Unfolding Through the Web of Recovery

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List of Abbreviations

- **APA**: American Psychiatric Association
- **BPS:** British Psychological society
- **DSM-5**: Diagnostic and Statistical Manual of Mental Disorders. 5th Edition Text Revision
- **HCPC:** Health and Care Professions Council
- **ICD-10:** International Classification of Disease-Ten
- **NICE**: National Institute of Clinical Excellence in Health
- **NSW CAG**: The NSW Consumer Advisory Group
- **WHO:** World Health Organisation
- **BME:** Black and Minority Ethnic

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Declarations

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Section A: Preface

Personal Journey

The overarching theme of this portfolio is the value of evolution and change in experiences of life. It can be said that people change over the course of their lives yet how people make sense of this is scarcely known (Bench, Schlegel, Davis & Vess, 2015). In the process of fundamental change or perhaps in life itself, we can be thought to become more ourselves than ever before and recognise ourselves to be so (Fosha, 2005). As I rummaged my way through this training and research, I too recovered and became aware of my own changes and growth in my professional and personal recovery of life.

I have always been enthralled by the complexity of human beings and particularly interested in making sense of mental distress not limited to objectivity. I am often enticed towards unpacking what can be construed as an unknown or silenced part of human experience. This appetite was further fuelled by my aunt who owned masses of emotive biographical books including some on selective mutism, which I read growing up and which resonated with the younger me. As I grew older with life I developed an interest in helping people communicate unspoken distress, recognise their strengths in suffering, make personal sense of their own experiences and ultimately find value within themselves. This evolved me into seeking employment within psychiatric wards as a mental health assistant. It was here that I experienced a true awakening to the various manifestations of human distress wrapped in various shapes, languages, statuses, affects and physicality. I learned how to be flexible, yet remain close to peoples' personal experiences whilst having to satisfy my professional duties. This movement was joyful and challenging and I became motivated in bridging the clinical barriers in order to open up lines of communication between 'staff' and 'patients'. It was fundamental to me to bring a sense of humanness in a place which often felt impassive and this acted as a vehicle to connect with peoples' subjectivity despite differences and alongside clinical needs. These experiences were to be integral to my own progression in this (DPsych) training.

My openness to explore insights into the wholeness of human distress and better equip myself to help people in their recoveries led me to pursue a variety of clinical placements. I encountered opportunities to practice within different modalities across varying presentations and the course provided me with the theoretical knowledge to develop my

practice and understanding. However, towards the latter stage of training, I recognised that even with clinical experience I was still left with uncertainty and curiosity. Despite working closely with lived experiences, facilitating recovery and conducting research on depression, to what extent did I know what recovery meant and felt like for the individual beyond what I observed? I questioned whether I truly understood recovery beyond treatment and discovered that perhaps I looked more at the sphere of depression/distress than at recovery itself. Therefore, my interest for this research was twofold. Firstly, I engaged with recovery from depression within professional and personal capacities and, secondly, I engaged with a hole in my knowledge of recovery from depression beyond clinical ideology and perspective. Thus, I sought to explore the essence of recovery from the individual's raw window and could not have anticipated the depth I was shown.

Recognising clients and/or patients as 'people' remained central for me and I typically seek to tailor therapy to the individual where possible. Gaining a sense of an individual is as valuable as knowing the phenomenon, as exploring oneself can be powerful. Attempting to cover a range of placement areas and challenge myself perhaps also portrayed me as being in search of myself as a practitioner, just as people might be in search of themselves during recovery. At the start of training, I struggled to quickly fit and firmly identify with only one modality, whilst some colleagues appeared to do this more easily. Although I felt sure of my sense of self, I felt slightly apprehensive about my identity as a practitioner. However, progressing through this diverse training taught me to welcome rather than doubt uncertainty. Consequently, this positioned me to receive, be styled, challenged and touched by a vast amount of learning.

In the final year of training I sought an integrative secondary care psychological out-patient service which ultimately sealed my position as an integrative practitioner. Simultaneously, I returned to my first-year primary care placement. As I sat in these two different chairs, I physically felt the growth in myself and confidence in knowing my identity and values as a trainee counselling psychologist. These chairs allowed me to reflect on my professional evolution perhaps mirroring my before and after. One in particular resonant recollection involved my consciousness in the first training year upon whether my external impressions e.g., the perception of my age or my many visible ear piercings would be a barrier in therapy. However, as I progressed it felt that these facets of myself in some ways made me more human and/or authentic and perhaps the consciousness was largely my own stuff. Thus, I

then drew strength from my own quirkiness and felt that I was perhaps sharing an unspoken piece of myself just as I was anticipating the same from clients. Moreover, I had progressed from trying to be a counselling psychologist trainee to just being. Complementing this was a memory which stayed with me and involved a client who expressed that they were not simply talking to a therapist, "I am talking to you, you are just you". Although there were some possible underlying matters and personal meaning to the client, it also reflected where I was by the latter stage of my training – I was just me.

This training contributed to nurturing my sense of self in order to battle through the taxing and enriching experience of life and study. Ultimately, I discovered more of the missing pieces of my puzzle of recovery from depression but recognised that this was not a model of truth but rather my portrait of understanding. Nonetheless, all those I met throughout this process were sketched into me and helped develop me into the integrative counselling psychologist I aspire to be. Thus, I will continue to evolve my knowledge and practice within counselling psychology and remain curious and empathetic towards the broad experience of recovery. This portfolio marks a growth in my interest to effect change on a macro level as it has fuelled a previously undiscovered passion towards recovery policy. I am hoping that as a qualified counselling psychologist I can have an opportunity to make such a contribution. As science-practitioners we can contribute to developing framework, comprehensive models and guidelines whilst responding to the pulls of the individual voice and expression of recovery. Overall, this focus could have a valuable impact on the support provided to individuals seeking recovery from their sense of suffering.

Preface Outline

This section presents the components of this doctoral portfolio and the choices involved in deciding on each component. It further presents how the components relate to the shared theme of *change and evolution* through recovery. The four chief components within the portfolio are: Section (A), the preface; Section (B), original exploratory qualitative research; Section (C), a case study; Section (D), a paper for publication highlighting some of the findings obtained in the original research. The portfolio attempts to encourage clinicians to have a broader perspective on what constitutes recovery from depression and increase awareness of the value of personal experience and meaning. Further, I hope this can offer a platform

for those who feel that their personal experiences of recovery are not always well reflected in the clinical field and trumpet the virtues of their knowledge.

Over-arching Connection of the Portfolio: Change and Evolution

Change as a concept has been reported to have a sense of paradox in that it can include the thought of something changing and yet elements of an original state of affairs remaining the same (Kallio & Marchard, 2012). Therefore, in this context there can be an element of unchangeability, which can seem a paradox (Kallio & Marchard, 2012). In relation to recovery, change and growth can be thought to emerge through continuous effort as well as struggle. Whilst change can be enlightening it can also be difficult; however, it might rather be that being *stuck* is perhaps even more painful than change. Together the research, case study, and publishable paper display a relationship with the concept of change and evolution through a form of recovery.

Section B: Original Research

This section presents a piece of original research exploring the personal experiences and meanings attributed to recovery following depression. The research aims to provide greater depth into individual experiences and meaning-making of recovery from the perspective of the individual. It involved conducting semi-structured interviews across a homogenous sample of seven individuals. The data gathered was analysed using interpretative phenomenological analysis (IPA) which prioritises meaning and the researcher's subjectivity (Smith, Flowers, & Larkin, 2009). The research focused primarily on how individuals understood their own recovery process from depression. The emerging findings were explored and subsequently discussed within the context of existing literature. It concludes with implications, recommendations, future research and a personal reflection. It represents the shared theme in that it demonstrates how recovery leads to many changes which were integral for living. As people moved through recovery, meaning became pivotal and evolved the participants and their recovery. This research reinforces the need for more subjective knowledge which can further advance clinical practice and inquiry. Overall, by drawing attention to this underexplored area, the research uniquely contributes to counselling psychology and mental health fields.

Section C: Client Case Study

This section presents a professional case study undertaken during counselling psychology training and explores the clinical work between myself and my client (Jenny) across nine sessions. The study unpacked her personal conflicts, uncovered significant events and associated meanings towards Jenny's sense of self following a chronic physical health condition. Initially I had difficulty getting a sense of Jenny as she appeared entangled and defined by her physical health. Recovery for Jenny was primarily about making sense and coming to terms with the pain of her sense of personal loss and ultimately making sense of herself beyond her condition. Exploring how Jenny personally made sense of her physical health led to pivotal changes which helped her recover in some way from the sense of threat she seemed to experience. Through a psychodynamic approach, Jenny gained insight into her distress and understanding of regulating her affect, which led to her own growth during our sessions. This case also highlighted my own conflicts both professionally and personally. Following this work, I realised that personally, I align more with an assimilative psychodynamic approach incorporating other disciplines, rather than the single psychodynamic premise. Retrospectively, I further recognise how much I have changed in my therapeutic work since this piece, which is another example of evolution. Following the knowledge, I have gained from this doctoral research, reflecting back upon this case study, there are aspects I would have engaged more with as I have a better understanding just how multifaceted recovery can be.

Section D: Publishable Paper

This section presents an article paper written to meet the requirements for publication in the *International Journal of Qualitative Studies on Health and Wellbeing*. The paper presents part of the larger doctoral research; it focuses on the findings which captured the paradoxical and lasting impact that recovery from depression can have upon one's sense of self. It further demonstrates how the latter stage of recovery can be particularly pivotal for meaning-making and ultimately propel recovery and the self. The intention behind presenting these findings is to shed light on an aspect of recovery from depression that feels fertile yet underexplored. Drawing attention to how individuals attempt to negotiate contrasting shadows and brightness of their identity and experience is felt to be transformative and valuable for this client group as well as informative to therapeutic practice.

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Section B: Doctoral Research

'*Recovery is not a normal progression back to normal*': An Interpretative Phenomenological Analysis of personal experiences and meanings of recovery from depression.

Personal reflexivity

At the start of this research I was an outsider, comfortably at a distance, looking in at the experiences of recovery to understand what I thought would be a clear answer. However, I was unprepared for how quickly I would be hauled away from this space of comfort and enmeshed in a web of complexity and breadth, unable to find my way out. In a parallel process that was mirrored by the participants, I initially struggled and attributed this sense of entrapment to being full up by the large volume of data and limited space for further consumption. I perhaps felt bloated, wondering how I would digest all the information I had guzzled. In one sense, I was too hungry to explore and share everything I learned about recovery. I also may have subconsciously hung onto the participants' closing wishes of wanting to be heard more and therefore attempted to include everything. However, as I paused to untangle this web, I later interpreted retrospectively that being an outsider was possibly somewhat limiting. Whilst I was unaware of it in the moment, on reflection, I think that to gain a fuller understanding of recovery, I had to be unknowingly drawn into my own sense of fragmentation and messiness, almost as though I had engaged to some degree in a parallel process with my participants. It was not the same experience, but it felt similar to their recovery process: to understand themselves, it seemed participants had to experience destruction, and only through the process of sense-making were they able to gain clarity on themselves and life and ultimately recovery; I had to tussle with and make sense of the findings, which eventually led me to my own sense of clarity.

I was enthused by the participants' depictions of 'inner' strength in enduring their struggle, and it helped me uphold my own perseverance in times when I felt helpless. There were periods when I felt a punishing powerlessness, challenged in ways I had never anticipated during this latter stage of training/research. I also experienced some wearying and aching personal circumstances but thought I could power through; however, my body decided to painfully intervene, and simply shut down. I had never experienced such a physical shut-down. I had to surrender, as I was taken hostage by my own body, much as the participants experienced to some degree. Although painful, this shut-down saved me from experiencing something worse such as becoming physically unwell and made me realise the value of self-care, which I had neglected. It is possible that it was necessary for me to feel physical pain, as I ignored all other alerts. This was an integral part of the learning process for me and resulted in some fundamental changes in how I treat myself. Such insights in connection with

the findings only became apparent through writing up my reflections towards the end of this research. I recognised that what can be described as the psyche found ways, whether through physical or psychological anguish, to perhaps communicate that we are not indestructible, that healthier responses to life are needed, and that suffering is sorrowful but not solely detrimental.

As I reached the closing of this research, it felt cathartic, somewhat like the end of my own recovery; I now made sense of life and distress differently and with fresh eyes. The research unexpectedly showed me some of my own early wounds: although I had overcome them, I realised or perhaps accepted that traces remained harmlessly with the 'backgrounds' of me. I reflected on how courageous the participants were in embracing their scars and recognised that perhaps I did not embrace my own enough. In this research, something shifted in me; I began to be more self-compassionate, something I effortlessly do for others but can neglect for myself. Perhaps this was another striking comparison with some of the participants. Remarkably, I found a new sense of love for imperfections I had rejected, and strangely I wanted to show them off to the world, something I do not recall feeling before. This felt quite exciting and freeing, and I suppose it was a question of being comfortable with myself and finding courage like all those I met during this research. This is something I feel can be important for 'clients' and 'patients' view of themselves and which I see during my therapeutic practice and in my workplace. Perhaps we all have some form of scarring, whether perceived to be raw, unknown or healed; these marks of life hold a dialogue that can sometimes serve a valuable purpose in our lives.

I have come away from this research having learnt multiple lessons, one being that pain can throw up remarkable insights towards an improved life. However, most remarkably, I am left wondering whether there is a need for a conceptual shift in how we write about recovery, and question whether this term is suitable for the experience. This research suggests that to understand recovery, we cannot only be aware of its mechanisms and procedural experiences; we must also be aware of the unruly spirit that is perhaps at the heart of recovery (Deegan [1996] makes similar reflections]. Although I had finished my research, I came away feeling that recovery was an unfinished story and one with multiple and personal levels. It was not a question of searching for the answer; rather, this research comprises one part of many answers. I feel that, initially, I perhaps underestimated recovery somewhat. However, my understanding has evolved, and I have an increased determination to effect change, particularly within mental health recovery policy. Moreover, I wish to open

discussions regarding the purpose of depression beyond 'illness', as this can provide further insight into how people recover and perhaps what they are personally recovering. Whilst substantial knowledge may have been amassed on depression, how much of it really relates to recovery for the individual? This research suggests that it may not be enough to understand depression; understanding recovery, in terms of how it looks, feels, sounds and tastes to the individual, might also be a vital component.

Although the research process felt never-ending, I feel that I have a more rounded and secure sense of myself as a person and a professional as a result of it. I am forever grateful to all those who have shared their lives with me for this project, as it could not have been completed without their contribution. I hope I have captured just how valuable their experiences are to the counselling psychology field and perhaps life as a whole. Overall, this has truly been a demanding yet enthralling journey. I feel privileged and grateful to have embarked on this voyage with all those I have encountered on the way. It is possible to suggest that symbolically, recovering from depression re-introduced participants to what they described as their true selves; perhaps this research re-introduced me to the deepest professional and personal insights into my own life.

Abstract .

Despite considerable research into depression and recovery from a treatment perspective, limited empirical attention has been given to exploring specific meanings and experiences from the perspective of those with the lived experience of recovery from depression. In relation to the current literature regarding recovery in the context of mental health, it can be argued that studies disproportionately focus on individuals with a diagnosis of schizophrenia and/or other diagnoses including, however not limited to, a diagnosis of depression. Therefore, it seems necessary to develop a deeper understanding of recovery in relation to experiences of depression as this could further enhance existing research and practice.

Aim: To explore and gain an in-depth understanding about the experience of recovery from depression and the meanings attributed to recovery from the perspective of those who self-identify as recovered.

Method: Semi-structured interviews were conducted with seven adults. The interviews were analysed using the Interpretative Phenomenological Analysis (IPA).

Findings: Four themes emerged from the analysis: Difficulty moving forward; Plunging in for change alongside struggle; Reconnecting mind and body; and The blemished trophy. Overall, the findings conveyed a complex experience of voyage, change and insights. Recovery appeared to be a paradoxical experience of freeing oneself from the grips of depression, yet not escaping completely unscathed.

Discussion: The findings provide an insight into salient and personal understandings about the complexities of the participants' experiences and meanings of recovery in relation to depression. The current study highlights how we need to take recovery at the pace of the individual and provide support to help them reconnect and develop a new understanding of themselves.

PREAMBLE

1. Use of terms

The current research acknowledges that the concept of recovery can be interpreted in different ways and people can convey varying experiences. However, as a shorthand, the research refers to the term recovery as a way to convey personal experiences of overcoming depression.

The present research is primarily focussed on how people experience and make sense of their recovery, yet it acknowledges that the participants were given a diagnosis of depression. The introduction chapter includes only a brief account of a diagnostic (DSM-5) description of depression, as the primary focus is on the lived experience of recovery in relation to the experience of depression.

The term 'mental distress' instead of 'mental illness' will be recurrently referenced throughout the research unless otherwise required by context. The term 'mental illness' is often medically laden and associated with disease, which implies a reliance upon traditional values of recovery. The research is not seeking to medicalise recovery and rather aims to focus on lived experience. This research recognises the potential complexity of what is described as recovery and acknowledges that this understanding can differ from person to person. Nonetheless, this research assumes that people can define and experience recovery in multiple ways, irrespective of their clinical diagnosis.

In addition, the research recognises that particular terms are often the most commonly used descriptions in both lay and professional understandings when referring to experiences which can be understood as depression.

The terms 'self' and 'sense-of-self' in this research are not seeking to refer to an existing detached ontological 'self' and understands that people's experiences of themselves are changeable and relational. Nonetheless these concepts are understood to conceptualise the ways in which some may think and feel about themselves.

2. Outline

Recovery is considered to be a complex and debatable concept in mental health; however, it remains a central focus in how health professionals understand the ways in which people can overcome mental distress. While research on lived experiences of depression is more common, to my knowledge, no empirical studies can be found to explore lived experiences of recovery from depression in detail from an interpretative phenomenological position.

The concept of recovery is thought to have no single meaning for people who experience mental distress and remains a debatable concept despite its guiding principles (Jacob, 2015; Veseth, Binder, Borg & Davidson, 2016). From a traditional perspective, recovery places emphasis on symptomology whilst contemporary perspectives can be thought to often focus

on the view of the person and their social worlds. For those who have experienced depression, understanding recovery may involve varying meanings of significance to their lives and wellbeing. To gain an in-depth understanding, it is imperative to access something of these individuals' lived experiences as they hold valuable insights beyond current normative paradigms and concepts.

Despite the potential ways of perceiving the notion of recovery, more attention is needed in order to flesh out what this concept means for those who self-identify as recovered from depression to further clinical understanding. In considering that the present research is interested in exploring how people themselves make sense and experience recovery from depression, it is essential to be close to this lived experience. Developing a particular focus on the meaning might further assist in gaining clarity on the existing literature.

Counselling psychology practices embrace complexity within the human experience beyond objectivity, and allow for critical evaluation whilst reconciling personal understanding (Strawbridge & Woolfe, 2003); this further speaks towards the present research.

This chapter therefore begins with a brief insight into the concept of recovery and will highlight how this concept can be understood in different contexts. The research will then address the diagnostic description of depression and briefly consider alternative conceptualisations. Following this, the research will address the broad theoretical paradigms of recovery followed by a framework of recovery processes. The chapter will then highlight further key empirical studies to further illuminate the subjective experiences and meanings in relation to recovery from depression. The final section will highlight the gaps in the research and provide a rationale for the study.

