namely: i) thoughts are thoughts and not facts; ii) become aware of your thoughts at the moment; and, iii) let your thoughts pass like clouds in the sky. In contrast, the three distraction instructions were: i) at the moment your thoughts are causing you distress; ii) distract yourself from your thoughts; and, iii) silently count backwards in sevens from 700.

The dependent variables were anxiety accompanied by an urge to neutralize and were assessed on visual analogue scales (VAS) at three time points within the three phases. Anxiety was rated on a 0-100 scale with 0 being "no anxiety at all" and 100 "the most anxious I have ever felt". Urge to neutralize was rated on a 0-100 scale with 0 labelled "no urge to neutralize at all" and 100-labelled "extreme urge to neutralize".

Data was averaged for three time points during each condition and a 3 x2 ANOVA, with phase (baseline, experimental condition, return to baseline) as the within-subject factor and experimental condition (mindfulness versus distraction) as the between subject factor was conducted on anxiety and urge to neutralize. In addition, T tests for independent samples were calculated to analyze differences in compliance and perceived helpfulness with instructions for the different conditions. No significant differences were found.

As predicted, participants experienced a greater decline in anxiety and urge to neutralize after having engaged in a mindfulness-based strategy than those who engaged in distraction. Results are unlikely to be accounted for by the different levels of compliance with the instruction between groups, as there were no significant differences between groups regarding compliance measures.

Data from this study replicates and extends findings by Marcks & Woods (2005) and Najmi, Riemann & Wegner (2009) who investigated the management of naturally occurring intrusive thoughts in the laboratory. In both studies, the use of a mindfulness-based strategy had an immediate beneficial effect (reduction in anxiety) in healthy individuals (Marcks & Woods, 2005) and also in patients diagnosed with OCD (Najmi, Riemann & Wegner, 2009). Wahl, Huelle, Zurowski & Kordon's (2013) research extends these findings, revealing that individuals also benefit from a mindfulness-based strategy when applied during brief exposure to obsessive thoughts.

Results from Wahl et al.'s study (2013) demonstrate that intentionally focusing on one's obsessive thoughts and then imagining them passing by like clouds in the sky is an effective way of managing anxiety and the linked urge to neutralize. However, the mechanisms of change through which a mindfulness-based strategy reduces anxiety and urge to neutralize during brief exposure are obscure and can only be imagined. It is possible that it was the focused attention towards the obsessive thought that was helpful not the metaphor of letting it go. Moreover,-applying metaphors such as clouds in the sky may simply act as a distraction from the immediate distress of the thoughts.

The researchers did however control for this by selecting a counting backward task in the distraction group intending to distract participants to the same degree as the mindfulness-based strategy had. Nevertheless, if the mindfulness intervention had not distracted participants, these participants would still have undergone more exposure to their obsessional thoughts than those in the distraction condition.

Future studies will need to be conducted to explore whether a mindfulness-based intervention is better than brief exposure alone for OCD. Additionally, only short-term effects of mindfulness intervention were assessed. Replicated studies with follow-ups are needed to assess longevity of therapeutic effects. A further

methodological weakness was the use of subjective reports of anxiety and urge to neutralize on VAS scales. Results could have been strengthened by additional use of valid and reliable psychometric properties. Lastly, the implementation of brief aspects of mindfulness in experimental studies is not representative of the multi-faceted construct of mindfulness as incorporated into mindfulness training and practice over a period of several weeks.

To conclude, the results indicate that a mindfulness-based strategy during brief exposure to obsessive thoughts may be more beneficial compared to a distraction strategy in the case of OCD. These results are consistent with other studies documented in this review (Handstede et al., 2008, Patel et al., 2007 and Wilkinson et al., 2010) and a meta-analysis on the effects of mindfulness-based therapy on anxiety and depression (Hoffman, Sawyer, Witt & Oh, 2010) as noted by Wahl et al. (2013).