1. Chapter One: Introduction and Literature Review

Whilst we accept that recovery from depression can be possible, it might be argued that we perhaps do not know enough about what it means to experience and be recovered. From this perspective, perhaps in our attempts at *deciding* what *is* and *is not* recovery, we perhaps move further away from hearing and connecting to what this experience might mean for the individuals themselves, and how they appear to understand what it might be like for them to be recovered. Therefore, an important place to start is from the voices of those recovered from depression. In order to understand this experience, we need to have an understanding of a person's experiences and meanings.

As we understand our lives within this world, we form meaning to recount our personal experiences (Fullagar and O'Brien, 2012). Meaning-making is thought to be fundamental to our experiences of wellbeing. However, the experience of recovery in relation to mental distress can be described as a struggle for meaning. In the case where one experiences the world as meaningless, this might also say something about how one experiences recovery.

People can move through life in the midst of serious mental distress and find ways to handle life challenges (Slade, 2009). It can be understood that many people diagnosed with depression can find meaningful ways of experiencing and making sense of their recovery, which may vary for each individual. It can be argued that there is an abundance of concepts and meanings of recovery in the literature, however only a limited number of studies offer a detailed interpretative analysis into recovery from depression.

Conceptualisations, and perhaps expectations, of recovery can vary and be shaped by the individual's world in ways of which we may be unaware. Whilst there is interest in validating knowledge from the lived experiences of recovery processes and mental distress, it seems that we need to unpack these experiences more closely in order to gain a shared sense of meaning in the context of recovery from depression.

1.1. *Insights into Specific Aspects of Recovery*

Following the broader theoretical underpinnings of the concept of recovery from depression, this section briefly acknowledges the common dimensions of recovery to help gain a more diverse picture of the ways recovery can be made sense of and experienced. Each of these aspects have a particular focus and in some way illustrate potential positions which experiences of recovery can be perceived, with each appearing relevant to understanding recovery experiences.

1.1.1. Recovery: Lessons from Addictions and Trauma

Recovery is a concept addressed with addiction and trauma; and it is likely that we can learn from what has been identified in this field. Recovery from addiction is considered to be a lifelong dynamic process, which involves time and effort (Laudet, Savage & Mahmood, 2002). Whilst abstinence is believed to be managed for a period, often with the sense of continuous vulnerability and cautiousness, the experience of recovery is often a transformative and continuous experience (Laudet et al., 2002; Hansen et al., 2008). In this context, recovery goes beyond abstinence and involves the individual changing and growing in positive ways, living life without the substance and restoring lifee (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Hansen, Ganley & Carlucci,2008). Therefore, the impression is that there is not necessarily an end to recovery from addiction, and one can be interpreted as remaining in recovery rather than being recovered.

In relation to trauma, recovery is typically understood as 'no return to a previous condition' (Davidson et al., 2005; Connell, Schweitzer & King, 2015). In this context, an individuals' perception of how they view themselves and the world is understood to be essentially changed following the experience of trauma. Therefore, recovery involves integrating or making sense of the trauma and loss in a manner that allows for the individual to move forward in their lives (Davidson et al., 2005). Ultimately recovery in relation to trauma can be experienced as a gradual or lifelong process. Alternatively, it can be considered as an experience with traumatic memories shifting from the forefront of one's mind, where it exerts control over daily lives, to where it no longer disrupts or disturbs, and the individual has more control (Davidson et al., 2005; Herman, 2002).

Both trauma and addiction recovery can appear to involve some sense of what can be construed as positive changes from their distressing experiences. The concept of post-traumatic growth (PTG) can often be considered in some relation to recovery, particularly in the context of trauma. This construct often describes the positive changes experienced as a result of the psychological and cognitive efforts made in order to manage highly challenging life crises (Tedeschi & Calhoun, 2004). In both trauma and addiction narratives, PTG can appear to relate on some level with recovery experiences. Although not considered to be the same concept as recovery, there are aspects of recovery and it manifests in a variety of ways such as positive changes in self-perception, a richer existential and spiritual life, improved interpersonal relationships, development of new goals, greater appreciation of life, personal strength and philosophical changes (Tedeschi & Calhoun, 2004; Connell et al., 2015; Ramos & Leal, 2013). It can be seen to resonate with the notion that there can be some benefit

from great suffering. However, it can also differ in that it is not considered to simply be a return to a previous baseline level of functioning; instead it is rather an experience of some improvement which can be deeply profound for the individual (Tedeschi & Calhoun, 2004). Although this research briefly summarises how different contexts potentially shape and change our understandings of 'recovery', particularly in western cultures, it is not in the scope of this research to address this in further depth. The intention is rather to highlight the diverse yet overlapping streams within the concept of recovery.

The next section will move more specifically towards the context of depression and start to gain a sense of the ways the concept of recovery can make sense for people in this context.

1.1.2. Conceptualising the Diagnostic Definition of Depression

Predominant clinical models conceptualise depression as a mental illness. In this context, depression is thought of as one of the leading causes of disability worldwide (Ridge & Ziebland, 2006; World Health Organisation (WHO), 2017). It is estimated that the global *prevalence of depression* has been increasing in recent decades, with over 300 million people estimated to experience depression (WHO, 2017). The DSM-5 (American Psychiatric Association: APA, 2013) categorises depression as a mood disorder, with a pervasive low mood exceeding the 'typical' feelings of sadness. In this context, it is distinguished from usual mood fluctuations and short-lived emotional responses to everyday challenges (WHO, 2017). The presentation and duration of symptoms are described to be highly variable and understood in this context to manifest in cognitive, behavioural, psychological and physiological changes (The National Institute for Health and Care Excellence NICE, 2004), which can impair a person's social, occupational and other significant areas of functioning (APA, 2013). A diagnosis of depression ranges from mild to severe and a presentation of four or more symptoms consistently across a two-week period can lead to a clinical diagnosis (NICE, 2004).

However, it can be argued that there is no agreed scientific test to confirm the presence or absence of depression (Ridge, 2009) and the legitimacy of a diagnosis can be debatable. Recovery from depression from this perspective suggests an absence of clinical symptoms and a return to normal functioning. The symptom-based approach can be accused of undermining the multiple and correlating factors which are also important to consider in the experience of recovery (Dobson & Dozois, 2008).

There is an alternative viewpoint where depression is considered to be a personal and subjective experience (Ridge & Ziebland, 2006; Karp, 1994). In accepting that people can

make sense of themselves as recovered, and the potential diversity of meanings and experiences of recovery, this makes the question of how people understand their recovery even more pertinent. Whilst there is often ambiguity and debate surrounding the nature of depression, this can also be said for how we interpret experiences of overcoming depression. Although the concept of recovery is often understood as something individuals experience, professionals encourage, and services facilitate (Jacobson & Greenley, 2001), it is argued that what is meant and experienced of the concept is not always well understood. It has been proposed that: **'**The meaning of recovery will vary, depending upon who is asking and interpreting, in what context, to what audience, and for what purposes' (Jacobson, 2001, p.15). In the context of depression, it is argued that empirical research insufficiently explores the subjective experiences of overcoming depression, not limited to symptomology.

Without this knowledge, can clinicians have a fuller understanding of how best to provide a more nuanced and appropriate type of support to individuals if required? The present research builds on the argument that people can personally understand and experience recovery from depression and these experiences may differ, surpass or be aligned to traditional notions of recovery. In addition, recovery from depression may be experienced in complex ways. Therefore, moving beyond normative scripts of recovery and exploring accounts of lived experiences can be beneficial in gaining a fuller sense of recovery, as individual voices can be a valuable yet often untapped resource in empirical research.

In western societies, depression is not an unfamiliar concept and is often acknowledged to result from an interplay of bio-psychological influences (Fullagar & O'Brien, 2012; Scheunemann, Schoeneman & Stallings, 2004). Whilst the DSM-5 (APA:2013) is thought of as a useful benchmark, there is the argument that it does not relate to everyone's experience, particularly in cultural terms (Gotlib & Hammen, 2002). In western societies, aside from the illness narrative, there is a tendency for individuals to draw from psychological and metaphorical understandings, which describe depression, for example, as 'darkness' or 'emptiness' (Karp, 1996; Refaie, 2014). This highlights possible conventional and shared understandings in relation to one's sense of wellbeing.

Thus, culture is understood to shape experiences and expression of depression (Chentsova-Dutton, Ryder & Tsai, 2014.). In other societies the medical model is not widely accepted and depression can be conceptualised in culturally specific ways. For example, some Eastern European cultures perceive depression as a normative part of human experience (Jurcik, Chentsova-Dutton, Solopieva-Jurcikova & Ryder, 2013). Alternatively, in China people can fluctuate in their use of bodily metaphors and locate depression sometimes in the heart and

other times in the brain, each with different manifestations and inferences (Pritzker, 2007). Other Asian cultures conceptualise depression as a somatic experience, whilst people from some African cultures consider more spiritual explanations (Kalibatseva & Leong, 2011; Slade, 2009).

In drawing further interpretations, experiences of depression can be difficult to convey to others (Ratcliffe, 2015). More specifically, in first person accounts, people can describe experiences associated with suffering, pain, alienation, disconnection, embodiment, meaning of illness, emotion and the development of depression (Ridge, 2009; Karp, 1996; Ratcliffe & Stephan, 2014). There might further be an existential emphasis whereby depression is experienced when one questions life, meaning and existence (Ratcliffe, 2015). In addition, exploring the experience of hope, guilt, agency, self, time, space, body and isolation can bring valuable insights to understanding depression (Ratcliffe, 2015). Exploration into first-hand accounts of the experience of depression allows us to attempt to view the world from the individual perspective, and this brings more understanding of the experience. It can be argued that current diagnoses employ the medical model in order to understand illness and can impose predefined categories on the individual, potentially distancing professionals from the experience of the individual. Therefore, an interpretative-phenomenological approach can mediate such tensions and provide valuable insights into the field of recovery. Ultimately, experiences of depression are argued to be a complicated and multi-faceted phenomenon (Ratcliffe, 2015); no one theory can fully explain individuals' experiences of depression and there are also challenges in the recovery approaches.

Whilst this research is focussed on the individual who has had a clinical diagnosis of depression, it is not committing to the notion of depression as a concrete experience or entity. Instead, this research uses the diagnosis as an inclusion criteria, to capture the lived experiences of a small number of people who are recovering from a similar journey. It is the recovery from these experiences that is the focus of this research, although the term depression will still be used in this thesis in order to convey these experiences.

1.2. *Conceptualising Depression and Recovery*

We will now explore recovery from mental distress in relation to the medical model, the recovery approach and the social approach.

1.2.1. Medical Model – Clinical Recovery

In this context, depression is considered to stem from chemical imbalances, dysregulation of neurotransmitters, genetic irregularities and brain dysfunction (Deacon, 2013; France, Robinson & Lysaker, 2007). The experience of depression is understood as being contained within the individual, therefore the environment remains separate. However, many argue that such pathology of depression ignores so much of the person's subjective experience and context (Pilgram, 2007). The discourse of empirical science has great authority in western medicine, psychology and clinical practice. However, some individuals with lived experiences argue that professionals can appear to take ownership and conceptualise their experiences by perceiving them as an object of illness (Deegan, 1996).

The medical model describes recovery as an absence of illness, reduction of symptoms and/or a return to a pre-morbid state of health (Slade, 2009). Furthermore, it can be described as an absence of something that was not part of a person's life prior to depression, such as medication, hospitalisation or treatments (Slade, 2009; Whitwell, 2001). These descriptions are thought to define recovery as a clinical outcome with a fixed ending that is objectively assessed by an 'expert' clinician. The outcome and/or effect can be thought of as 'cured' or at the very least, management of symptoms. From this perspective, recovery is invariant across individuals, and such definitions are understood to be dichotomous in the way that people are either recovered or not (Slade, 2009; Resnick, Fontana, Lehman & Rosenheck, 2005). Such a narrow position can potentially struggle to gain insights into complex experiences of recovery, for example, diagnoses such as bipolar disorder are considered to be treatable yet at the same time incurable (Lehman, 2006).Those with a diagnosis of bipolar disorder have been found to experience recovery as movement towards taking care of oneself and becoming an active agent in their care (Veseth, Binder, Borg & Davidson, 2012). Therefore, this continues to challenge the argument that those with a diagnosis can also have experiences which are not dichotomous and should therefore be explored to gain a better understanding and challenge our assumptions.

Nonetheless 'full recovery', where symptoms are subjectively and objectively absent, is not always considered possible. Therefore, individuals are considered dependent upon mental health systems, psychological services and medication to achieve a 'normal' and productive life (Borg & Davidson, 2008; Deacon, 2013). Similarly, the term 'remission' is used to describe a form of recovery whereby a level of symptomology is present although not impacting behaviour or usual activity (Andreasen et al., 2005).

It can be argued that symptoms of mental distress are largely elicited from the questioning of individuals and observations by mental health professionals. Therefore, the diagnosis is often elicited from the subjective experiences of the individual **(**Bracken & Thomas, 2005). It allows us to question whether objective knowledge can be possible to understand what it means and feels like to overcome depression. Paradoxically, this model can be argued to treat individuals as passive recipients of care and in some ways devalue their views as 'subjective', inferior to objective knowledge. However, despite a diagnosis people can and do recover in ways which are not synonymous with cure and yet are still considered as recovery. This is one of the challenges with the medical position as it can imply that there is only one way of recovery, which perhaps cannot reflect the different ways people view their being in the world. This model denotes a clinical perspective where the experience of a person's recovery can only be understood by a clinician as opposed to the person with the lived experience.

In the context of conscious beings we hold rich experiences *formed* and *felt* beyond others' observations (Rudnick, 2012). Therefore, rejecting what we can learn of subjectivity potentially denies the legitimacy of an individual's experience and we are less able to comprehend the complexity of recovery. The medical approach can be inept at exploring personal meaning and accommodating for a holistic appreciation of human experience, diversities and existential growths (Johnstone, 2000; Deegan, 1996). Objectifying experiences of recovery can further be thought to neglect the very idea of idiographic knowledge (Pettie & Triolo, 1999; Slade, 2009; Moore & Goldner-Vukov, 2009; Rudnick, 2012). For example, Deegan (1997) describes an experience of relapse as a breaking out of old fears and entering new worlds, rather than as a failure or return to ill-health. Such assertions strengthen the value of exploring recovery from the perspectives of those with lived experience as they can offer insights, which may help close the gaps in our understanding and further enable people to be closely supported.

Several authors argue that some individuals are unable to return to former health even with medication, suggesting other influences in recovery (Jacobson & Greenley, 2001; Davidson & Roe, 2007; Deegan, 1996; Borg & Kristiansen, 2004). Liberman and Kopelowicz (2005) suggested that although the remission of symptoms is imperative, it remains insufficient as a definition of recovery, particularly where psychosocial improvements are unaccounted for. Individuals can experience functioning in one or more areas of life while simultaneously be experiencing difficulties and/or symptoms in others (Deegan, 1992). Furthermore, such definitions as pre-morbid functioning can be ambiguous and difficult to determine (Bellack,

2006); it should also be considered that individuals may construe their meanings of this differently. Thus, a single criterion approach and operational definitions in general can be criticised for a lack in social credibility (Liberman & Kopelowicz, 2005), however they can further place greater emphasis on the illness, symptoms and on other clinical factors than on the experience.

Medicalised views of recovery can be thought to provide less hope as it can often appear to equate mental illness with the loss of a meaningful future in place of a life of disability and dependence (Everett et al., 2003). However, for many people a reductionist approach can also define their experiences of overcoming depression. Whilst this may not represent every individuals' lived experience, it can for some offer a sense of reassurance. In addition, medicalised conceptualisations can be viewed by others as helping people recognise that their experience of mental distress is not unique to them and there are others who may share their experiences thereby normalising feelings of 'abnormality' (Refaie, 2014).

The medical frame of reference can be the dominant or only available position for some individuals to make sense of their own experiences, as it permeates cultural consciousness and widespread understandings (Beresford, 2005). Such criticisms called for a fundamental shift in conceptualising recovery as some individuals in recovery needed more than just symptom relief or the few available meanings of illness narratives (Anthony, 1993). To some degree, deconstructing oppressive discourses can be imperative to find alternative and suitable ways towards living well and understanding recovery. Recovery might instead mean freeing oneself from the restrictive constructions dominant in society and no longer striving towards 'normality', as advocated by mainstream cultural standards and assumptions of inadequacy. It might instead involve accepting a wider variety of experiences as part of human life as opposed to pathology.

Whilst outcome measures can provide us with helpful insights about a potential ending or an individual's functioning at one point in time, it continues to tell us less about how this may have been experienced and further, what this might feel like and mean for the individual. From this perspective, there can be an implication that people just recover. However this research seeks to understand more, therefore considering recovery less as an outcome may be better at advancing our understanding of what else may be endured for the individual in recovery. Therefore in this context, although important, outcomes alone can be insufficient in providing ethical justifications for recovery services.

1.2.2.Recovery Approach – Personal Recovery

Conceptualising recovery from this perspective is to make sense of recovery as a process which individuals work towards, and is perceived to be individually experienced. Recovery is not necessarily perceived as an experience arising within a social vacuum; instead the emphasis is on considering the social vacuum as an integral *part* to the process (Davidson, 2003). Therefore, the *pers*on continues to be the centre of the focus whilst relationships, resources, professional care and other environmental factors are perceived to have a *role* in what is viewed as a personal journey (Slade, 2009). This approach argues that individuals' experiences of recovery cannot be adequately described by the language associated with traditional models and discourses of deficits (Roberts, 2018). Therefore, primacy is given to idiographic and subjective knowledge, which shifted a philosophical change in traditional mental health and recovery narratives (Jacobson & Curtis, 2000; Slade, 2009; Anthony, 1993; Davidson & Roe, 2007). Whilst in this context recovery is viewed as primarily unique to each individual, multiple definitions attempt to depict this experience (Parker, 2014). However, Anthony's (1993) definition continues to be one of the most widely cited defining statements of the recovery movement:

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993, p.527)

This meaning of recovery is thought of as the grounding of what is termed a 'recovery perspective'; it remains silent on the causality of illness and illuminates a sense of healing and growth (Slade, 2009; Atterbury, 2014). This approach it described as offering a broader perspective of recovery which involves a process of change and/or transformation experienced with or without the presence of mental illness (Deegan, 1998). Whilst the approach recognises the benefits of minimising the impact of mental illness, it concurrently focuses on empowering personal strengths, aspirations and competences to build a fulfilling life with or without mental illness (Davidson & Roe, 2007; Deegan, 1988; Jacobson & Greenley, 2001; Amering & Schmolke, 2009. The knowledge underpinning the basis for this approach emerged from the personal accounts of people (consumer/survivor/professionals) who have themselves lived experiences of recovery in the midst of mental distress and sought to define recovery in ways which were perceived as more relatable to these

experiences (Schiff, 2004; Deegan, 1998; Jacobson & Curtis, 2000) alongside qualitative studies of first-person accounts.