Summary of the empirical research

The benefits and otherwise

Though the studies varied in their aims and methodological designs they were more uniform in that overall they appeared to point to mindfulness-based interventions being a helpful therapeutic intervention for OCD. Studies that measured OCD symptoms with psychometric tests demonstrated reduced OCD symptoms in participants as a result of mindfulness-based therapy. Qualitative studies also bought about an improved tolerance to the participants' OCD and an overall progression in their ability to manage it.

It appeared that the following interventions were effective for OCD sufferers: body scan, mindful daily living, letting thoughts pass like clouds in the sky, focusing on intrusions instead of trying to distract oneself from them, mini-meditations,

accepting feelings without trying to dispel or change them and the recognition that thoughts are not facts.

The above interventions appeared to assist participants with OCD in feeling more grounded, improving their ability to detach themselves from intrusive thoughts, reducing feelings of distress about the OCD, reducing urges to indulge in neutralizing and reassurance-seeking reinforcing behaviours, enriched living, ability to live in the present, increased ability to tolerate unpleasant emotions and even improved sleep.

Though the overall results suggest mindfulness-based therapy for OCD is effective, there are also findings that revealed it was not helpful for some. As quite a few of the studies were of a qualitative nature, some clear examples of what participants found unhelpful were voiced and less helpful aspects of mindfulness-based therapy were not missed or hidden in a pool of ordinal data.

For some, OCD symptoms interfered and compromised their ability to engage in mindfulness practice. For others, the mindfulness interventions were found to be too challenging as accepting unwanted and distressing thoughts and feelings seemed to exacerbate distress; being surrounded by other OCD sufferers proved to be an uncomfortable and oppressive experience. Others perceived difficulty implementing mindfulness in everyday life.

It also appeared from the studies that what may have been helpful to one participant was not helpful to another. Some found the focus and acceptance on unwanted intrusions distressing. Others found it helpful. Some felt able to complete the mindfulness interventions alone. Others felt the need for ongoing assistance and guidance.

The limitations

Since most of the studies were of a qualitative design, many of the results cannot be generalized and may have been unique to the participants included in the research. The low number of recent studies conducted on mindfulness-based therapy for OCD, as well as the low number of participants in them, excluding Wahl et al.'s (2013) study with 30 participants, furthermore significantly restricts their reliability. Statistical analysis on studies has been limited and restricted by the study designs. Moreover, some of the studies were described as pilot studies intending them to be incorporated into larger scale studies. Nevertheless, the pilot studies will have provided the researchers with opportunities to replicate the investigations on larger samples to find more reliable results.

There is some evidence that mindfulness may act as a neutralizing or even distracting strategy in OCD (Wahl et al., 2013). However, (Baer, 2003) has noted that by bringing full awareness to experiences, individuals can identify the transient nature of thoughts and that this alone may assist individuals in letting go of them and understanding that they will pass. In this case it would not be akin to a safety behaviour where one might look for solutions to override, challenge or ignore them. Furthermore, it should be recognized that implementing brief aspects of mindfulness in experimental studies might not be representative of the broad and complex spectrum of mindfulness-based therapy, which is typically incorporated into intensive training over an extended period of time. Finally, participant drop out rates were documented in every study reviewed suggesting attrition rates may be higher than Ma & Teasdale (2004) stated.

Future research

Further research on the effects of mindfulness-based therapy for OCD may benefit from a clarification of the mechanism of change through which mindfulness based strategies reduce anxiety and the urge to neutralize.

As it is not clear whether it is focused attention towards unwanted thoughts or urges, amounting to exposure, that are the moderating factors in mindfulness-based interventions for OCD, it would appear that further case control studies would make a beneficial contribution to the mindfulness-based therapy for OCD literature.

As it stands only one has been conducted by Handstede in 2008, albeit not with analogue samples. Overall, more studies with analogue larger samples, more psychometric testing, longer follow-up periods and identification of mechanisms of change are required to move the mindfulness literature for OCD forward beyond these preliminary findings.

Overall conclusions

Again, whilst the findings from the studies are interesting and generally indicate positive effects of mindfulness-based therapy for individuals diagnosed with OCD the small samples and study limitations make it difficult to draw any firm directive conclusions. It would seem that mindfulness-based therapy might be valuable for people experiencing intrusive thoughts and urges to neutralize. It seems that the use of short meditations and brief mindfulness interventions helps people to cope with their obsessions and compulsions. Furthermore, it appears that mindfulness could successfully be integrated into existing treatments of OCD. It was suggested by Fairfax (2008) that mindfulness could help access to the meta cognitive perspective in CBT treatment for OCD and Liu (2011) found mindfulness-based cognitive behavioral therapy effective for OCD.

However, any conclusions are provisional and further research needs to be done. The evidence to date is however inspiring to me as practitioner and I plan to adopt some of the mindfulness interventions highlighted in this review into my practice with those clients diagnosed with OCD.

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APPENDIX A – ETHICAL APPROVAL FORM

Dear Vanessa,

I was actually in the middle of emailing you, as I have been informed today that your ethics application has now been approved. Please refer to the details below:

Reference: PSYETH(UPTD) 11/12 113

The unique reference number **'PSYETH(UPTD) 11/12 113'** should be included on the top of all information and consent forms, and in all future correspondence about your ethical approval for ease of reference.

The Psychology Department Research & Ethics committee has approved your application for ethical approval.

On any Information sheets or Consent form, please also include the following text:

"Comments, concerns or observations procedure:

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London (project approval number PSYETH 11/12 113).

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** ____
	Somewhat difficult 8
	Very difficult ____
	Extremely difficult ____

ZT274388

if U can say your not depressed

APPENDIX B - CORE FORM

APPENDIX C – PARTICIPANT RECRUITMENT EMAIL

STUDY ON FIRST TIME EXPERIENCES OF DEPRESSION

My name is Vanessa Pilkington and I am looking for participants for my doctoral research in counselling psychology at City University.

My research question is "how do people experience emotional suffering subsequently diagnosed as a first episode of depression"

It is a qualitative study, requiring a semi-structured interview to explore the in-depth experience of first time experiences of depression. I am looking for adults between the ages of 18 and 65 who have been diagnosed with a first episode of depression by a GP or Psychiatrist and been treated for it at least 3 months prior to participation in the study. I will be conducting 1 hour interviews at a private clinic in Harley Street, London, W1 9QD and paying participants a £10 Amazon voucher for taking part in the study.

Obviously all information received within the interview, will be treated with complete confidentiality.
If you are interested in participating, or would like more information, please contact me via email (or on [redacted]). My email address is: [redacted]

Many thanks
Vanessa

[redacted] is a charity and a company limited by guarantee. Registered in England no. 986761. Registered Office: 103 Borough Road, London SE1 0AA.

APPENDIX D – SEMI-STRUCTURED INTERVIEW

Interview Shedule (Guide)

Hello, thank you for being here. During the next hour I will ask about when you first recognized that you had what we might call depression. Some of the questions I might ask you will be looking at broader themes such as low self esteem, self dislike, self worth, loss of identity, feelings of punishment and shame, indecisiveness, and your feelings about your past, present and future.

How do you feel at the moment? Just relax. Please answer as honestly as you can. I may make some notes for reference. Is that okay with you?

Could I ask your age?

Gender?

Background?

Subjective experience

Can you tell me about the first time you felt something was not quite right?

Where were you?

What were you doing?

Can you describe what you felt?

What was your reaction to that feeling?

What did you think was happening to you?

How did you react to it?

What sort of things went through your mind when this was going on?

What was your understanding of what was happening to you?

Did you experience anything such as a desire to punish your –self? If so, how did this manifest?

Did you experience any feelings of shame? If so, how?

Did you experience any changes to your self –identity and any related feelings of loss? If so, how?

Did you feel you had lost anything? If so what and how?

How did you feel about your future at the time?

How did you feel about your past?

How long did the feelings persist?

What was the experience of meaning in your life at the time?

How did others respond to your experience of emotional suffering that we might call depression?

Causes

Had something changed in your relationships before your suffering began? If so, how?

Had something changed in your work? If so, how?

Treatment

What did you do about your emotional suffering? Did you approach anyone for help?

Who did you talk to?

How long did you suffer before you seeked help?

Diagnosis

What was your emotional suffering diagnosed as?