In addition, in recent years, there have been further contributions to this approach. Leamy, Bird, Boutillier, Williams and Slade (2011) conducted a systematic review and modified narrative synthesis on 97 international papers (including the United States of America, the United Kingdom, Canada and Australia) exploring personal recovery in mental illness. Based on these findings, they developed the acronym CHIME, which represents five recovery processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment. However, the study can be criticised for a limited amount of quantitative studies included in the review. O'Hagan (2009) supposed that this approach gives meaning, fuller human significance and a pathway to a better life.

Recovery from this approach is a re-authoring of one's life narratives and a recapturing of one's social roles or functioning sense of self (Davidson & Strauss, 1992). Many individuals with lived experiences of mental distress describe recovery as a way of finding a way back to oneself (Topor, Borg, Girolamo & Davidson, 2011). Drawing from empowerment narratives, the approach places importance on valuing human beings and an individual's ability to change their circumstances (Deegan, 1997). A further dimension is that it pulls from psychological and existential considerations in that recovery can be experienced as a humanising experience. However, recovery is considered to be non-linear and marked by continual growth and improvement, which can also include experiences of setbacks and disappointments. Therefore, this approach shifts from an outcome-oriented perspective and considers that, for some, recovery can be experienced as ongoing process where one can also be considered in recovery with a mental illness (Davidsons & Roe, 2007).

Therefore, individuals are not expected to experience the same levels of functioning and autonomy (Atterbury, 2014) and all people are considered to have the potential for personal recovery. Whilst this can perhaps appear uplifting, it can be criticised as being idealistic and inconsiderate of other realities. There might further be pressure on those to strive for an autonomous life from this perspective, which can subsequently heighten feelings of inadequacy and hopelessness if not 'reached'. In addition, the meanings and definitions can also be challenged for appearing vague, inconsistent and potentially meaninglessness (Liberman & Kopelowicz, 2002; Noordsy, et al., 2002; Gask, 2006). From a clinical perspective, it has been argued that these conceptualisations are limited in their potential to empirically operationalise and utilise as criteria for clinical practice and policy (Bellack, 2006)). However, proponents of the recovery approach would assert that the model is not

seeking to measure or perhaps quantify what it perceives to be primarily subjective, as ultimately it is the person who is recovering rather than the 'illness'. In support of this point, whilst meanings might appear ambiguous from a clinical perspective, this does not mean that it is meaningless for the individual in recovery. We need to be more open to recovery experiences, which we may not immediately understand as this offers an opportunity to further explore and gain insight into these meanings, rather than devalue an experience due to a lack of mutual understanding. Experiences of recovery may be indefinable - however this might rather tell us something about the individual experiencing the recovery.

An overemphasis on an individualistic world view and subjective experiences can be argued to ignore the interpersonal integration of recovery experiences (Price-Robertson, Obradovic & Morgan, 2016). There seems to be a tendency in relation to this approach to move towards ego-centric values such as self-sufficiency and self-determination (Adeponle, Whitley & Kimayer, 2012). Whilst there is an emphasis on valuing independence, it might devalue those who need support and impact upon how people perceive themselves in recovery and the world. In this context, it can appear to place emphasis on distress being 'within' the individual and potentially exacerbate feelings of self-blame (Meehan, 2008; NSW, CAG, 2009). While the recovery approach offers a wide range of meanings, it can be criticised for not offering new insights beyond the broad concepts. Without looking more specifically and in-depth at recovery, we are potentially left with the repackaging of mainstream understandings (Davidson et al., 2005; Ralph, Kidder & Philips, 2000). The approach can potentially overlook the complexities of an individual's being in the world, their circumstances and realities. Considering this more closely may enable us to acknowledge something more of this experience.

The next approach aims to broaden the individual perspective on recovery by describing additional aspects of a journey, which taken together can either hinder or facilitate individuals' recovery experiences.

1.2.3. Social Approach – Relational Recovery

There is a developing focus on the notion of social recovery; this approach encourages a socio-political take on mental distress and moves away from the medicalised notions of illness (Beresford, 2005). From this perspective, depression is potentially a 'normal' meaningful response to challenging social and personal circumstances. This approach views recovery as inherently a social process, as it considers individuals as interdependent beings and inseparable from the context in which they are embedded in (Topor et al., 2011; Price-

Robertson et al., 2016). This experience of recovery from mental distress is considered to take place in relation to others and their surroundings (Tew et al., 2011). Factors such as economy, demographics, education, income, culture and relationships contribute to people's perceptions and wellbeing (Topor et al., 2011; Roberts & Wolfson, 2004).

Social support, whether it be family, friends or other, offers interpersonal connections, which can allow people in recovery to feel a sense of belonging, value and affection which in turn can be helpful in the recovery experience (Tew et al., 2011; Corrigan & Phelan, 2004). Such experiences and intimacy can be understood to nurture the recovery experience and be important for overall health, sense of satisfaction and hope in recovery experiences (Corrigan & Phlean, 2004; Andresen et al., 2003; Harding, 1994; Spaniol & Wewiorski, 2012). In addition, employment or engaging in vocational activities help people in recovery gain a sense of worth and experience themselves as individuals who can be of use in the world despite their experience of mental distress (Ramon, Healy & Renouf, 2007). What can seem most essential for some individuals is having a 'place in the world' to recover (Bradshaw et al., 2007). A lack in necessary resources can limit opportunities for social roles, building relationships and living life meaningfully (Onken, Craig, Ridgway, Ralph & Cook, 2007). Such resources help people see themselves as more than their limitations and provide a sense of identity and purpose (Lloyd, Waghorn & Williams, 2007). Similarly financial instability can limit access to therapeutic resources and increase difficulties. Social-economic factors can support recovery and increase feelings of empowerment, self-efficacy, self-fulfilment and reduced symptomology (Bullock**,** Ensing, Alloy & Weddle, 2000; Provencher, Gregg, Mead & Mueser, 2002; Young, Green & Estroff, 2008; Davidson et al., 2005).

In relation to cultural beliefs and social attitudes, people who experience mental distress can describe feelings of isolation and stigmatisation that in turn can influence their recovery journey. Mainstream biases and stereotyping of cultural groups can further impact on experiences of recovery (Gopalkrishnan & Babacan, 2015). Some cultures may associate family shame or dishonour with the experience of mental distress and this can be detrimental to how the individual with mental distress perceives him/herself, help-seeking behaviour and treatment (Gopalkrishnan & Babacan, 2015). For example, collectivist societies place greater emphasis on the family and mental illness can seem to have a stigmatised reflection on the family as well as the individual (Botha, Shamblaw & Dozois, 2017).

Leamy et al. (2011) identified a sub-group comparison between the experiences of recovery from the perspective of the individuals of black and ethnic minority (BME) origin who shared

similar themes to their counterparts, however with a greater emphasis on spirituality and stigma. Cultural-specific factors and the collectivist notion of recovery experiences involved engaging in traditional therapies as well as faith healers and belonging to cultural groups. Collectivist notions encompassed hope and support from these groups, however for some others, these groups added to the pressure of mental distress and the experience of recovery. Recovery goes beyond the individual level, as for some cultures the whole family experiences the stigma. This draws attention to the ways in which clinicians may need to think about recovery in more adaptable and systemic forms. In relation to spirituality, belonging to a faith community, having a religious affiliation and a belief in God as a higher power were important aspects to individuals' experiences of recovery. However, non-BME participant studies often conceptualised spirituality as encompassing a wider range of beliefs and activities. Whilst these are important directions to explore, exploring what this higher being feels like in recovery can perhaps add further insight to the relational experience. The authors further found that the experience of stigma in BME studies was largely associated with race, culture, ethnicity and mental illness. Therefore the experience of recovery can also be made sense of as recovering from racial discrimination and not simply mental illness. Thus, these findings continue to remind us to be sensitive towards these contextual intricacies, which can further our understanding of diversities in recovery.

However, it can be argued that there can be disagreement in what people seek and value in a social perspective. There can be an assumption in the literature that support is necessary for recovery to be experienced, which may not be reflective of every individual's experience. Furthermore, there may also be individuals who feel unable to engage in their social worlds and have difficulties with perceiving and utilising possibilities, supports and opportunities. It has also been suggested that experiences of autonomy and agency can be compromised by family norms, offering another dimension in relation to recovery (Aldersey & Whitley, 2015). This approach can be argued to insufficiently consider what people may make sense of as the psychological and intra-psychic elements of the recovery experience (Beresford, Nettle & Perring, 2010). A loss of familiarity with oneself can increase insecurity, existential isolation and powerlessness (Ratcliffe, 2015). Withdrawal or loss of interpersonal worlds can further heighten a sense of inescapable estrangement (Karp, 1996; Ratcliffe, 2015). Relatedness can be altered as one no longer finds themselves within an everyday context of activity and possibilities for action. Whilst the sense of ability may not be completely diminished, acting may require too much effort (Slaby, Paskaleva & Stephan, 2013). Therefore, re-engagement in recovery may require time, process and understanding and perhaps also exploring this

process of connectedness can add further depth towards the social approach. In addition, a medical diagnosis can, for some in recovery, feel as though their experiences are legitimised and perhaps this model can be perceived to take some element of this away.

1.2.4. Reflection about the Concept of Recovery

Davidson and Roe (2007) suggest that all forms of recovery can co-exist in any one person with fluidity across varying experiences. From the aforementioned approaches, the concept of recovery can appear to develop in an interchange between the personal, the interpersonal, the social and the meaning-seeking journey (Hummervell, Karlsson & Borg, 2015). Thus, it is possible to expect that people's meanings and experiences will be multifaceted and specific to their context. Such findings strengthen the importance of exploring from the perspective of those with lived experiences in more depth in order to gain a sense of direction, perhaps before attempting to theorise or categorise these experiences. In addition, it might be argued that, whilst useful in offering broad knowledge of recovery experiences, can approaches and models inform us enough of the individual voices of these experiences? To further understand these approaches, clearer conceptualisations shared by those with lived experiences of recovery from depression are needed alongside such categories.

1.3. *Recovery Concepts and Processes*

The next section draws from the conceptual framework identified from the meta-analysis conducted by Leamy et al. (2011). This empirical framework synthesised individuals' personal experiences of recovery in 'mental illness' to be summarised by the acronym CHIME - Connectedness; Hope and optimism; Identity; Meaning; and Empowerment. This evidence-based framework is of most proximal relevance to this current research topic; therefore, it is a useful starting point to address these processes in relation to recovery from depression. The literature on these individual constructs identified as core constructs of recovery will now be explored.

1.3.1. Connectedness

Having support from others, whether through, peers, family or relationships, continues to be described as critical in recovery experiences (Davidson, 2009). Having relationships with family and friends can enable people to feel connected and can help people feel like a *person.* The presence of family members can also be a reminder of what individuals used to be like

and that there is more to them than their experience of mental illness (Topor et al., 2011). Mancini, Hardiman and Lawson (2005) conducted a grounded theory study with 15 men and women in a framework of symbolic interactionism, exploring recovery from schizophrenia, schizoaffective disorder, major depression and bipolar disorder. The findings suggested that family and friends were crucial and provided belief in participants' abilities to recover, heightening hopefulness and comfort. In addition, relations with health care professionals were important particularly where individuals felt as though they were collaborative partners. Relationships where participants were not viewed through the lens of disability helped facilitate recovery and humanise their experiences. A further finding suggested that supportive messages from family countered hopelessness and feelings of incompetence in recovery. However, it should also be noted that the participants of this study were individuals described as leaders in the consumer provisions of mental health services with all in the past having been hospitalised, therefore such positions potentially heighten the need for a sense of equality and humanness. Furthermore, their professional positions and familiarity with the recovery concepts perhaps make them a distinct group of individuals rather than a reflection of the majority population with these clinical diagnoses. Connectedness can also be experienced from people with shared experiences (peer support) or others whom people feel they can relate to for having gone through similar challenges (Slade, 2009). It might be argued that those with experiences of depression may feel a loss of connectedness, or a feeling of otherness heightened by one's sense of isolation (Karp, 1996). Therefore, this sense of union with something or someone may be an important way to slowly help those with experiences of depression.

Schon, Denhov and Topor (2009) conducted a grounded theory study involving 58 Swedish men and women described as having recovered from mental illness (Bipolar disorder, Psychosis and Personality disorder). They found social relationships to emerge as the core category. The findings identified three overlapping dimensions: social self; social intervention; and connection to others. The findings relating to a social self-conveyed 'internal' recovery and participants described finding healthier parts of themselves and utilising individual coping strategies. The participants perceived themselves as the driving force in recovery, leaving the 'passive self' behind and engaging with the 'active self', allowing them to feel powerful. The second finding suggested that social relationships within recovery interventions were integral to their experience rather than the interventions directly. Professionals deemed to go beyond the expected standards of care and who are interested in their experiences and knowledge fostered reciprocity, which constituted an

important part of their recovery. The final finding suggested that a sense of coherence, by engaging with others and being able to give support to others, fostered self-worth and value. These findings convey the relational experiences of recovery providing security, sameness and grounding. A strength of the study is that it portrays the sense of connectedness to change over time, it is not a static experience, highlighting personal growth, strategies and changes in needs for support. However, a limitation might be that the study focuses on 'helpful' needs, which potentially neglects other experiences. In terms of sampling, the findings are limited to individuals treated in 24-hour psychiatric care and are perhaps specific to this population. In relation to the findings, it is possible that the rigor of the analysis phase may not be strong enough, as the authors compiled the data from each of their separate interviews to provide larger depth of findings; each author could have elicited responses which could be lost in the merging of the data.

1.3.2. Hope and Optimism

The concept of hope is a central focus in recovery from mental distress (Onken et al., 2007; Deegan, 1988). Clarke (2003) describes 'hope' as a fundamental human experience which encourages people in times of difficulty. Lovejoy (1982) proposed recovery to be impossible without hope, as hope provides a person with courage to change, try and trust. However, hoping might need to be more than an ideal to make difficult changes (Ragins, 1991). Most commonly, hope is considered a primarily future-oriented expectation of attaining personally valued goals, which give meaning (Schrank, Hayward, Stanghellini & Davidson, 2011). In relation to depression, Schrank et al. (2011) stated that individuals can be overwhelmed by their past and future, and all which is important appears in the past. Therefore, the present and future is consumed and conditioned by the past, thus making looking into the future difficult. As personal recovery is often grounded in restoring meaning, hope seems essential. Smith (2007) asserts that hope is so embedded to human life that it can easily go unnoticed, whilst hoping is not necessarily the same for all; essentially it feels necessary for survival and fulfilment.

The notion of hope can also be experienced as an emotion, *a feeling* of a way out of difficulty, or belief that something positive can materialise (Lazarus, 1999). In this context, there is a strong desire to be in a different situation and a sense of possibility (Schrank et al., 2011). Whilst hope can also be built on cognitive processes with emotional and behavioural outcomes, Clarke (2003) argued that 'hope' as a cognition is limiting, as it is accompanied by will, desire and expectation. Steinbock (2004) agreed with hope as a basic human experience,

and proposed three central themes of hope: temporality, relation to otherness, and the modality of possibility. Temporal orientation towards the future is as an awaiting-enduring, whilst relation to otherness is an orientation to what is beyond oneself and the possibility of hope relates to engagement and sustainability (Steinbock, 2004; 2007). In this instance, it is distinct from expectation, probability, wishing, longing and denial.

Whilst the concepts of hope and expectation orientate towards the future and occur with activity rather than passivity, expectation often leads towards actuality, than possibility (Steinbock, 2004). Here, 'hope' encourages patience, one waits rather than expects. In addition, wishing and imagining can be casual without requiring personal commitment, like hoping (Steinbock, 2004). An engaged possibility is unique, as one can live with wishing without 'actual' engagement in the outcome. In relation to otherness, there is the experience of oneself as insufficient or not in control, therefore something unordinary can govern the situation. Alternatively, being completely confident to bring something about, there would be no motivation to hope (Steinbock, 2004, 2007). Thus, there is an essential interpersonal dimension to experiencing hope, which can be important in the experience of recovery.

However, Ratcliffe (2015) distinguishes between 'a loss of hope' not specific to depression, and experiences of depression involving loss of more hopes or hopes one has invested more in. There is a further distinction between the loss of hopes and the loss of existential hope (Ratcliffe, 2015). Hopelessness can often refer to existential hope conveying the loss of orientation to hope for 'anything'. In this context, anticipation is absent; nothing feels significant or offers the possibility of meaningful change. There may further be a painful awareness of loss and one can experience a sense of disappointment, sadness or regret (Ratcliffe, 2015). Whilst hope can give comfort, such complexities can make the experience of hope a challenge in recovery.

It can also be argued that hope can prevent the acceptance and/or understanding of circumstances. Therefore some may perceive it as illusory and be discouraged (Eliott, 2005). Clinical recovery perspectives can present low expectations and result in an unwillingness to motivate oneself (Slade, 2009). The recovery approach's notion of recovery being possible for all can also ignore those who struggle (Davidson & Roe, 2007). Offering a 'false sense' of hope may result in feelings of inadequacy if one is unable to recover (MacCulloh, 2011). Nevertheless, achieving a level of wellness, growth and satisfaction with or without 'mental illness' can instil hopefulness and encourage people to believe in their aspirations despite mental distress (Amering & Schmolke, 2009).

Spirituality can be experienced as an extension of hope and is an important resource for mental health recovery and maintaining wellness (Mental Health Foundation, 2018; Lukoff, 2007). It can be understood as a deeper connection with oneself, religion, meditation, nature and universe. A varied definition might be found in the quotation below:

'Spirituality is the outward expression of the inner workings of the human spirit, intrapersonal in that it refers to the quest for inner connectivity, interpersonal in that it refers to the relationships between people and within communities, transpersonal in so far as it reaches beyond self and others into the transcendent realms of experience' (Swinton, 2001, p.20).

Most commonly, it can be a feeling of connection or belonging to a higher being, greater than the individual, providing a sense of solace and way of coping (Slade, 2009). Spirituality can help people ascribe meaning to recovery experiences (Mental Health Foundation, 2018; Slade, 2009). It can also foster hope and encourage people to overcome distress (Slade, 2009; Green, Gardner & Kippen, 2009). Conversely, it can also have a detrimental impact on recovery and how individuals experience themselves in their worlds following a diagnosis. However, in other experiences, finding a newfound spiritual awareness can transcend 'negative' experiences, thereby helping aid recovery (Green, Gardner & Kippen, 2009). Ultimately, it can be thought to help some go beyond illness to find new meaning, purpose, interconnectedness and integration in one's being (Deegan, 1988; Russinova & Cash, 2007). Remaining aware of such diversities is important in order to develop more meaningful insights into understanding recovery and enables us to remain curious towards lived experiences and contemporary ideals.

1.3.3. Identity

The concepts of identity, self or the sense of self are viewed to be important in recovery for those with lived experiences of mental distress (Onken, et al., 2007; Andresen et al., 2003; Deegan, 1997; Young & Ensing, 1999). This concept is seen as a way in which people attempt to make sense of themselves in recovery and is often conceptualised as an experience of self-discovery, self-reclaiming, self-renewal and self-transformation (Spaniol, 2009). This sense-making is further embedded in the cultural, psychological, social and symbolic arenas of the individual and considered to be changeable and relational to other people, context and being in the world. Ultimately, it can help people understand distress and live with who they perceive themselves to become (Jacob & Munro, 2014; Manici, 2008), Literature can interchangeably refer to the complex concepts of the sense of self, identity and an authentic self (Ridge, 2009). The ways in which people come to understand their vulnerability and

purpose of their experiences seems crucial in developing our understanding of recovery. Several studies highlight the role of the self particularly in terms of the historical assumptions of normality and illness.

Piat et al., (2009) conducted semi-structured interviews amongst 54 women and men in Canada exploring the meaning of recovery from those with diagnoses, which included schizophrenia and bipolar disorder. The findings identified two contrasting meanings: recovery as an illness and recovery as a wellness. The illness definition associated recovery to a cure, medication or better health and a return to a former self. Some also expressed accepting or adapting to illness, as recovery was not perceived as entirely possible. The second definition viewed recovery as a wellness, involving a determined self and affirming self over illness. These participants described an evolving self, where recovery was ongoing. This conceptualisation helped participants make useful sense of their suffering and growth. The findings often cut across both perspectives therefore suggesting that perceiving recovery as both medical and psychosocial conceptualisations was important for these participants. There were further distinctions between the descriptions of the self as 'broken' in relation to illness recovery, and perceiving the self as the driving force in the wellness identity'. A strength of such findings is that it offers an insight into the different ways in which people can use the concept of self as a way of recovery and further illustrates how cultural ideologies play a role. The authors mentioned that in Canada, at the time, notions of self-empowerment in mental health were just infantile therefore this lack was reflected in the data. However, the study's methodology lacks explicit detailing and is without a pre-set theoretical framework for analysis. In addition, the findings should be considered in the context that the majority of the participants were on medication and some had been hospitalised, therefore these factors may have driven their experiences and meaning-making of recovery.

From a feminist frame of reference, Lafrance and Stoppard (2006) conducted a discourse analysis investigating the recovery from depression of 15 women within a social constructionist framework. The findings suggested that participants' descriptions of depression revolved around their lives as women, consumed by domestic practices and needs of others, whilst experiences of recovery were constructed within a personal transformative narrative, where women let go of their expected female customs and attended to their own needs. However, caring for themselves threatened their identities as women yet remained central to their wellness. Such findings suggest the psychological conflict and struggle during recovery in depression and in relation to social norms. These findings reiterate the importance of exploring what recovery means for the individuals' lives.

In this case, overcoming depression involved an ongoing resistance where the women struggled to position themselves in a cultural context, which made them feel secure about who they were. The findings encourage us to think about potential meanings which can be a barrier in recovery as for these women being a 'good woman' conflicted with the changes needed to engage in recovery. A strength of these findings was contextualised to the demographics of the women, adding depth to the themes, particularly as most were mature in age, mothers and other related factors. However, the study might be criticised for overlooking the wholeness of womanhood and potentially missing other experiences. There is a further assumption of depression as something to 'get out of' in their opening interview question, which may have driven the responses. The methodological focus on the linguistics of participants' descriptions can insufficiently capture experiences and meanings as lived; it is important to also go beyond language in order to understand a fuller experience of recovery.

Whilst it is often argued that recovery research is disproportionately focussed on the experiences of women, men can also engage in conceptions of the self, whilst overcoming depression. Emslie, Ridge, Ziebland and Hunt (2006) conducted a secondary qualitative analysis exploring recovery from depression amongst 16 men. The findings suggested that men experienced recovery from depression in ways that validated masculinity. The reconstruction of a valued sense of self and their own masculinity seemed integral in overcoming depression. The findings further suggested that most common were the values associated with hegemonic narratives, such as re-establishing control and being responsible (as opposed to weak). Whilst this supported recovery, it also added pressure of conforming to these standards, potentially leading to self-harm. Contrastingly, a minority of men found ways of being masculine, which were outside of the hegemonic discourses involving creativity, sensitivity and intellectual activity, which helped redefine their experiences positively. These findings emphasise the importance of being aware of the ways people make sense of themselves in recovery, as it offers an understanding of the complexities which some can endure. A limitation however is that the study draws from a secondary qualitative analysis and the use of original data can fail to explore whether these experiences were still relevant or changed over time with these men.

Such studies offer a richer understanding in which both men and women may make sense of recovery from depression in the context of their lives and ideologies. From a clinical perspective, understanding the ways people conceptualise 'self', although complex, can be important in recovery for some. Gaining an understanding beyond objectifying recovery can

be crucial in supporting people appropriately and sensitively. For instance, Rogers, May and Oliver (2001) reported that differing discourses between professionals and patients can result in inconsistency between patients' needs for recovery and the professionals' communication of those needs. A key difference involves professionals' failure to recognise the importance of reshaping the subjective experience of the 'self' during recovery, which was integral to the patients. This highlights how meaningful experiences can go unnoticed through the normative lens and potentially be detrimental to one's recovery. However, these studies should be considered in the light that they are from western societies, where it is argued that the sense of self and identity can be emphasised more in relation to mental distress. From the research, it might be supposed that values of 'normality' can seem challenging in the context of depression. Therefore, gaining in-depth insight into these experiences might help us ascertain more about this experience and consider its relevance for recovery. Whilst these studies offer insight into recovery experiences, it can be argued that there is less of a focus on how these experiences felt to the individual, which can offer greater emotional depth to the findings.

1.3.4.Meaning

There are multiple examples of meaning in the literature presented. However, this section predominantly focuses on meanings associated with a sense of phases in overcoming mental distress. Several studies have identified possible stages or dimensions in relation to the experiences and meanings in recovery from the perspective of those with lived experiences of mental distress (Davidson & Strauss, 1992; Spaniol & Wewiorski, 2012; Spaniol, Wewiorski, Cagne & Anthony, 2002; Clarke, Oades & Crowe, 2012; Andresen et al., 2003). Meanings, which can often be found in the literature, can generally convey hope after despair, shifting from denial and gaining understanding and acceptance, moving from isolation to engagement in life and actively coping (Ridgway, 2001). Thus, it informs us that there might be various changes people may feel they experience and gaining some sense of meaning of these transitions becomes an important part of their experience.

Young and Ensing (1999) conducted a grounded theory analysis in order to explore the meaning of recovery in 18 men and women with lived experience of those with a number of diagnoses including (bipolar disorder, schizophrenia, depression, schizo-affective disorder, psychotic depression, borderline personality disorder, post-traumatic stress disorder, claustrophobia, bulimarexia, and those with 'mental retardation') living independently. The findings identified three stages of recovery: *Initiating recovery involving accepting illness; a*

desire to change and overcome stuckness; and regaining what was lost and moving forward. The participants made sense of growing from a 'stuckness', which perhaps is crucial in understanding potential barriers of change. Spirituality was a source of hope and fostered a desire to change and survive in suffering. One's ability to do basic self-care, which the authors state is often overlooked in the literature, was a meaningful part of these participants' experiences. However, it might be argued that the study suggests assumptions such as accepting 'illness' to move ahead; such meaning can be difficult for some and others may also struggle in the implication of a fixed beginning, middle and ending of recovery. It would be interesting to consider what it means for recovery when there is no acceptance - would this mean one is stuck in a phase of recovery and cannot be recovered? Such findings in relation to acceptance of 'illness' can also be driven by western discourses. A methodological issue can be seen in relation to the interviews, which involved a focus group and interviews, however those in the focus group were not asked to tell their personal recovery experiences due to time constraints. Therefore, the findings may lose a closeness to their lived experiences and group discussions can also stifle individual experiences. This study, along with others, often focuses on multiple diagnoses which potentially draws less attention to possible idiosyncrasy relevant to the experiences of depression.

Such studies can be criticised for appearing prescriptive and encouraging presumptions about the course of recovery, or employ an inflexible understanding of people's experiences and emotions. From an empirical perspective most staged studies can lack in empirical validity and theoretical foundations due to minimal empirical testing and rigour to support the development of these stages. It can also be argued to restrict human growth and development into unchanging experience (Slade, 2009); this may be particularly difficult for those with fluctuating experiences. Some individuals could potentially feel a sense of failure and inadequacy, if stages are perceived literally and linearly (Rudnick, 2012; Slade, 2009). It might therefore be important to consider that these experiences reflect a moment in time and may not be the case for every individual.

From a cultural perspective, in western societies we are usually drawn to progressive experiences. However Ralph (2004) reported that individuals can experience themselves as fluctuating and overlapping between stages as a normalising experience of recovery. Roberts and Broadman (2013) suggested that there is a risk of such approaches assuming allegiances or divisions, however this is to mistake the frame for the picture. Such models or stages can be understood as maps rather than guides, which can further foster reflection. Shepherd, Boardman and Slade (2008) asserted that stages should not be understood as a linear

progression, which everyone must go through, instead they can be aspects of engagement where individuals can find their own way at their own pace. Proponents further suggest that stages may help therapeutic optimism and establish pathways of recovery (Deegan, 1996; Anthony, 1993; Andresen et al., 2003). There is also the suggestion that such dimensions can help conceptualise progress (or the lack thereof) in a non-pathologising way (Slade, 2009); understanding recovery as a journey rather than as a model.

Therefore, what more can we understand about this journey? Perhaps recovery from depression is not simply a journey of growth, connections or an absence of symptoms as research has indicated thus far. Recovery from depression may be more multifaceted and involve conflicting experiences and meanings, which may not necessarily be neatly packaged, yet still offer a greater insight into other complexities and bring us closer to the feeling which can thus far seem somewhat lacking in the field of research.

1.3.5. Empowerment

Whilst acknowledging that the concept of recovery takes in the context of one's surroundings, an important principle of recovery is the notion of the individual as the author of their own recovery. This concept recognises the support and care given to the individual in recovery, yet positions this as support rather than cure (Herman, 2015). From this perspective, interventions and assistance perceived to take power from the individual in recovery can potentially be harmful for recovery and invalidate the individual's experience (Herman, 2015). Drawing from the notion of self-empowerment, Fisher (2008) argues a dominant narrative of achievement and normality can undermine the positive sense of self that seems crucial for one to feel empowered. Fisher (2003) asserted that there is a cultural assumption that all individuals who experience mental distress and/or 'mental illness' need medical support to possibly recover due to the medicalised notions of mental distress. Fisher (2003) instead aligns with the narrative of support being a tool in recovery. Houle (2016) asserts that empowerment-based approaches are focussed on the person and his or her preferences, needs and health objectives. It is important however to consider that power is central to this notion and depending on the individual's context this sense of power and/or control can be experienced differently within different contexts. Others may feel empowered by the supports around them. Recovery literature can be found to draw on those who have engaged in mental health services and this perhaps heightens the loss of freedom and control. Gaining a sense of empowerment can be thought to enhance self-esteem, shared connectedness and meaningful being in the world. Overall, the concept of

empowerment can be perceived as an ongoing experience rather than as a destination, as growth and change can be thought to always be possible and beneficial (WHO, 2010). Nonetheless, experiences of mental distress can be described particularly by those who experience depression as a sense of powerlessness (Karp, 1996).

An example of where a sense of self-empowerment can be challenging for those with depression can be seen in Cartwright, Gibson and Read (2016). The authors conducted a thematic analysis on 50 women using telephone interviews to explore agency-promoting and diminishing experiences of using antidepressants and personal efforts. The findings showed that antidepressants promoted agency when they gave relief from depressive symptoms, resulting in: *proactivity in recovery; engagement in a range of activities such therapy; and social support–enhanced agency.* Simultaneously, the long-term use of medication, failed attempts to discontinue, fear of relapse and the biomedical model of depression created dependency and diminished personal agency in recovery. These findings reveal important insights into the struggle some individuals may face in negotiating conflicting feelings of support and agency during recovery. It draws attention to the impact of the medical model upon one's ability to feel hopeful and empowered in one's recovery. However, a weakness of this study is its use of telephone as opposed to face-to face interviews, which could gather more nuanced data and elicit deeper and non-verbal communication. In addition, the group reporting negative experiences of antidepressants was significantly under-represented, which could have skewed the findings. Participants were asked about 'problematic' and 'positive experiences', which is potentially leading participants to think about their experiences more conventionally. Furthermore, enquiring into the causes of depression may have imposed a narrative and restricted more explorative findings. It might also be argued that there is an assumption that antidepressants do not require 'personal effort', giving the impression that the two are not interrelated.

1.4. *What Do We Know From Quantitative Research?*

Quantitative research has been found to attempt to explore recovery from the perspective of those with lived experiences of depression; this section includes mixed-method findings. Several studies explore recovery and can typically be found to highlight recovery experiences to involve self-care, agency, social supports and health beliefs having a role in people recovering from depression. A further study conducted by Brown, Rempfar and Hamera (2008) utilised a Spearman's correlations analysis in order to examine the relationships between the insider (hope and empowerment) and outsider factors (symptoms and

cognitive variables) of recovery on 66 men and women from five community support programs. The participants were diagnosed with bipolar disorder, major depression, schizophrenia or schizoaffective disorder. Reduced symptoms of depression and anxiety were found to have the strongest relationship with self-reports of hope and empowerment. This informs us that that some aspects of hope and empowerment have some association with the symptoms of depression, which strengthens the argument that hopefulness and empowerment typically emphasised in personal narratives may be important in the recovery experience. The findings further suggest that people can make sense and experience recovery in co-existing ways, perhaps reiterating that there is no one way to experience recovery and the interplay of notions might be important to be mindful of. However, the study is unable to tell us more about this important relationship and the personal meanings in relation to the participants' lives. This cross-sectional study cannot seek to gain something of an overview of their experiences and further imposes specific elements of recovery to explore, thus moving away from allowing participants to more freely bring their interpretations. The study 12-item hope scale is further limited in exploring complex experiences of hope. In addition, participants' engagements with community services potentially influences their perceptions of the available ways to achieve goals and therefore are not reflective of other populations. These contextual differences are important to explore in-depth and may have helped to offer a greater sense of their experience. Questions remain regarding what it means to perhaps be hopeful or empowered in recovery.

Dobb, Mezes, Lobban and Jones (2017) conducted a cross-sectional online survey in order to explore how specific psychological processes underlie recovery amongst 184 men and women diagnosed with bipolar disorder. The study involved participants completing nine self-reporting measures and a demographics questionnaire. Pearson's correlations and multiple regression analysis found associations between appraisals, beliefs, and recovery. The findings indicated that depression, negative self-appraisals of depression, extreme positive and negative appraisals of active states and negative beliefs about mood swings had negative relationships with recovery. However, normalising the appraisals of mood changes was positively associated with recovery. Similarly, after controlling for current mood symptoms, negative illness models (how controllable, long-term, concerning, and treatable mood swings seemed to be), employment, and current and recent experiences of depression were predictors of recovery for these participants. Overall, the findings can be considered to strengthen the relational model of recovery. The study further points towards psychological processes and life circumstances that might hinder or encourage recovery for this group. The

findings further suggest that more positive illness models may be more supportive for personal recovery experiences with those diagnosed with bipolar disorder. This offers clinical insights and encourages us to think about the usefulness of illness narratives in recovery. The authors suggest that these findings imply the need for the development of a psychological model of personal recovery, as they suggest that different psychological factors potentially underpinned the symptoms and feelings of recovery. The study contextualises the findings to some degree, strengthening their relevance. However, a drawback of this study is that the online nature of data collection may have lost humanness, limiting the depth of the findings. A further criticism is that self-report questionnaires can be reductionist and potentially overlook any other areas which may be of relevance. While the bipolar recovery questionnaire is developed and grounded by those with lived experience, the number of questionnaires may be excessive for individuals to respond to in a meaningful manner. Again, this adds to the loss of what the experience feels like and means, which is crucial to developing our understanding.

Clarke, Oades and Crowe (2012) conducted a cross-sectional study utilising the chi square analysis, Spearman's correlations and a cross-tabulation analysis of 242 men and women in recovery and 83 mental health workers, to explore goals set across the 'psychological stages' of recovery in line with the five-stage model designed by Andresen et al. (2003). The participants had diagnoses of schizophrenia, bipolar disorder, schizo-affective disorder and major depressive disorder with psychotic features. The findings suggested that people in the latter stages of recovery made more goals that were aimed towards maintaining positive outcomes and reflecting broader life roles (approach goals). In addition, physical health goals such as exercise, nutrition and medication were more significantly reported upon and were rated as the most important by the majority. Goals in relation to employment, careers and relationships were all important goals that were considered central to recovery and their sense of self. In the final stages, considered to be the growth and rebuilding stages, participants felt more able to approach and stay with their difficulties rather than avoid them. A strength of this study is that it captures a sense of psychological growth, or perhaps readiness, which might be a useful insight when considering how people might experience recovery. In addition, it might potentially encourage professionals to explore the types of goals individuals might feel ready to engage with (depending on where they perceive themselves to be in their recovery) in a more therapeutic way. This can foster self-reflection, normalise expectations and allow professionals to engage in tailored practices.

A limitation of these findings is that they can imply a prescriptive way of understanding recovery and potentially infer a sense of expectation and pressure on stages. The use of assessment scales, such as the self-identified stage of recovery (SISR) only presents limited statement options, which may insufficiently capture the depth in their responses and tell us more about the meanings, for example how it may feel to no longer avoid 'negative' outcomes and engage in approach goals. Whilst these methods suggest associations between categorical variables (which is helpful when quantifying recovery elements) they are unable to tell whether being in employment or having relationships impacted on recovery or whether feeling more recovered enabled them to engage more in their social worlds. The 83 mental health workers ranged from social workers, nurses, psychologists, occupational therapists and welfare workers, and community and crisis teams. All the participants engage in a collaborative recovery approach and this familiarity may have influenced the psychological and functional direction of the findings, therefore the data might not be entirely representative of goals developed within services where more traditional models of treatment are prominent.

Cruwys et al. (2013) utilised longitudinal data collected about adults in a study of ageing that explores the effect of group memberships on depression symptomology over time. The findings suggest that engaging in several social groups can offer 'protection' against developing depression and a 'curative' effect. A strength of this study is its large and longitudinal sample, which allows for generalisability and the opportunity to strongly test hypotheses that include multiple variables and sensitive analyses. However, all the participants were over the age of fifty, therefore the findings may not be as reflective outside of the population of this group. In addition, it is not clear if the participants drew on other sources of support, which may be overlooked. Moreover, it might also be argued that not everyone may have the opportunity to engage in social groups; therefore, the findings are not as inclusive for people with less social engagement. In such cases, these findings might be discouraging for those individuals. In addition, although it is useful to have some understanding about the different groups people participate in, this fact is unable to tell us how the participants experienced these groups and what effect it had on their experiences of depression, both of which would have provided more in-depth insights. It could be argued that it might not necessarily be that the number of groups is significant; rather, it might be that the quality of the experience or the relationships formed within the groups are the key to recovery. Brown, Schulberg and Prigerson (2000) conducted a randomised control study in order to examine the health-related clinical and psychosocial factors and beliefs associated

with treatment outcomes in a sample of primary-care patients with depression. The participants were randomly assigned to a standardised treatment or to the physician's usual care. The study found there to be lower depressive symptom severity at an eight-month follow-up; this was related to higher baseline functioning, minimal medical co-morbidity, self-reporting ethnicity as white (race) and standardised treatments being either interpersonal psychotherapy (IPT) or nortriptyline (NT). The authors found that those who received standardised treatment and perceived themselves as having more self-control of their health indicated a greater reduction in depressive symptoms at the eight-month follow-up. Moreover, those who received standardised treatment perceived greater control of their health and lacked a lifetime of generalised 'anxiety disorder' were more likely to recover by month eight than those who received the usual physician's care. The findings revealed that clinical severity and treatment adequacy can have an impact on the symptomatic improvement and recovery from a depressive episode. In addition to health beliefs, non-depressive psychopathology and functioning can also influence recovery from depression.