What did the diagnosis mean to you?

What do you consider to be the triggers for your emotional suffering subsequently diagnoses as depression?

Treatment

What did you do to help you cope with your emotional suffering?

Was this linked to your treatment in any way?

After your depression diagnosis did you decide to start any treatment? If not why?

What treatment helped you and how?

Depression terminology

What was your understanding of depression before you were diagnosed?

How would you describe depression now?

APPENDIX E – CONSENT FORM

Consent To Audio & Transcription.

Vanessa Pilkington C.Psychol, City University

I understand that this study involves the audio taping of my interview with the researcher Vanessa. I am aware that neither my full name nor any other identifying information will be associated with the audiotape or the transcript. Only the researcher or the researcher's supervisor will be permitted to listen to the tapes.

I understand that the tapes may be transcribed by the researcher and erased once the research is complete. Transcripts of my interview may be reproduced anonymously in whole or part for use in presentations or in written products resulting from this study.

I further understand that I can withdraw from the study or have my recorded interview erased at any time with no explanation as to why and no adverse consequences.

Participant's signature **Date**

I hereby agree to abide by the participant's above instructions

Researcher's signature **Date**

APPENDIX F – PARTICIPANT INFORMATION SHEET

'PSYETH(UPTD) 11/12 113'
Participant information sheet

My name is Vanessa Pilkington and I am a chartered counselling psychologist working in private practice and currently conducting some PhD research. My research will explore people's experiences of a first time diagnosis of depression. I am especially interested in chartering the journey people undergo from feeling that something is not quite right all the way up to diagnosis. I aim to investigate how a first episode of depression affects people's life experiences, feelings, thoughts, behaviour, values, opinions, knowledge, work and relationships.

I intend to recruit participants through support and service user websites. I will interview adults between the ages of 18 and 65 who have had a first time diagnosis of depression by a GP or psychiatrist and been treated at least 3 months prior to participation in the study. All participants will be interviewed at my private practice where a receptionist and other professionals will be present in the building.

I intend to interview volunteering participants for approximately 1 hour. In this time I will ask participants to read and sign a consent form that will explain the confidentiality conditions of the interview and the study you may partake in. If you agree to the conditions and sign the consent form you will agree to be interviewed about your experience of a first time diagnosis of depression for this research. I will inform you about the research I am conducting and you are welcome to ask me any questions.

Participants will be asked to sign their first name only on the consent form. All data will be treated in the strictest confidence and kept in a locked cabinet for which only I will have the code. The names or any descriptions of the participants will not be attached to the study. All comments used in the study will be presented anonymously or with a pseudo name. Participants will have the right to withdraw from the study at any time with out providing a reason as to why with no adverse consequences for the treatment of the participant.

In addition to signing the consent form I shall also ask you to complete a short standardised psychological questionnaire (PHQ-9)) that assess depression. As I am a recruiting participant who will have been treated for depression so I do not anticipate that scores will reach a clinical range. However, in the unlikely event that anyone does I shall still provide you with your full hour allocated for the interview to discuss how and where you will be able to seek professional help if you choose to. As a fully qualified charted counselling psychologist running my own private practice this is something I am fully trained to discuss with anyone in need.

All interviews will be recorded for transcript purposes only and will be seen only by the researcher and the research supervisor. The recorded interviews will be destroyed after the research is complete. I have a deadline of 4 years to complete the research but I am registered to complete it in September 2013.

The consent forms will be signed by all participants and myself prior to the start of each interview. You may request to see a copy of the final transcript after and a final copy of the report.

APPENDIX G – EXAMPLE OF TYPED TRANSCRIPT

You were talking about you felt around other people. How did you find people reacted to you at the time?

I think I was kind of standoffish but also very polite and warm to people, so people would think "Right, here's someone I can talk to," and then all the walls would kind of come up, so I think people found it very awkward. I think that's something which continues to this day in varying degrees in places I've worked. I like to think I'm very approachable, I'm quite a warm person, easy to get on with – all those kind of things – and I do all that. I do all the social niceties and then I just throw up a brick wall, so it's like "Actually no, you're not coming any nearer ((0:09:06.3?)) that's fine. People are like "Then why are you being pleasant? Why are you starting all this stuff off and then not following it up with more regular social behaviour?"