A strength of this study is that whilst it recognises functioning and symptomology as an integral part of recovery, it also suggests that non-pathological beliefs can influence one's recovery. Such findings suggest that personal beliefs in relation to health as well as therapeutic support can have an impact on the reduction of symptoms; this combination may have been imperative. The authors conclude that over time, more trait-like factors and health beliefs can influence recovery from depression. The findings regarding the perceived control of health only significantly relate to the improved outcome among those randomised to IPT. As such, nortriptyline (NT) may speak to potential cultural norms such as accessing therapy being perceived by some as taking control over health and recovery, whilst needing medication might instead be perceived for some as a loss of control. A drawback of this study is that it is unable to offer much detail about the experience of 'recovery' considering the implications regarding non-depressive psychopathology and health beliefs in relation to recovery. These elements would have been useful to explore at greater depth; however, the methodology is limited in gathering further findings.

Drawing from the quantitative research, the findings seem to strengthen the argument that despite a focus on symptomology, there are other psychological and social insights relating to recovery, which seems important for our understanding. The findings have pointed towards health beliefs, non-depressive psychopathology, functioning and pro-activity, amongst other related experiences, as having some influence in relation to overcoming depression. However, questions remain around whether such methodology was able to

gather a fuller sense of the participants' experiences and we also seem to lose a greater sense of meaning to these findings as most studies cannot sufficiently tell us how these recovery factors perhaps felt to the individuals and what it meant for them to experience these outcomes. In order to unpack these valuable findings more comprehensively, we need a more detailed understanding of the experience and meaning of what individuals may go through to overcome depression.

1.5. *What Do We Know from Qualitative Research?*

1.5.1. Mixed Methodologies

Griffiths et al. (2015) conducted a mixed-methods longitudinal study exploring personal resilience strategies amongst primary care patients who reported symptoms of depression. Following interview responses, participants were categorised as 'users drawing on social or personal relationships', 'users expanding their own inner resources', 'users of both' or 'users of neither strategy'. The study drew from interview and survey data, and the outcomes of depression in primary-care patients. A total of 564 participants answered a computer-assisted telephone interview at a 12-month follow-up on what they found most helpful for their depression, worries or stress. This study found improved long-term outcomes for depression for those who identified personal resilience strategies, such as relaxation and religion, as most helpful. There was also noticeable improvement with those engaged in 'expanded inner resources' which involved commonly available strategies and people gained positive reinforcement for continuing this strategy, whilst drawing on relationships was not the most helpful strategy. A strength of the findings is that these offer evidence that personal resourcefulness can give individuals a greater sense of purpose which in turn impacts upon symptomology and recovery. However, there were a few limitations, for example, in relation to methodology, whereby the categorisation of inner resources seemed complex and based on an active voice, which may have excluded other resilience strategies if they were unclear to the authors. This questions the extent to which these findings are reflective of personal resilience strategies and whether the participants themselves would make the same categorisations. A further limitation is the examination of 'helpful' strategies, thus failing to capture diverse experiences. In relation to interview questions regarding depression, worries and stress, it might be supposed that those identifying with depression may engage more in treatment and feel less empowered, which could influence how they make sense of 'inner' resources. Overall, whilst we do have a sense of a functional experience towards recovery,

the study inadequately offers a deeper sense of meaning into the recovery experience of the participants or their sense of resourcefulness.

Badger and Nolan (2005) conducted a qualitative study using semi-structured interviews amongst 60 women and men to explore their perceptions of their primary care treatment, recovery and reflections on their experience of depression. The participants experienced recovery as multifaceted: *two thirds felt medication contributed to their recovery; recovery experiences changed with the passage of time; personal strengths were important; professionals who encouraged empowerment and multifaceted care were perceived as caring and offering individualised care.* Some participants felt they had to hide their medication fearing judgement from others and/or experienced this as something needed to kick start recovery. They found stigma associated with professionals and the public in relation to recovery can also heighten the sense of fear in recovery. Some participants questioned the effectiveness of medication as they experienced depression to improve with time and therefore wondered if they would have recovered regardless. This implies a sense of temporality in the recovery experience and the consideration that time is perhaps a healing element, although there might also be other factors contributing to their sense of improvement as participants also described depression as a learning experience where they recognised the need to slow down in life. Overcoming depression provided insights and turning points for the participants in how to be in the world which contrasted to how they previously experienced themselves in the world. A strength of this study is that it reinforces the argument that there is a fullness in this experience and the participants felt attributing recovery to only a few factors is not representative of the recovery experience. However, a drawback to consider is the methodological 'framework approach', which is not in line with a theoretical background, and lacks an ability to sufficiently capture and explore more ambiguous and idiosyncratic data which can make the difference in understanding what seems a complex experience. In addition, the primary care practices may not be reflective of other practices and populations.

Fullagar and O'Brien (2012) utilised a narrative approach in order to explore how 80 women used metaphors to construct meaning about the gendered experience of depression and recovery. Key metaphors were identified: *the struggle of self-transformation; the immobilising effect of depression; recovery as a battle to control depression; and a journey of self-knowledge.* The participants drew on different metaphors and constructions, such as medical (chemical imbalances), psychological (personality, inability to cope), family (histories of childhood abuse), and social (work, family pressures, relationship, stigma, and gender

discrimination). The findings capture a powerlessness in moving during depression and a striving for control in recovery, suggesting a battle between one's wishing and experiencing in recovery. There seemed a strong sense of fight in relation to their perceptions of themselves and their attempts to fit into the clinical notions of recovery which seemed difficult. This highlights potential conflicts where striving for normality is incongruent to their living experience. Such findings reiterate the importance of normalising different experiences, so people can feel recovered despite normative expectations. The study raises questions as to whether people are neglecting or fighting their lived experiences, devaluing their process to meet societal and clinical standards. These tensions may be detrimental to overcoming depression and draw people away from just being with their experiences and instead battling.

The findings were also suggestive of some participants living with the effects of depression and further issues around having to change the surroundings in which participants felt depression flourished. Further findings suggested recovery as an ongoing development of self-knowledge in the context of everyday challenges, past history and desires for a different future. These themes strengthen the argument that there are multiple experiences to consider in recovery, which can be overlooked through the normative lens, as the participants described recovery as being more complex than a search for a cure or fixed 'self'. One of the strengths of this study is the contextualising of the findings; we learn that participants who utilised medication over the long-term described recovery as a lifelong battle whilst others perceived themselves as compliant and responsible. Such findings raise critical questions around the beneficial and detrimental impact clinical and social norms have on the experience and meaning-making of recovery for women. Overall, these findings offer an emotional, relational and embodied experience of recovery and strengthen the argument that there are many ways of being in recovery and remaining open to this can help develop our understanding. However, a limitation is that the narrative methodology is unable to explore life as lived and portrays a re-representation of those lives as told by the authors. In addition, relying purely on metaphorical constructions can limit other forms of expressions into recovery. Language is not the only means by which one can communicate recovery and perhaps this is where future development is needed. The authors also acknowledge that their metaphors are not specifically reflective of the metaphors used at different times during their recovery, which could have offered further context. It might have also been useful to explore to what extent the background of the second author (who had first-hand experience of depression) impacted the collaborative analysis of the findings.

Johnson, Gunn and Kokanovice (2009) conducted a modified grounded theory analysis on 576 primary care patients, men and women who were involved in a larger scale mixed methods study and represented a broad range of depression severity. The participants were asked in a one-year follow-up interview an open-ended question to describe how they would know if a person had recovered. The participants found this challenging due to definitions of recovery, subjectivity, possibilities, and concealment of feelings. However, some of the emerging themes were: *a person's actions; appearance; thoughts and feelings which participants described having to capture through observation and human interaction*. The findings suggest a move towards more holistic and subjective insights contrasting traditional symptom-based experiences of depression. The concealment of feelings or the experience of depression also offers another dimension to the experience of recovery, which conflicts with the notion of recovery as always being an observable experience. It suggests a potential obstacle in recovery, which can be overlooked but seems important in understanding the complexities in overcoming depression. A strength of this research is that it encourages discussion about the ways in which recovery is clinically assessed and the ways those with lived experience self-identify as recovered. The authors conclude that there appears to be a preference for personal rather than professional approaches in dealing with depression; there was an overall sense that recovery was much more about understanding the person in recovery than simply the symptoms of depression. However, a limitation is that it focuses on a hypothetical scenario and one quarter of the participants were reported to draw on their own experiences, therefore the findings may not be as close to lived experiences. In addition, focusing on one question fails to offer in-depth insights into the intricacies which seem to emerge, and utilising computer-assisted telephone interviews are insufficient at unpacking the layers and feeling of recovery.

Shifting away from a specific context, Ridge and Ziebland (2006) adopted a modified grounded-theory approach exploring how 38 men and women gave meaning to overcoming depression. The findings related recovery to: *authentic subjectivities of oneself, responsibility, rewriting depression into the 'self', the storying of their recovery, and strategies deployed to renew life following depression.* The findings highlight that, for some, recovery is living with depression in some way and not purely about cure. This experience for some participants involved understanding and rewriting depression in a less destructive and more meaningful form into their lives, which helps to experience themselves as renewed. This experience gave some an opportunity to identify what was most 'real' and important in their lives. In a sense, recovery seemed to allow reflexivity and a degree of

symbolism, which helped provide a sense of normalisation for those who may struggle in the enduring sense of depression. More salient findings suggested that perceiving depression as only one aspect of their life was integral to their recovery experience. Whilst some participants drew from medical constructions, many described overcoming depression in the context of a higher experience, one that helped them live what they considered to be a purposeful life, develop self-care and acceptance. Such meanings were found to help the participants challenge feelings of hopelessness and illness chronicity. Those participants who were unable to find supportive meanings and struggled to shift from medicalised notions of mental distress were found to struggle in their recovery from depression.

Such findings are suggestive of recovery as a life-changing experience. From a counselling psychology perspective, these findings suggest the importance of supporting people in recovery to find meaning to their distress beyond illness narratives. A strength of this study is that it captures an array of personal meanings useful for understanding the diversity of recovery. Utilising open-ended, unstructured and semi-structured interviews allowed for greater and perhaps wider exploration into participants' experiences. A limitation however is its focus on 'severe depression' and its inclusion of some participants who identified as still experiencing symptoms of depression. These factors may have influenced the emerging findings, particularly in relation to recovery involving the presence of depression. The authors gathered a diverse sample in terms of age, social class and experiences however despite their efforts to include people from ethnic minorities only five were interviewed, and the rest were white and of British ethnicity. The authors felt this was a limitation of their findings as more diversity may have offered different perspectives on recovery.

However, a study which offers a closer insight into recovery from depression in relation to stages is Schreiber's (1996), who conducted a grounded theory analysis exploring the meanings 21 women attached to recovery from depression - and found they redefined the concept of 'self' in six phases, forming a social and psychological process. The phases were: *the self before depression; entering the 'abyss' of depression; struggling to tell the story of their depression; seeking an understanding of the self and the social world; 'clueing in' to who they are and the world around them; and 'seeing with clarity'.* This study conveys emotional and psychological feelings relating to these transitions, such as fearfulness and a desire to act in recovery, which again helps us gain a sense of their experience. It further captures the changes of self-perception during recovery and in relation to how they experience themselves relationally. One of the strengths of the study is that it conveys the depths and changes of the experience within the different phases of 'self' and informs us that this

experience involves gains, losses and conflicts, therefore presenting a more complex sense of overcoming depression. It can also be argued that it contrasts the typical discourse of the 'old vs. new self' notion and perhaps suggests that focusing predominantly on depression seems to reveal other experiences of the self, which might not be so dichotomous. However, there are drawbacks, which involve participants, who were thought to refine and expand the emerging theory, were selected; this might have influenced the process which emerged. Furthermore, having 'more educated' participants with advanced degrees might question the extent to which the findings are representative of other populations. In relation to the experience of stages, the findings can be suggestive of a set number of phases, which adds to the inconsistencies with staged recovery experiences. One might be left wondering how this fits in for those who experience an ongoing process; what happens once you reach that sixth phase and perhaps do not feel recovered? This is one of the tensions with the notion of stages in overcoming mental distress.

Gwinner, Knox and Brough (2013) conducted a 12-month qualitative analysis to explore their accounts of recovery and 'mental illness' using Participatory Action Research (PAR) on eight women and men artists diagnosed with a mental illness. The findings identified six themes: *To know who me is; I can't separate it; Recovery; Systems; A bit more better; Layered identities.* The study captured an evolution in the understanding of themselves as a person with a mental illness as an artist to a final point of acknowledging their valued identity as an artist despite their mental illness and this provided a sense of self-respect. The findings further suggest that mental illness was not external to the participants' understanding of the self or as something removed from their experiences as it shaped how they perceived the world and themselves. The findings further convey their sense of self as negotiated and lived, rather than imposed and categorised. We further gain a sense that the term recovery was not felt suitable for these participants, and all experienced tensions with the rhetoric and their being in the world. All participants expressed different aspects of their identity to understand and legitimise their experience, ultimately recovery was experienced as an ongoing-process, but not one which simply emerged from mental illness. A strength of these findings is that they draw us into thinking more dynamically about recovery and highlighted the devaluing of both the clinical and idealised language associated with the term in relation to their experiences.

This perhaps strengthens the argument that current paradigms can still feel unrelatable to lived experiences and a nuanced approach is needed, as perhaps current paradigms are unable to reflect such fuller experiences and meanings. In further utilising participants'

artwork to gather themes illuminates diversity in expression of meaning and feeling which perhaps is missing in research. A limitation of this study is that it does not explicitly detail their diagnoses therefore to what extent these findings are meaningful for overcoming depression is uncertain. In addition, the PAR methodology, whilst it offers a rich understanding of the findings, the authors sought to understand participants' recovery by intentionally effecting change in their experiences which shifts from the focus of the thesis. Furthermore, the artists' engagement in one another's studio during the second interview could have further influenced their responses and the shared findings of the research.

1.5.2. Phenomenological Insights

There is a limited understanding of recovery from depression from a phenomenological perspective. Several studies can be found to explore phenomenological experiences of recovery from mental illness (Bradshaw, Roseborough, Armour, 20007; Van Lith, Fenner & Schofield, 2011; Dunkley & Bates, 2015), although a lot of the research fails to focus purely on experiences of depression, and often only focuses on a specific form of recovery.

Higginson and Mansell (2008) conducted an Interpretative Phenomenological Analysis (IPA) exploring how and why psychological change occurs amongst six men and women who experienced personal change and recovery following a significant life event. A semi-structured interview explored details of the problem, its impact, how they overcame it, and how they felt retrospectively. The findings identified: *hopelessness and issues of control; the change process; new self versus old self; and putting the problem into perspective.* These findings were discussed in relation to the Perceptual Control Theory (PCT), which focuses on the mechanisms of change and self-regulation. This study offers useful theoretical insights into the meanings and experience of shared psychological processes of change and recovery within diverse life experiences. It provides a sense of how recovery can feel for example, gradual and sudden, which can be argued to be lacking in the literature. The emphasis on the thoughts, feelings and beliefs throughout the participants' process of recovery reiterates the changes in the experiences of recovery. An interesting insight is that participants change in describing their crisis without anger or resentment from a retrospective position. Perhaps this strengthens the importance of helping people put their experiences into perspectives, which can help those recovering. The study further demonstrates good transparency and coherence in their detailed methodological approach and contextual insights. However, it can be criticised for its diverse major life difficulties: bereavement; substance misuse; major depression; chronic fatigue syndrome; anorexia; and trauma following abortion, which loses

closeness and distinctiveness which may otherwise be meaningful in understanding the experiences of depression more closely. There is also the assumption that all major life experiences are comparable, which can be debatable and potentially adds to the issue of expectations of change and recovery. A further contention is the focus on 'psychological change' potentially excluding other experiences or perceptions of change and influence the findings which emerged. All participants were PhD or degree educated; therefore, the findings might be reflective of these contextual factors. Similarly, three of the six participants received psychology course credits for participation, such incentives alongside their psychology backgrounds could influence their responses.

Sutton, Hocking and Smith (2011) explored the meaning and experience of occupational engagement in recovery from mental illness (depression; schizophrenia; bipolar disorder; post-traumatic stress with associated depression) with the aim of understanding something of the multi-layered experience of engagement in recovery. The authors interviewed 13 men and women and their analysis was guided by hermeneutic phenomenology. The findings conveyed recovery from complete disengagement to full engagement in the everyday lived world. The participants described becoming unwell as an undoing of ordinary patterns of living and recovery seemed to be a continuum of dynamic engagement, which identified the themes: disengagement; partial engagement; everyday engagement; and full engagement. Many layers of being were experienced, for example in relation to the body, their descriptions captured the development of no longer feeling numb and having to deliberately awaken physical senses, to then experiencing unconscious action. A further finding was the experience of disengagement that protected some participants and created a space, which defended them from the demands of daily life and connections. During recovery, helping people find a healthier spatial balance between disengagement and engagement can also be integral. These findings offer less conventional experiences in that they convey a sense of disengagement as part of the recovery process and not simply a symptom of a person's diagnosis, which can be helpful for clinicians to consider when working with recovery.

The findings further infer that a range of occupational experiences throughout recovery can be experienced and moves away from exclusive focus of fixed and unidirectional experiences. Ultimately, there were ways of relating to the world which fluctuated over time and the losses of freedom to move in and out of engagements were also crucial findings. Such knowledge is useful in understanding perhaps the time limits which services can place on those in recovery and encourages clinicians to be more aware of the embodied and relational experiences in recovery. All participants self-identified as recovered from the

'effects of illness' but also perceived recovery as an ongoing process, suggesting that it goes beyond symptomology. Such nuanced findings can perhaps be overlooked in the existing research, this phenomenological inquiry helps illuminate experiences which can go unnoticed in other qualitative and quantitative approaches. However, it may have been useful to further explore whether participants' history of periods of hospitalisation, and two experiencing secure institution in their pasts, despite them presently living in the community, may have heightened sensitivity to their surroundings and the ways they make sense of re-engagement. The authors mention that a limitation of approaching this retrospectively may have restricted the range and depth of the participants' descriptions in relation to their engagements.

Veseth, et al., (2012) conducted a hermeneutic-phenomenological approach within a reflexive-collaborative framework in order to explore recovery in those with a diagnosis of bipolar disorder. This study utilised open-ended interviews with 13 men and women and examined what they found to support their own recovery. Four main themes were: *handling ambivalence about letting go of manic states; finding something to hang on to; becoming aware of signals from self and others; findings ways of caring for oneself.* The findings portrayed how participants experienced the process of recovering through the various ups and downs they experienced in life. It further offers unique insights into potential obstacles in pursuing their lives to the best of their abilities, such as describing the uneasiness some can feel in giving up on their manic experiences. Some participants found these destructive experiences to also be their favoured way of being or having a positive impact in their lives. Such insights allow us to think about potential paradoxes and idiosyncrasies which can have a crucial role in recovery, as there is an implication here of some sense of security conflicts with their aims of recovery. These findings point towards helping people find more healthy ways to be with their distress as a pathway to recovery. The authors however report that finding ways of caring for oneself seemed to be the most powerful, as it helped move participants towards improvements and positive changes in relation to self-worth. The authors further mention a form of acceptance needed for this change to be experienced: participants needed to see themselves as they were, accepting their needs and yet treating themselves with kindness. This study offered a detailed and reflexive analysis and illuminated some of the emotions and complexities which can be experienced in recovery, which can also be unique to their sense of distress.

A further strength of this study, which can also be considered as a limitation depending on one's perspective, is the collaboration of service-users with lived experience in designing the

study and exploring the data. The authors felt this enabled them to be open to explore more closely the participants' experiences and draw out meaningful insights, whilst it can also be considered to potentially drive or highlight specific themes central for these co-researchers and overlook others. Nonetheless, the study reports the researchers to have engaged in reflexivity towards potential biases. However, a drawback is that it lacks in differentiating individual voices which would have added further depth to this study.

Drawing from these studies it can be argued that gaining in-depth exploration into the ways people understand and make sense of their own recovery illuminates intricacies, complexities and paradoxes, hence the importance of utilising phenomenological-inspired methodology. This approach allows us to consider more nuanced ways of understanding individuals' ways of being in recovery and their worlds.

1.5.3. Brief Reflection

Recovery can be described as something beyond articulation, potentially defying definition (Davidson et al., 2005). In this context, it can be an attitude, a way of life, a feeling, a sense of safety, a vision, a natural healing, and an experience (Anthony, 1994; Deegan, 1996; Deegan, 1988, Hatfield, 1994; Roberts & Boardman, 2005). This research is suited to grasp a sense of the many interpretations of individual experience, draw similarities and distinctions and illuminate novel insights which can build upon existing literature and better integrate our understanding of recovery. Primarily it departs from normative scripts of symptom reduction but recognises that this can be part of peoples' experiences.

The literature on recovery suggests that recovery is more than a concept and largely constitutes a holistic way of tussling, being and learning in strife. According to the presented literature, recovery cannot simply be one model, outcome, philosophy or experience. It can be argued that the approaches thus far do not seem able enough to capture this meaty way of experiencing and perceiving health. It is possible to suggest that as we attempt to gain further understanding of recovery, we perhaps merge with those experiencing recovery who are also attempting to gather understanding of the world and themselves. Perhaps recovery from depression might be about allowing oneself to merge with life, becoming healed yet still vulnerable. From a research perspective the qualitative paradigms appear to offer more insight into the many layers of recovery from depression. However, the quantitative research has been able to show that reduction of symptoms alone perhaps may not seem enough for people to feel recovered, as recovering, according to an interpretation of the findings, seems to not to stop at the reduction of symptoms and continues to be coupled with personal

and/or evolving beliefs. The qualitative findings go beyond and offer us more of the sense of the experience. From a clinical perspective it encourages us to think about how we approach people experiencing recovery and perhaps question whose recovery are we speaking of when we talk about this concept. However, a prominent implication is that irrespective of the presented diagnoses or clinical treatment, people continued to seek understanding, which holds valuable meanings to their life and sense of who they perceive themselves to be in their experiences of depression and recovery.

1.6. *Gaps in the Literature*

Whilst the current research is invaluable to our understanding of recovery in the context of mental health, questions remain regarding whether these findings are reflective of those recovering from depression, or to what extent other experiences of mental distress reflect experiences of depression. Although there are helpful shared insights which emerged across these experiences, it can be argued to lower the profile of depression or encourage interpretation that overcoming depression is a straightforward process. It can further be argued that whilst the current research findings appear to be equally relevant to a range of experiences in mental distress, the research tends to lean towards a greater focus on diagnoses such as schizophrenia or bipolar disorder, and less on depression. There might be an assumption in this that experiences of depression are perhaps more likely to be short-lived and less debilitating, which can neglect others who may have different experiences. Gaining this knowledge can help clinicians consider whether there are aspects of recovery which may be more salient to experiences of depression, which clinicians, who are facilitating recovery, may need to be aware of or support people with. This is one of the main gaps in the current research, as there is limited in-depth exploration into experiences of overcoming depression, without being considered alongside other diagnoses or crisis events.

A further disparity can be the lack of more nuanced findings which the current research can be found to draw some attention to, however it can appear insufficient in its ability to explore in greater detail and at multiple levels of experience.

1.7. *Rationale for the Current Research*

The current findings can seem to emphasise components of recovery without greater attention as to how people may endure these elements of recovery, which can draw us closer to a fuller sense of what might be experienced by these individuals. Similarly, it can be argued that the current research gives us a sense of some of the feelings and emotive experiences

which may be experienced in overcoming depression, however more exploration is needed to illuminate potential complexities in the expression and experience of such varying emotions. Such data can further help to normalise experiences which are potentially valuable for recovery.

However, a strength in the current research is the offerings of varying meanings in relation to overcoming depression, although it has been argued that such an array of findings can appear vague and meaningless. Therefore, focusing more closely on a small number of participants might help gain further clarity and illuminate diversities, as much as the commonalities in meanings, which can be integral in holding onto individual experiences in recovery.

It can be suggested that rather than exclusively examining diagnostic meaning of symptomology, more enlightening for recovery is perhaps exploring subjective meanings of symptoms and how they might feel to the person (Johnstone, 2000). Such findings might offer other salient insights, which could strengthen the argument that those diagnosed with depression may also draw on non-medical reflections in recovery, and this may offer us a greater depth of meaning.

Gaining an in-depth understanding of this experience can support counselling psychologists and healthcare professionals to gain a sense of how best to support the experience of recovery, which may be crucial when working with and understanding this concept in the context of depression. In turn, this can help develop clinical practices which are closely grounded in lived experiences and better support individual health.

The findings may also help to advance the inclusion of personal meaning in relation to recovery knowledge and encourage further empirical research into this area. In addition, it is hoped to enhance and broaden professionals' and stakeholders' understanding of the area and offer supportive insights to those seeking recovery from depression.

However, ultimately, it is hoped that this research can give a voice to those with lived experiences of recovery from depression and strengthen the value and appreciation of their knowledge. These voices might further help those in recovery, who may feel unable to make sense of their own experiences, begin to develop their own understanding of what recovery means for them. There also is also a need to further understand the experience of recovery.

1.8. ***Research Question:***

A phenomenological approach to this research was identified as being the most appropriate to answer the research question, which was:

What is it like to experience a recovery from depression?

This study aims to explore the lived experience, and to understand the personal and subjective meanings attributed to the experience.

2. Chapter Two: Methodology

2.1. *Overview*

This chapter will provide a rationale for employing a qualitative approach, explore conceptual underpinnings and address the epistemological considerations of the research. The methodology will be outlined, followed by the research plan and ethical considerations. To close, a methodological reflection is offered.

2.2. *Rationale for Adopting a Qualitative Approach*

In attempting to understand the lived experience of recovering from depression and the idiosyncratic meanings of this experience for the participants, the research prioritises the individual perspective and exploration of meaning. Adopting a qualitative approach allows participants to describe experiences that are meaningful and integral to them without being confined by positivist notions (McLeod, 2008). It gathers individual experiences embedded not only in meaning but process (Borg & Kristiansen, 2004). Some qualitative approaches, such as Interpretative Phenomenology Analysis (IPA), are particularly suited to exploratory and reflexive research and encourages the researcher to explicitly integrate aspects of their identity within the data. It supports the notion of individuals holding different perceptual constructs and would depict the richness of varying recovery experiences (Harper & Speed, 2012). This approach is not only congruent with counselling psychology values but fitted seamlessly within the research aims, subjectivity and lived knowledge. These components lend themselves to the aims of gaining enhanced understanding and greater insight into human experience and the salient aspects of recovery from depression. Thus, to further understand the approach adopted for this research, it is first helpful to consider its three main influences, phenomenology, hermeneutics and idiography.

Phenomenology

Underpinning the experiential feature of IPA is phenomenology. Rooted in philosophy, phenomenology is concerned with how phenomena appear in our consciousness and the meanings phenomena have in our direct experience (Fade, 2004). It can be described as the study of how things (events in everyday life) show or give themselves to the experiencing person (Manen, 2017; Zahavi, 2003). Rather than explaining what might form a phenomenon, phenomenology is particularly focussed on how a phenomenon is experienced

and the way it is experienced. Furthermore, exploring and understanding human experience is a phenomenological interest and places this enquiry as an approach to the study of subjective experience (Langridge, 2007). This pertains to the phenomenological concept of 'lifeworld'; the world as it is experienced by the individual and thus is the subjective experience of consciousness (Finlay, 2012). Each phenomenological-inspired approach has a different emphasis depending on the specific strand of phenomenological philosophy that informs the methodology (Langridge, 2007). Phenomenology is often considered to have two significant orientations, these being the transcendental and hermeneutic (Larkin & Thompson, 2011).

Husserl (1962) is recognised as one of the earliest influential figures in phenomenology and introduced the significance of '*life worlds*' or '*lived experience*' as the foundation for understanding, rather than empirical science (Fade, 2004; Laverty, 2003; Reiners, 2012). This position is understood to prioritise *experience* as the most basic knowledge, and recognises the value in utilising individuals' understanding of experience in discovering the world (Laverty, 2012). Husserl advocated for a focus on 'the things themselves', the experiential content of consciousness (Langridge, 2008; Smith, flowers & Larkin, 2009). He believed that it is only in consciousness that something can materialise, and only by reflecting upon the way something appears without bias can it be possible to comprehend what it is to know something. The notion of intentionality of consciousness and the related notion of intentional content is considered as the crux of Husserl's philosophical investigation. He postulates that intentionality (which includes the experience of perceptions, memories and emotions) refers to the direct relationship between consciousness and the object of it, thus asserting that when we are conscious, we are each time conscious of something (Langridge, 2008; Smith et al., 2009). Therefore, to study our everyday experience according to Husserls' work, it is imperative to move outside of the 'everyday experience' by shifting from the object in the world, to the perceptions of those objects (Smith et al., 2009). This approach was understood to transcend the circumstances of appearance with the potential of drawing attention to a given experience for others. For Husserl, transcendental phenomenology is concerned with identifying the essential core structures of a given experience through a process of reductions (Larkin & Thompson, 2011).

This process of bracketing (epoché), involves adopting a phenomenological attitude that requires the researcher to bracket one's pre-understanding, everyday knowledge of the world and interpretations to let the phenomenon show itself in its essence (Finlay, 2011). This implies that setting aside judgements of the 'realness' of recovery from depression

through a series of reductions and rendering oneself non-influential or as neutral as possible to perhaps strive to grasp an individual's experience of recovery from depression in its appearing. It can be assumed that working towards this ideal can potentially lead to novel insights and encourage researchers away from possible misdirection of their own assumptions of the world (Langridge, 2008; Smith et al., 2009). Nonetheless, Husserl's methods have been influential on the more descriptive forms of phenomenology, as the methods are concerned with capturing the essence of experiences and resists going beyond the participants' data. This approach does not seek to explain the experience or attribute any meaning to it from outside the experience (Willig, 2012). Moreover, setting aside pre-conceived knowledge is suggestive of there being a pure experience. However, this position differs from IPA, which does not seek transcendental knowledge but rather draws from the later considerations of phenomenology by Husserl's successors such as Heidegger (Larkin & Thompson, 2011).

Hermeneutics

Marking a move away from transcendental and descriptive phenomenology, Heidegger (1962) argued that no knowledge can be accessed outside of it (Smith et al., 2009). He therefore, along with other philosophers, encouraged a move towards a hermeneutic and existential stance of phenomenology (interpretative-phenomenology). Hermeneutics essentially relates to the 'theory of interpretation' and regards interpretation as the only means to gain understanding (Smith et al., 2009). Heidegger built upon the work of Husserl's phenomenology, which seeks to uncover essential, general meaning structures of a phenomenon and abstains from abstract and/or external influences (Smith et al., 2009). Heidegger proposed that existence is not simply a phenomenon out there in the world in a general sense, but rather it is an existence that is personally owned (Moran, 2000; Becker 1992). Heidegger's notion of 'being-in-the-world' views human beings as always being in context, and places emphasis on our engagement with the world. Interpretative phenomenology assumes that we are embedded in the pre-existing world of language, social relationships and the inescapable historical accuracy of all understanding. Therefore, human experience cannot be meaningfully detached from a pre-existing world of people, objects, language and culture (Taffour, 2017). This position postulates that we are permanently entangled with the world and in relation to others. It speaks to the notion of inter-subjectivity, a term referring to the shared, overlapping and relational nature of our

engagement in this world. Moreover, whilst we attempt to make sense of the world, we also attempt to understand ourselves.

According to Heidegger, all experience is an interpretation and our observations are always made from somewhere, suggesting that there can be no pure experience. In this context, interpretation is not regarded as an additional process; it is an inevitable and basic structure of our 'being-in-the-world'. Thus, interpretive phenomenology is grounded in hermeneutics, discards the possibility of entirely setting aside the researcher's experience and encourages critical awareness of one's own subjectivity, biases and interests and reflection on how these factors might impact on one's findings (Finlay, 2009). In accepting that a description of an experience cannot be separated from the interpretation of what is being said, gathering detailed understanding and meaning of a participant's experience might then involve the researcher reflecting on an individual's account in relation to wider meanings (Willig, 2012). In relation to meaning, it can be *transparent* or *latent* however brought to light through interpretation (Langridge, 2008; Reiners, 2012 Smith et al., 2009;). Whilst interpretative-phenomenology explores phenomenon as it appears, it then engages in analytical thought to move beyond its appearing. Heidegger remained interested in how the world appears to us and how we make meaning of the world. He further asserted that the relational nature of our engagement in the world is not only fundamental to our sense-making of the world and others, it is also central to phenomenology (Smith et al., 2009). Furthermore, interpreting another person's experience is assumed to always involve the researcher bringing something of themselves and their own resources into the process (Parker, 2011). In reflexive-relational perspectives, meanings and data is assumed to emerge out of context or dialogue between the participant and researcher, leading to the co-construction of interpretation. Therefore, whilst this approach does not consider Husserl's form of bracketing as being entirely possible, Heidegger does maintain that priority should always remain with the new object than on our preconceptions (Smith et al., 2009).

2.2.1. Interpretative Phenomenological Analysis (Overview)

Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) is an approach to qualitative analysis, considered to particularly have a psychological interest in how people make sense of their experience (Larkin & Thompson,2011). Central to IPA is the understanding of meanings attached to experiences and how people make sense of their world through '*looking into'* their explanations (Reid, Flowers, & Larkin, 2005). It explores specific experiences and gains understanding without seeking to establish generalisations at

an unanimous level (Larkin, Watts & Clifton, 2006; Eatough & Smith, 2008). IPA is concerned with meaning and processes and meaning-making is conceptualised at the level of the person in context. (Larkin & Thompson, 2011). These factors resonate with the present research, which intends to explore individuals' personal experiences of the specific phenomenon of recovery from depression and the meanings participants attribute to their experience. Therefore, based upon the research question and aims, IPA is the adopted qualitative methodological approach.

IPA is understood to follow an experiential approach to psychological inquiry theoretically grounded in phenomenology, hermeneutics and idiography (Smith et al., 2009). IPA is interested in the detailed examination of lived experience and in exploring the subjective experience of 'something'. IPA is further thought to be phenomenological in that it aims to capture something of the participants' cares and concerns and orientations towards the world, in the form of the experiences that they claim for themselves (Larkin et al., 2006). IPA and phenomenology share the aim of attempting to explore the participant's experience through the individual's own perception (Willig, 2012). In addition, this approach permits exploration of a personal experience whilst concentrating on the significance that this experience holds for the participant. IPA is further phenomenological as it is concerned with the detailed consideration of participants' lived experiences and seeks to explore the processes through which participants make sense of their personal and social worlds (Smith & Eatough, 2006; Smith & Osborn, 2003). In brief, exploring and understanding human experience and individuals' perceptions remain a matter for phenomenology and IPA (Langridge, 2007). However, IPA differs particularly from descriptive phenomenology, which seeks to explore the eidetic meaning structures that describe the singular and invariant meaning of a certain phenomenon (Manen, 2017). The present research is not concerned with uncovering the accurate and unchanging features of the recovery experience from depression. IPA attempts to initially gain a sense of the texture and concerns that particularise people's worlds and seeks to explore people's lives through engaging in sense-making and reflection.

IPA aims to go beyond describing people's experiences in detail and further adopts an interpretative stance of the explored phenomena (Howitt & Cramer, 2011). Moreover, Heidegger's assertion of phenomenology, including an interpretative element, links IPA to hermeneutics. The interpretative orientation within phenomenology and IPA suggests that descriptions and human awareness are already interpreted as we experience them, suggesting the impossibility of being separate from the world and bias; hence the difficulty

with bracketing (Vanscoy & Evenstad, 2015; Laverty, 2003; Reiners, 2012). Adopting an interpretative-hermeneutic approach allows the researcher to become a part of the phenomenon without engaging in epoche and reduction techniques, which contrasts with descriptive phenomenology. IPA rather identifies more strongly with acknowledging the central role of the researcher,and does not advocate Husserl's form of bracketing (Finlay, 2009). Thus, IPA argues the impossibility of gaining a pure first person's account of an experience. It accepts that the researcher's subjectivity is inevitably implicated in the research and, therefore, emphasises the interconnectedness between the researcher and the researched (Finlay, 2009). Smith et al. (2009) states that experience is never accessible as we observe it after the event, and, therefore, a phenomenon that has not been interpreted is believed in this context to not exist (Smith & Eatough, 2012). In relation to the concept of 'appearing', Heidegger suggested that there is always a phenomenon visible but that the researcher must bring it to the forefront. This approach considers the process of exploration as co-constructed by the researcher and the participant. The IPA researcher takes an active role in making sense of what is being expressed by the participant and thus the analysis becomes the researcher's interpretation of the participant's experience (Willig, 2008; Smith & Osborn, 2003).

IPA is primarily concerned with the *insider perspective* (Willig, 2008) whilst simultaneously, descriptive, critical and empathetic interpretations will be applied to participants' accounts, which helps to create a richer understanding of the participants' text (Eatough & Smith, 2008). Participants may share the experience of *recovering from depression*, however, different perspectives of reality and participants' backgrounds may impact how they make sense of their recovery experience. Additionally, it is further asserted that the evaluation of participants' experiences will be distorted by the researcher's phenomenology, conceptions and subjectivity (Coolican, 2004; Smith, 2007). IPA acknowledges that an individual's experience cannot be accessed directly and the analysis is an interpretation that is required to understand the meaning of the partial disclosure rather than an objective account of '*pure experience*' (Willig, 2008; Moran 2000).