What goes through your mind when you get that feeling to just wall up and detach? It's kind of detachment isn't it?

Yeah it is and I've never really kind of criticised it much when I was younger. It's only now I look at it just annoys me now. It's just very irritating. It's a battle to undo it.

Right, so it's not necessarily a choice, it's just something that kind of happens.

Yeah, it's a defence mechanism I guess and it's something I haven't thought about for absolutely ages, to be honest.

There seems to be something about detachment here and that you were saying you felt like an alien, you felt this kind of divide between you and them, and talking now about you're sort of getting to know people and then kind of just pushing ((0:10:05.6?))

I guess your original question, I was very accepting of it when I was younger. I just kind of felt that's the way it's going to be, that's fine.

So you just kind of surrendered to it?

Yeah, totally because I had work to get on with. I had stuff to do, learn and etcetera and that's why I was there and I wasn't meant to have a good time. So, so what?

APPENDIX H - CODED TRANSCRIPT

And when you said you did not like the way you looked how did you experience that, was it a feeling or a thought

Don't know every time I look in the mirror I just think 'oh really, is that what I look like' I can't do anything to change it, I do what I can

So you are not happy with what you see and there is a sense of powerlessness as you cant change what you see

Makes me feel miserable makes me hate myself. I don't like looking in the mirror And then it makes me question why my fiancé is with me even though he says I look beautiful

You can't believe that anyone could think that

No. I get really fed up with him paying me compliments. Ah, I want to argue with him about it

Sounds like it really annoys you

It really does

Do you only have these experiences of self-loathing only when you look in the mirror?

No other times

Do you feel it in your body?

Yeah I just hate myself completely and utterly and that is why. It is horrible and hard to describe I feel guilty for hating myself as I have a these good things going for me that people keep telling me about. I feel stupid because no body else feels that way. I know it is the depression talking but there is still nothing I can do about it

When you say feelings of hating yourself do you think that is depression or a real hatred founded on something hate worthy?

I do not know. I think because I am on a psychology degree I am more aware of what's going on. I know that my negative thoughts and everything are because I have depression but then again I still feel it

Yes you have an awareness of what it might be but it does no take it away. But that does not necessarily make it any easier to endure just knowing what it is.

So what did you do it about it when it was going on? It sounds like it lasted quite a few years

APPENDIX I - DEVELOPING THEMES WITH SUPPORTING TEXT (excerpt)

recognition	body	social withdr	anxiety	thoughts	control	anger	body	missing
p1, 13	p6, 3 catatonic		p11,1,2		p7,28 taking c	p6, 19,20	p1, 1,2	p1,16 no joy
awareness			rumination		p12,14 powerl	p6,24 irritable	crying	p6, 3 nothing
p4,24,25			noise			p13,4 violence	p12,22 rockin	p7,19
p12,7-10 awareness challenged			p11,4-6			p19,1		
acknowledged			worry, obsessions					empty
p17,15			p11,13 cogntive repetition					loss body cont
p17,24			terror					
			p12,28 terror					
			p13,18 paranoia					
			p14,29 ocd					
	acknowledgment		length sufferin	structure	can't	childhood instability		
	affirmation							
	validation	fantasising						
			numb					
	just low mood		diagnosis					
			means to an end					

affirmation	identity	self esteem	façade	self doubt	dissociation	blame	alienation	change
	p3, 8, self hate			p1,3 questioning	p7,10,11	p,11 20 self bl	p1, 11 different	
	p4, 4, self doubt, 7,8 self question						p1, 19	
	p4,18-21, inadequacy			despondent	detached	guilt	p9, 12,13 lonely	
	p5, 17				p1, 19 apart	p2,6,7,8,9	p12,30	
					p7,19 void, cold			
					p9,23 apartne	shame		
						p1, 6,7,8,9		
						dissapoinment		

loss B4 DEP	loss ES	1st episode	physical negl	accumalatior	safety	denial	destiny	bullied b4 de
							p2, 3 p5, 14	p3, 13,14 pers
							p12,12	p12,12, persec