To access the participants' worlds the researcher aims to be aware of their own biases whilst recognising that these are important for the researcher to understand their own world and the participants' through interpretation. Smith et al., (2009) referred to the 'whole' as the researcher's ongoing biography and the 'part' as the new encounter with the participant. Ultimately, meaning making is iterative, and remains circular and dynamic to capture a sense of wholeness of an experience (Smith et al., 2009; Willig, 2013). The IPA approach requires a

reflexive stance and the use of *double hermeneutic*, whereby the researcher endeavours to understand the participant, who is striving to make sense of the world through interpretative activity (Smith, 2007). Moreover, the researcher interprets the participant's own interpretation and sense-making of their recovery experience from depression. Awareness of how the *double hermeneutic* might facilitate and impede the understanding of an experience is paramount (Finlay, 2011; Vanscoy & Evenstad, 2011). Thus, in accessing the meaning of phenomena for participants, a constant task is always to prioritise making sense of phenomena themselves as a form of bracketing (Smith et al., 2009). I address this through reflexivity, monitoring preconceptions and explicitly illustrating the points in the research where my personal interpretations are established alongside the data, as IPA is an explicit pursuit.

Another aspect of IPA is that it adopts an idiographic approach in its commitment to researching 'individual persons' and further exploring people's experience in context as a single case (Smith et al., 2009). Whilst IPA is not concerned with forming generalisations, the idiographic approach enables IPA to put forward accounts of a particular experience and offer findings which can potentially contribute to the field of Counselling Psychology and wider research. In producing a case by case analysis of a small sample group, it is argued that it can provide something detailed about the individual lived experience and the group itself (Smith & Osborn, 2003). Moreover, IPA endeavours to understand the ways that particular phenomena are experienced by particular individuals in particular contexts (Smith et al., 2009). Therefore, in attending to the phenomena of importance and how these phenomena impact on situations in the world and their meaning might ultimately help reveal their particular being in the world (Larkin et al., 2009; Smith et al., 2009). Therefore, IPA's focus is on the person - the personal experience of an individual and their views and understanding - rather than on the phenomenon itself (Finlay, 2009). It further differs from some phenomenological studies in that it seeks to ascertain the cognitive and affective responses people have towards what is happening to them and gives precedence to how participants make sense of their experiences (Smith, 2011; Finlay, 2011). Exploring the particular can be thought to draw us closer to what is considered as the universal, and the detailed study of the individual experience is believed to bring us closer to a shared humanity (Smith, 2004; Smith et al., 2009).

2.2.2. Rationale for Adopting IPA

IPA is an approach considered to be applicable for a wide variety of research topics (Smith, 2011). This research seeks to explore the personal meanings and experiences of recovery from depression, hence the significance that IPA places on the careful analysis of how participants experience recovery from depression and how they make sense of this experience. IPA's inward-looking approach explores subjectivity and meanings that people attribute to their experiences, which is core to the aims of the present research in relation to understanding of recovery from depression. It further captures the *psychological, contextual* and *inter-subjective* experiences yet attempts to prioritise the *personal voice* and the *idiosyncratic* ways of deriving meaning through experience of a phenomenon (Smith et al., 2009).

In addition, a phenomenological approach allows for exploration of embodied experiential meanings, aiming for rich descriptions of the participant's lived experience. Rather than focusing on casual relationships, it focuses on the exploration of meaning through inductive methods, therefore making this approach well suited for understanding something of the personal experience and significance of recovery for these particular participants. Another motive is IPA's gathering of a *nuanced* and *in-depth* understanding of personal experiences. It seeks to unpack the *substance, texture* and *quality* of recovery from depression and regards the account as an existing experience for the participant. IPA was further considered to be most applicable as it explores how people think and feel about their own experiences (Smith & Osborn, 2008). All these factors are central to the aim of this research.

In addition, it has been argued that individuals intentionally give meaning to their experiences, hence the primacy given to their perspectives (Lubisi, 2008 as cited in Young, 2010); the present research resonates with this. It might also be suggested that the interpretation of meanings can be further redefined and remoulded by individuals, reiterating the value of exploring phenomenon from their understanding (Benzies & Allen, 2001). In this perspective, the participants are also considered to be the experts in their recovery and able to offer personal meanings that are grounded and salient to them, consequently enriching our understanding beyond theory. Whilst IPA and phenomenology share the concern of exploring and capturing rich, complex descriptions of lived experiences and meaning, IPA primarily attempts to commit to understanding specific experiences as experienced by particular individuals. Thus, the present research aims to prioritise participants' perceptions of what the world *is like*, embodying personal knowledge, interpretation and subjectivity (Lester, 1999; Vanscoy & Evenstad, 2015; Frost, 2011).

Adopting an interpretative phenomenological position considers the participant's descriptions and reflects on its standing in relation to its wider meanings, exploring the experiences in the context in which they appear. Therefore, IPA researchers recognise that all questioning and interpretation involves assumptions based on prior experience that potentially regulates the extent of what can be made known. IPA accepts the impossibility of gaining direct access to the participant's experience and acknowledges that what is understood is an interpretation of this experience (Willig, 2008). Consequently, the phenomenon can never reveal itself in its entirety and interpretative work is required to understand the meaning of the partial disclosure (Moran, 2000). The researcher accepts that what participants say about their own experiences of recovery is their truth and no judgement is made on its integrity. The focus is rather on the meaning of the situation as suggested by the participant's experience and embracing the phenomenon as it presents itself to interpretation by participant and researcher. Thus, IPA is ideal as it is concerned with the meticulous exploration of the human lived experience and allows this to be expressed in its own terms and from the individuals' perspective (Smith et al., 2009). With that said, the researcher endeavours to be as present as possible through engaging with the participants, transcripts, interviews and what is being described.

Furthermore, IPA can be known for its attention on matters of health, illness, psychological distress, life transitions and identity (Smith et al., 2009; Brocki & Wearden, 2006); recovering from depression can fall under these paradigms and, therefore, corresponds well to the methodology. In addition, IPA's idiographic nature helps to explore personal experiences such as the experience of recovery from depression. Such examination might help to highlight unique perspectives and provide further insights into this research area. Upon reflecting on the philosophical approaches underlining IPA, it was felt to be a robust method for this research.

2.3. *Other Methodologies*

In deciding on methodology, discourse analysis and grounded theory were considered.

Grounded theory and IPA are both concerned with the individuals' interpretative activity to construct meaning and can position findings within related frameworks. However, grounded theory is more suited to exploring sociological aims, as theory construction and social processes hold primacy in explaining recovery for a broader population. The present research does not aspire to develop a new or adequate theory from the findings. Conversely, IPA leads more from a personal and psychological focus, gaining *in-depth* rather than broad

understandings of individual meaning from first-person accounts. Moreover, the co-construction of data is not best suited to the epistemology of grounded theory (Charmaz & Henwood, 2008).

Discourse analysis centres on language as a means to construct and negotiate knowledge, meaning and identities (Willig, 2008). This method could have been utilised as it acknowledges language to construct rather than denote reality (Willig, 2008). However, it was felt to be rigid in its approach, as its chief exploration is only through language to confer recovery experiences. Whilst IPA utilises linguistics, it is not limited to this as the only form of communication to engage with one's experience.

IPA remains distinctive due to its idiographic approach (the study of the individual) and its primary motivation to explore a specific context for those sharing a particular experience (Vanscoy & Evenstad, 2015). Whilst IPA preserves *uniqueness* of an individual account, prioritising each case independently, it then considers divergence and convergence across cases, which is suited to the present research (Eatough & Smith, 2008; Smith 2007; Vanscoy & Evenstad, 2015). Rather than be guided by a particular theory, IPA first aims to describe and interpret lived experience, then relate theory to the findings which the present research echoes (Vanscoy & Evenstad, 2015). Therefore, IPA can be more flexible, dynamic and perhaps reflective compared to pragmatic methods of interpretation. It typically adopts a position of not-knowing to create a collaborative facilitation of co-constructing meaning (Willig, 2013). Ultimately, it exceeds description and leans towards deeper meanings that may have personal and specific factors impacting on the interpretation and account of recovery.

2.3.1. Limitations of IPA

Reflexivity is often a challenge as the researcher's qualities might not be helpful to the reader's understanding and could appear misleading (Brocki & Wearden, 2006). However, IPA is transparent in its reflections, particularly as the impact of reflections upon findings can be challenged (Brocki & Wearden, 2006). Reflections might further encourage readers to engage in flexible and deeper thinking of their own to perhaps illuminate the participants' phenomenology and worlds. A limitation can be small and unique samples, which mean difficulty linking findings within a broader context or to those of other groups (Brocki & Wearden, 2006). However, gathering rich, transparent and adequately related literature can assist in the findings' transferability (Smith et al., 2009). Moreover, IPA does not aim to achieve generalisations or be representative through populations; rather it intends to enrich

or reveal in-depth aspects of recovery from depression that can be sufficiently attained in small samples.

A further challenge in relation to this approach is the function of language constructing rather than describing reality, which can conflict with articulating one's actual experience and can consequently construct a particular version of that experience (Willig, 2013). Therefore, language can be problematic if it is perceived to precede and shape experiences (Willig, 2008) and thus remains debatable within phenomenological research (Willig, 2008). IPA recognises constructionism and the untainted experience, but challenges the notion of people only being discursive agents (Eatough & Smith, 2008). Whilst some individuals might have difficulty articulating nuances, thoughts and feelings sufficiently (Willig, 2008), the consideration of emotion and affect can also be interpreted by the researcher analysing what *is* and *is not* said (Eatough & Smith, 2008). IPA is not limited to verbalisation and can draw from other forms of communication, so remaining *symbolic, creative,* yet *systematic and rigorous* to gain insight into one's *inner* experience (Willig, 2008).

2.3.2.Summary

IPA is the optimum methodology for this, according to Smith et al., (2009), it remains self-reflective and focussed on the subjective human experience communicated in its own terms. It aims to capture complexity, process and novelty, appealing to the present research area (Smith & Osborn, 2003). IPA can be found to help develop existing theory, models and practice, and offers useful insights to enhance understanding whilst being enriched by a range of essential features concerning recovery from depression (Smith et al., 2009). To my knowledge, there are no IPA studies exploring personal meanings and experiences attributed to recovery from depression from the lived perspective. This could satisfy interests for learning about the lives and experiences of those recovered as opposed to standardised notions. Thus, IPA allows for the exploration of this topic from a different perspective, one that comes from a deeper understanding from the participants themselves. The research question is then asked in a way that is best suited methodology for this question. IPA orientation further fits more closely with the present research aims and interest in learning more about the individual experience of people who self-identified as recovered from depression.

2.3.3. Epistemological and Ontological Position

Ontology is understood as the study of being and is concerned with 'what is' the nature of existence and the structure of reality (Crotty, 1998). Epistemology, however, attempts to understand what it means 'to know' and what kind of knowledge is adequate (Crotty, 1998). Epistemological assumptions are concerned with how knowledge can be created, acquired and communicated (Scotland, 2012).

This research is interested in the individuals' experiences and seeks to gain understanding of how these individuals potentially make sense of their recovery experience from depression. Thus, this led to the implementation of a phenomenological approach that aims to gather knowledge through understanding experience. It further looks to gather detailed information on the meaning of a particular experience for the participants rather than discovering an objective single truth. With that said, this research's *ontological position* aligns itself with the relativity of reality and in consideration to the interpretative aspect of the enquiry, the *epistemological position* of this research adopts an interpretative/hermeneutic phenomenology stance.

Identifying these positions was initially challenging as I had difficulty aligning myself perfectly with one stance; there were aspects of each that resonated and conflicted with my perspective. Nonetheless, establishing these positions allowed me to gain a sense of the knowledge sought and how reality is understood. Thus, I will outline my stance in relation to the above considerations and their influence on the methodology and analytical approach. There is a range of epistemological positions in qualitative research and the ideal foundation of knowledge is debatable (Willig, 2008). In reflecting on the epistemological stance underlining this research, I consider three questions, as proposed by Willig (2013).

1. What kind of knowledge do I aim to produce?
2. What are the assumptions I make about the world?
3. How do I conceptualise the role of the researcher in the research process?

Firstly, I aim to collect knowledge that would reflect something of the subjective experience of recovery from depression and the attributed meanings. However, given that this understanding is through dialogue and interpretation between myself and the participants, I acknowledge that it is inter-subjective and not purely individual knowledge. In adopting an IPA method, I am indicating that I am concerned with how people see the world and further assume that individuals' accounts suggest 'something' about their thoughts and feelings. Although it provides a doorway to the participants' experiential worlds, any access to this world of experience is not without difficulty. As such, I will not focus on discovering the

accuracy or *truthfulness* of their experiences; rather, I aim to obtain the quality and texture of the experience.

Secondly, in accordance with Willig (2013), I acknowledge that from a phenomenological perspective, I assume that more than one perception of the world can potentially be explored and what might appear as the same event could be interpreted and experienced in varying and multiple ways, suggesting there to be multiple realities. This supports the assumption that there is no simple reality. Rather, it is argued that there are only interpretations of the world, as the world in this respect does not exist independently of our knowledge of it. This relativist position questions the outer world and ultimately forgoes the belief of a single truth and fixed meaning, as truth is considered dependent upon perspective (Crotty, 1998; Gray, 2005; Willig, 2013). This research aligns most closely with Willig, (2013) assertion that reality as we know it is formed inter-subjectively through meaning and understanding shaped independently, experientially and socially.

It can be supposed that we make sense of phenomena through our encounters with them and as sense-making creatures we impose meaning on our experiences, which are viewed from particular perspectives or individually situated (Smith et al., 2009). Having a pre-existing meaning-making system embedded in us might distort our understanding of recovery from depression and perhaps guide our actions, which we might also be unaware of.

Therefore, this research subscribes to the view that it is impossible to have a 'pure experience' and so this research is an exploration into the experiential worlds in which contextual influences are engaged with to formulate and experience different versions of the recovery experience from depression. Nonetheless, whilst the assumption of experience being the product of interpretation, and therefore constructed, it is still considered 'real' to the experiencing individual (Willig, 2013). Furthermore, IPA acknowledges the complex relationship between what people think, say and do, although it assumes that people's accounts are partly a reflection of what they think about the topic of interest (Smith, 2007; Eatough & Smith 2008). Thus, IPA believes in the meanings that individuals assign to their experiences and it is consistent with my affiliation with working more integratively yet holding individual differences and personal circumstances in mind in my therapeutic practice. Similarly, with phenomenology, I tend to explore what an experience *is like* for an individual/client and how they engage with their situation.

Thirdly, in answering the final question, as the role of the researcher I acknowledge that IPA draws from both phenomenological and interpretative elements and that insights gained in the analysis will partly be shaped by my interpretations. Whilst IPA seeks to understand the

participants' experiences, it recognises that this is only possible through my engagement and interpretations of their accounts (Carpenter, 2009). Therefore, I intend to actively engage and collaboratively connect with the data. Through the interactions and co-constructions between myself and the participants, individual meanings will be elicited. However, in line with Willig (2013), I attempt in some form to bracket, although not eliminate, my own experience whilst acknowledging the impossibility of producing a pure account of the participants' experiences, as a degree of my phenomenology will always exist. Therefore, the analysis aims to represent the participants' views of recovery from depression and their worldview yet remains dependent on my own standpoint, resulting in a reflective approach. In assuming that one cannot separate oneself from what is known, I and the area of exploration are connected. Therefore, it is thought that who we are and how we understand the world is integral to how we understand ourselves, other peoples' experiences and the worlds (Fosha, 2002). Moreover, an interpretative paradigm proposes that my values are inherent in all phases of the research.

The above considerations led me to position the research within an *interpretative phenomenologist* epistemological position. This more explorative stance differs from the descriptive phenomenologist's position, which seeks to capture experiences as accurately as they present themselves without attributing or detaching meaning from outside the account (Willig, 2013). The interpretative phenomenologist aims beyond surface level and further understands meaning of an experience by moving outside of the account whilst reflecting upon its standing as an account, and within a wider social, cultural and psychological context (Willig, 2013). The interpretative phenomenologist not only further strives to explore knowledge of the quality and personal understandings of recovery from depression, but also provides a critical and conceptual understanding of the individual's account and meaning. Furthermore, it resonates well with how I often work professionally. This position also differs from social-constructionism which is more concerned with how knowledge itself is constructed and how versions of reality are constructed through language (Willig, 2013). In addition, a realist position concentrates on uncovering autonomous objective truth uninfluenced by the beliefs and wishes of an individual (Willig, 2013). In contrast to this, an interpretative-phenomenology position acknowledges that meaning is not assumed to be something with independent existence, and further supposes that there is no value-free knowledge.

2.4. *Research Plan*

2.4.1. Choice of Data Collection

IPA seeks to extract rich, first-person accounts, therefore a semi-structured interview was the method for data collection. It provides flexibility and room for unique and unexpected issues which may need further exploration (Smith & Osborn, 2003). Additionally, my training helped me to respond to and formulate further questioning to novel responses. Semi-structured interviews further encourage value and space for varied opinions and allows real-time conversation to capture rapport, experience and verbal and non-verbal affect (Smith & Osborn, 2008). Open-ended questions seek to avoid hidden presumptions and encourage impartial responses, bringing richness to the data (Willig, 2008). Prompts were useful for clarity of a particular question or to draw out further meaning from participants' responses. However, Smith and Osborn (2003) suggest keeping prompts to a minimum as the aim is to allow the respondent to feel involved in the progression of the interview. Whilst semi-structured interviews remain open, they also offer a sense of structure in which participants can feel secure (Coolican, 2004). Interviews were face-to-face and audio-recorded to maintain the original form of meaning (Coolican, 2004). I allowed for 60-90 minutes for each interview, although this was flexible and reliant upon the interviewee's participation. Most lasted a minimum of 70 minutes. The first interview helped as a way of piloting the questions to make certain they corresponded well to the research aim and whether they provided adequate opportunities for participants to discuss their experiences freely.

2.4.2. Interview Schedule

Utilising a schedule in a semi-structured interview can be criticised as interfering with what participants feel is important to explore (Fade, 2004). Conversely, Smith et al., (2009) proposed that an interview agenda assisted in keeping in mind pertinent topics related to the research and enabled preparation for sensitive or complex areas. Organising and forming suitable and adaptable questions took considerable time. The schedule was informed by the research question, relevant literature and my own inquiry, resulting in a selection of open-ended questions alongside prompts (see Appendix 1). These were reviewed in supervision and by peers for clarification, adequacy and insight into any discrepancies. Additionally, utilising the first interview as a pilot led to slight adaptations to wording as I noticed some questions to be less straightforward than assumed, and thus needed more time for reflection by participants. The adapted schedule fitted well throughout the interview process.

The nature of the interview aimed to be quite conversational to create a flow in dialogue, develop rapport, ease comfort and result in rich responses. Questioning focussed on seeking understanding and/or recounting descriptions which allowed participants to express aspects of their experiences significant to them (Smith & Osborn, 2003). However, it appeared that some participants were not used to talking about the essence of recovery and needed prompts such as "*what did it feel like for you?"* to elaborate this dialogue. This allowed for reflection which consequently gave depth to responses and enabled me to gain a better sense of a person's understanding of recovery (Smith & Osborn, 2008).