:rol

					displaced	survival		separation
				health	normalised	invaded	sexual assult	
				empathy	pointless	troubed relationships		
		support				loss voice		low mood
		overwhelmed	gender issues	hatred				communicatior
				mistrust	distraction	projection	choice	self preservati
				body dissatisfaction			raw	

comparisons	escape	structure	hiding	stuck	pressure	acceptance	confused	normalised
p1,10,17	p6,8		p7.4,5,6		p14,7 façade		p11,27	
p2,2,3	p7,28, self harm							
difference	destructive			helpless		belong		
	p1, 9 self harm							
	p13,3,4							
	p13,7-9 self harm					connections		

protection	dep perecept
p7,10,11	p2,33
cution	differentiates b
	p17, 15
	p17,24
	p18,8,9
	p18,14 low mo
	p18,19 a reaso
	p18,25 her exp
reason	p18,28-30
	p19,15
abuse	
uncertainty	
n	absent
on	
ocd	

present	vicarious

APPENDIX J - SUPERORDINATE & SUBORDINATE THEMES (excerpt)

Major Themes	Subsidiary Themes	joe	Tulula	Jumania	elias	alessadnro	anna
Belief in a higher force	Destiny	p8,10		p3,28.p12,9,10		p13,17	p2,21
	Deserving			p15,6		p5,13,14p6,3	p2,19,20 dese
	Spirituality	p9,8,9			p3,9.p2,37,38.p5,29		
Avoidance tactics	Escape	p8,5.p14,34	p3,drinking.p4,6.p10,6		p6,13,22	p12,34.14,32.p21,20	
	Denial						
	Hiding	p8,9, p9,4. P1	p3,29			p14,13,22.p1,14.p5,hiding it	
	Façade	p8, 22, p8,22.p9, 18-21,p15,		p9,pretending	p16,26	p1,14.p4,1,2.p	p3,1-3 pressur
	Detachment	p4,16, p11,19	p5,4				p2,8 p3,11
	Disassociation	p4,14		p4,33	p3,29.p,10		p3,11-13,self
not included	Destructive		p5,7.p6,21				
not included	Projection					p3,18	p2,6,14,16
Self defence	Protection		p2,20,23.p3,25		p5,35	p4,10.p13,17	p3,20
	Social withdrawal		p3,17,20			p2,8.p8,35.p9	p2,9
	Self –preservation						
	Detachment				p8,35		
	Dissociation			p6,10.p5,16.p4,depersonalisation.p5,4,6			
	Survival						
	Surrender		p3,20				
Discipline	Control	p8,4. P11,13	p2,4,23.p4,22	p3,19.p8,22.p9,19.p12,4,22.		p2,23p6,22p9,	p7,13,24
	Structure		p1,6		p1,32.p3,36.p	p2,2p3 establihsing routine.p	
not included	Permission					p15,3	
not included	Responsibility					p7,30.p10, pressure and resp	
not included	Medication		p2,13.p8,27	p12,20,21			
	Stability		p1,5				
Connections	Belong	p4,9,10, 36		p2,26	p2,13.p12,40.p4,32		p4,9-11need t
	Detached	p6,13	p5,4	p3,30,33		p2,32.p3,35	
	Alienation			p4,15	p3,38-40.p10,8.p,34.p17,11		alone p2,10,p3
not included	Abandoned						p1,1-4
not included	Displaced						
	Troubled relationships	p11,21, p17,3	p9,20			p3,30	pg1,27,p2,14-
	Vicarious				p2,2.p6,19		p2,22 kept goi
not included	Bullied						
	Persecuted						

APPENDIX K – SUBMISSION OF CASE STUDY

To Whom It May Concern

I write to certify that the account that Vanessa Pilkington has provided in her case study is true to the work she has conducted with the client referred to as H. The client was seen by Vanessa in a therapeutic capacity in her private practice in 2011. I have supervised Vanessa's clinical practice over the last three years.

SusanVS
Susan van Scoyoc
Consultant Psychologist