Although the schedule was a helpful guide, not all questions were utilised in the interviews and the structure at times shifted depending upon responses, as some areas were covered by participants without the need for questioning. Smith & Osborn (2003) suggested that the researcher should decide whether to move away from a schedule and how much movement is acceptable. Deviation and adaptation of questions once the interview is active can be useful as other aspects may arise in relation to the research area that might not have been considered (Smith & Osborn, 2008). Additionally, the researcher should be aware of which avenues are more valuable and relevant (Smith & Osborn, 2003). However, I aimed to remain focussed on the research question. In the middle and latter stages of each interview more specific and/or personal questions were employed to elicit in-depth responses. An inviting general question at the close of the interview allowed participants to further share anything which may not have been addressed but which they felt important to highlight. Following the interviews, I noted down felt experiences, initial thoughts, observations, body language and any reflections which felt significant.

2.4.3.Sampling and Participants

IPA seeks for the sample to be homogeneous, meaning that participants share the experience of a specific condition, event or situation relevant to the research question (Smith & Osborn, 2003). Participants were purposefully selected for their insight/expertise in the phenomenon being studied (Smith & Osborn, 2003).

The first inclusion criterion for recruitment of participants was a diagnosis of depression for homogeneity. I acknowledged the potential tension around using a diagnosis of depression, and that I could have utilised a self-report instead, however, there were reasons underlying this decision. A diagnosis might be helpful when communicating the findings to the clinical world; starting with those who have been given a diagnosis of depression can make the findings both empirically relevant and meaningful to individual experience. Moreover, a key

motive was to illustrate that a diagnosis does not necessarily explain what will happen next or that clinical recovery is automatic. This research offers personal and subjective insights which can follow a diagnosis and focuses on the inner experience of recovery for the individual. Thus, recovery can be experienced *subjectively* despite a diagnosis of depression, and hence no adopted external recovery framework was used. The second inclusion criterion was that participants identified as having recovered and were not actively experiencing depression. Those recruited reported to have been recovered for a minimum of one year, and most much longer. The minimum age requirement for participation was 18 for consent; there were no further age restrictions as the experience is not considered to be reliant upon age. Further, all participants were able to communicate in English.

The exclusion criteria_further defined the sample. Ethical considerations were taken into account when selecting the samples and all participants were expected to be in good mental health. Therefore, exclusion was applied for those actively experiencing other mental distress or struggling with depression or recovery at the time of the research. This not only homogenised the sample but sought to prevent added distress to vulnerable volunteers. It was hoped that through the careful wording of the advertisements, individuals who considered themselves unsafe to participate would not volunteer. Nonetheless, it was vital for the researcher to assess the vulnerability of participants and ascertain whether they met the criteria detailed later in this chapter. This screening gave a clearer picture of whether participants would be able to complete the interview without becoming markedly distressed.

A further exclusion criterion was those unable to attend a face-to-face interview in London, which was the area within which I was able to travel. Volunteers only available to take part via telephone or Skype were unfortunately excluded, since it was felt that face-to-face interviews would enable me to better monitor and manage any possible risks or interferences. Visual and unspoken cues of distress could be better attended to in person rather than online or via telephone, where such signs might be missed and the possibility of losing the connection could be disruptive.

The recommended number of participants for research often vary; however, a guiding standard is often between six and ten, as larger sample sizes may lose subtle inflexions of meaning within the data (Smith et al., 2009; Smith & Osborn, 2008). Following the screening, the sample consisted of six female participants and one male participant, aged from their 20s to mid-40s. Although demographics are not explored here, brief information was collected to help provide a sense of the participants (see Appendix 2 & 16). The majority of interest for participation came from females; of the few men who volunteered, only one met

the inclusion criteria and/or made contact before recruitment closed. Additionally, all participants appeared to be functioning well and further reported either working, volunteering or studying. All inclusion and exclusion criteria is fundamental in conducting research (Smith & Osborn, 2008), though a sample will partly be defined by and dependent upon those willing to be included (Smith & Osborn, 2008). Therefore, consideration of those who did not volunteer may also be important when reflecting upon what this may inform us about the research findings.

2.5. *Ethical Considerations*

Ethical considerations were addressed throughout the research process. In advance of the study, ethical approval to conduct the research was granted from City, University of London (see Appendix 3) and the research adhered to the BPS (2009) and HCPC code of ethics and conduct (2012). Permission was obtained from the mental health charity SANE to advertise the research. SANE's and the City, University of London's research and development protocols were followed for the research advertisement.

2.5.1. Possible Risk

Emotional distress during the research was expected to be low due to the nature of the topic, client group and self-selection, which was thought to further minimise such risk. Nonetheless, I acknowledged that unexpected distress during or after the interview could still arise; this was assessed throughout the research process in case of any change in the risk. Reflecting on recovery from depression might traditionally be considered as generally positive, however, it could also open up difficult past feelings. It was hoped that vulnerable volunteers would be identified through an initial telephone screening. Although exclusions could present limitations with the sample, a duty of care to maintain welfare and safety remained paramount.

2.5.2. Initial Screening

Prior to approval of participation, an initial telephone screening was conducted to verify the suitability of the participants (see Appendix 4). The purpose of the study, participants' questions and their robustness to participate were addressed. One volunteer who expressed an interest was found, following the screening stage, to only recently be diagnosed with depression and not yet engaged in recovery. Therefore, this volunteer did not fit the focus

of the research. In an attempt to minimise feelings of rejection or inadequacy, I took time to discuss this exclusion and for the volunteer to express their understanding, which was confirmed. The volunteer was thanked for taking time and expressing an interest in the study, as was the case for all those who made contact.

2.5.3. Physical Safety

A public place for the interviews was located; pre-booked rooms within the selected University, where our whereabouts were known to others. It provided a quiet and private space for participants with a sign stating 'interview in progress' placed on the door. The window panels had grey areas, which further supported anonymity. I aimed to ensure that participants were not exposed to unnecessary harm within the building, and toilets, fire exits and safety procedures were identified upon arrival. In the room, water was accessible for participants if needed.

2.5.4. Onset of the Interview

All participants were aware of the purpose and nature of the research as there were no requirements for concealment. Information sheets had been sent via email following initial screenings so that participants would have time to read more about the research and make sure they wished to partake (see Appendix 17). The information sheet was further reviewed and reiterated at the onset of each interview and an informed signed written consent was obtained (see Appendix 5). Transparency can further develop rapport with participants and rapport can assist in the richness of data collected (Smith et al., 2009). Throughout all stages participants had the opportunity to ask questions and were informed of the right to withdraw themselves or their data at any time before, during or after the research. Participants were not expected to give reasons for withdrawal and would not be penalised in any way.

In addition, should any emotional distress unexpectedly surface, participants were informed that they could also take a break if things became unmanageable. All participants were further informed that data gathered would be for research purposes only and kept confidential to protect anonymity. Additionally, participants were informed that a breach of confidentiality would only take place under circumstances of risk to self or other (Coolican, 2004); the researcher would seek support from local mental health professionals or emergency services should personal contacts be unavailable. All participants understood and agreed; I was also confident that my counselling psychology training and mental health

experience would aid in assessing for signs of distress throughout the interview and allow me to act adequately and appropriately.

2.5.5. Closing of the Interview

Participants were verbally debriefed, and given an opportunity to ask questions or to give feedback. Firstly, this allowed me to assess and manage any distress or negativity which may have arisen. Secondly, it sought to ground participants back to their usual states and attempt to prepare them to go back to their everyday lives (Coolican, 2004). In addition, participants were given a written debriefing form to take away which also provided a list of contactable counselling and support services for additional advice and support should any issues arise post interview (see Appendices 6 and 7). The details of myself and my supervisor were also listed on a contact from should any participant have any concerns or need to withdraw from the research. A choice to obtain a copy of the summary report with the exclusion of any identifiable information was further discussed. No participant expressed any distress during or following the interviews. I walked participants out of the building due to the unfamiliarity of the building and to further confirm that they left the interview in a settled manner.

2.5.6. Data Confidentiality

Maintaining anonymity of participants is fundamental as personal and sensitive information was discussed and collected. Participants were reassured that identifiable information would be excluded and the intentions to manage this were made explicit in the information, consent and debriefing sheets. Identifiable information, transcripts and notations surrounding the interviews were coded and protected by pseudonyms and interview numbers. Digital recordings and documentation were stored securely on a password-protected computer. All data was stored inside my home in a locked cabinet only accessible to me. I aim to destroy the original data post evaluation of the research. It was further explained that confidentiality would be upheld in any possible publication of the results. In addition, with the use of a transcription service for three out of the seven interviews, a confidentiality agreement was signed confirming their responsibility to maintain full confidentiality and security of any data received (see Appendix 8). No names or personal details were present in any of the recordings provided.

2.5.7. Researcher Self-Care

The use of supervision, support, and guidance from peers safeguarded unexpected or difficult emotional responses evoked from the research process. I further made use of a reflective diary to ensure adequate consideration was taken of my thoughts and feelings.

2.5.8. Remuneration

A monetary payment of £15 was given to the participants following the interviews. I reflected upon the implications this could have towards participation, the extent to which participants involved themselves in the interviews or perhaps the dynamics between them and myself.
The practice of offering research participants monetary remuneration is a point of debate within the research community (Bentley & Thacker, 2004). The most commonly expressed concern relates to whether the use of payment or incentives could be coercive or serve as undue inducement to research participants (Grady, 2005). It can also be perceived to potentially undermine the autonomy of participant choice and conflicts with the principal of informed consent (London, Borasky & Bhan, 2012). Therefore, during the process of obtaining informed consent, careful attention was given to the participants' understanding and expectations of the research as well as their freedom to participate, right to decline or withdraw. All participants expressed great interest in the topic and a motivation to share their experiences. In addition, the screening was further used to ensure that individuals were taking part based upon their own lived experience, rather than purely to receive monetary reward. I remained aware that in anticipating remuneration, participants might feel the need to make more effort in the interviews. Moreover, some participants may feel pressure to give responses they assume will please the researcher. To minimise this, participants were verbally reassured that this research was about hearing their experiences as there were no 'right' responses.
For the present research, £15 was felt to be a modest offer and an offer which did not appear too excessive where people might be induced to take part against their better judgement. It was considered sizeable enough to show appreciation yet not enough to coerce participation. In addition, no effort was made to manipulate the purpose of the money as it was an expression of gratitude and compensation for the participants' time and effort. Sullivan and Cain (2004) viewed remuneration as demonstrating the researcher's respect and gratitude for the participants' time and participation. Overall, in this research, consent was not felt to be undermined or potential risks misunderstood, thus monetary remuneration on

this occasion was felt to be permissible. Although monetary offers can challenge the roots of voluntary participation within social science, I rather approached this from an appreciative stance which appeared to be received well.

2.6. *Procedure*

2.6.1. Recruitment of Participants

I recruited participants in London due to practicalities of the research. The mental health organisation SANE reviewed the research and was pleased to advertise the research poster (see Appendix 9) and information sheet on their website and social media platforms such as twitter. The team felt the research suited their client group well and was confident that a good amount of participants would volunteer, which was confirmed. Advertisements were also placed within the seclected University notice areas; both approaches were successful in recruiting participants almost immediately. Volunteers made initial contact through email and a time was arranged for telephone contact. The initial telephone screening allowed participants to find out more about the research and for an assessment of suitability, vulnerability and risk to be completed. Following successful screenings and prior to the interviews, the information sheet was emailed to participants.

Once participation was confirmed, a date and time were agreed via email. Directions for the location were given in advance to ease any anxiousness and aid travel arrangements. Confirmed participants were given a separate contact number in case of any difficulties and I obtained participants' contact details. Participants were told to wait in the reception seating area and I would meet them there.

2.6.2. Meeting

Upon arrival, I met the participants, warmly introduced myself and guided them to the interview room. This time provided a brief moment to begin to settle with each other and once inside, participants were welcomed.

2.6.3. Pre-Interview Discussion

I informed each participant of the purpose and requirements of the research, commitment to anonymity, confidentiality and rights to withdraw. I answered any questions and further reminded participants that they were not obliged to discuss anything they did not wish to. A signed consent form was obtained confirming their understanding and willingness to partake

in the research. Once all relevant information was obtained, the recording of the interview commenced with their consent.

2.6.4. Interview

Interviews lasted between 60 and 90 minutes. Participants, once comfortable, navigated themselves more easily through the interview, however, I sought elaboration at times for clarification of participants' meaning. At the end, participants were asked if they had anything more to share, which the majority engaged in.

2.6.5. Post-Interview Debrief

I took time after each interview to verbally debrief participants and discuss how they felt following the interview. A hard copy of the debrief form was also given, along with a contact support sheet should participants later feel uncomfortable about the interview or research (see Appendices 6 and 7). Participants were thanked for partaking in the research and informed that they could contact me if they had any queries. Participants were also informed that I would be happy to provide a summary of the findings should they be interested.
A plastic wallet was provided for all the sheets given and an envelope containing £15 in cash remained inside this wallet, which participants were made aware of. I aimed to avoid an overt staging of remuneration and allowed verbal appreciation to take priority. I explored whether participants were content with travelling back to their destinations and walked participants out to the entrance. After participants left, I utilised a reflective diary to record my observations and summaries regarding the interview as a form of reflection prior to transcribing. Smith et al. (2009) described the beginning of the analysis stage to be focussed on the participant. I recorded my recollections and observations from the interviews in my reflective diary so I could be aware of my influences. The next stage involved transcription and analysis of the data, discussed in the following sections.

2.7. *Analytical Strategy*

2.7.1. Data Analysis

The data was analysed using IPA measures detailed in Smith et al. (2009). Approaching data can be an adaptive process and reliant upon an individual's own personal way of working, allowing flexibility and a method which makes sense to the researcher (Smith & Osborn,

2008). Nevertheless, the analysis followed an iterative and inductive series, moving between the specific to the shared and the descriptive to the interpretative (Smith, 2007). The analysis is based on specific foundations presented below; however, this was a flexible rather than rigid guide and process (Smith et al., 2009).

2.7.2.Transcription

The interviews were transcribed verbatim. I transcribed four of the interviews myself and used a professional transcription service for the remaining three due to time constraints. The transcription service signed a confidentiality agreement, maintained data securely and assured deletion of files once transcripts were received. The decision to utilise a service was difficult as I considered the impact on the analytical closeness of the data.

The interviews were undertaken over some time before the transcriptions were undertaken. Due to time constraints, additional assistance was needed with transcribing the final three interviews, and a transcription service was required in order to meet University deadlines. At the time, Ethics Approval did not cover making contact with participants sometime after the interviews, which were completed three years previously. Therefore, following a detailed discussion with my supervisor, I ensured the contract with the transcription service paid attention to confidentiality and anonymity (see Appendix 8). The recordings were shared by a password-protected system and the recordings held by the transcription service were deleted immediately after transcribing. No names or identifiable information was shared with the service. The completed anonymised transcripts were then securely sent through the same way it was shared, to my secure profile. No data was retained by the transcription service.

Despite utilising a transcription service, capturing the nuances in conversation remained integral to the data. Thus, I re-read these transcripts multiple times and checked them against the recordings to ensure accuracy and immerse myself in the data. This process was completed alongside the four interviews transcribed by me, as it was important for me to be a part of the process as much as possible. Transcribing, re-reading and listening to recordings several times engrossed me in the data and enhanced my understanding of the participants. Smith et al. (2009) proposed that the primary aim of IPA is to interpret the meaning of a participant's account and for the data to be analysed on a semantic level to inform linguistics and the psychological nature of an individual's account. Linguistic elements included significant pauses, body language, valuable utterances, laughs, and any responses worth recording (Smith & Osborn, 2003). Lengthy pauses were signified by the pause word or "...",

emotional expressions and intonation were noted. Additionally, I sought to understand the presented accounts whilst simultaneously making use of my own interpretative means (Brocki & Wearden, 2006). Smith (2007) reports the quality of the final analysis to be dependent upon the personal systematic work achieved at each stage of the procedure. However, it is acknowledged that transcription may not capture the full interview experience and should not be perceived as a perfect duplication.

2.7.3. Reading and Re-reading

I paid close attention to each participant's world by listening to the audio-recording coupled with repeated readings of the transcript. This brought me back to the original data and allowed for recognition of my responses and connection to reflective notes made following the interviews. Smith et al. (2009) proposed that this stage enabled the researcher to become more aware of the development of narrative throughout the interview. I noted down thoughts that came to mind, and this further assisted in bracketing my understanding until full review of each participant's account was completed.

2.7.4. Initial Noting

During this stage I made broad descriptive notes which reflected my initial observations and associations upon encountering the text (Willig, 2013; Coolican, 2004). The researcher is expected to remain open-minded and record anything of interest or potentially significant as each reading can possibly reveal new insights from the text (Smith & Osborn, 2003). I went through the text line by line to create wide-ranging and non-specific notes and codes located mostly in the right-hand margin of the text. These notes focussed on content (matters discussed), linguistics (metaphors, repetitions, pauses, filters), context and initial interpretative comments (Smith et al., 2009). Distinctive phrases, similarities, differences, contradictions, non-verbal communication and affect were further recorded. Commentary was noted in black, with linguistic elements highlighted mostly in green and emotional content in yellow (see Appendix 10). I remained mindful of my role in making sense of the data. I attempted to distinguish my own perceptions from those of the participants' by regularly reviewing and challenging my commentary alongside supervision to discuss process and findings.

2.7.5. Developing Emerging Themes

The next stage required a more complex engagement with the text and identification of emergent themes for each interview; highlighting parts of the transcript and earlier notes (Coolican, 2008). These themes captured my individual interpretation of the participants' accounts and were mostly noted in the left-hand margin of the transcript (Smith, et al., 2009). My initial notations were condensed into brief phrases which depicted the quality of what was identified (Smith & Osborn, 2003). I conceptualised and made psychological interpretations towards the text as well as identifying expressions, so allowing theoretical associations within and across cases. Simultaneously, I continued to be grounded in the distinctiveness of their commentary (Smith & Osborn, 2003). At this stage, no parts of the data needed omitting or selection for special evaluation.

Considerable time was taken to relate themes to produce an early clustering of similar themes, due to the large amount of data collected. I used visual methods to aid this process, involving cutting out themes and placing them on a flat service in order to more clearly visualise similar patterns and clusters. Once themes were minimised to a reasonable amount, approximately sixty or under, I felt ready to identify further links between similar emergent themes and clustered them further together (see Appendix 11).

2.7.6. Exploring Connections Across Emergent Themes

I compiled the themes for each whole transcript and continued searching for connections between emerging themes, grouping them further and providing each cluster with a descriptive label. Such labels identify the essence of the themes, make sense of the original data and bring structure to the analysis (Willig, 2008). The process involved re-organising themes into clusters of concepts with shared meanings or higher-order relations, incorporating more primary themes with descriptive labels (Coolican, 2004). I engaged in a range of proposed techniques such as abstraction, subsumption, contextualisation, polarisation, frequency and function (Smith et al., 2009). I remained aware of both differing and similar categories and aimed to balance moving in close to and going beyond the data. Throughout this process, I referred back to the transcripts and recordings to aid clustering and confirm that interpretations were grounded in the participants' data (Coolican, 2004).

This produced a database of organised themes, together with quotations and references illustrating strong clustering and hierarchy achieved within each interview. A table illustrated the superordinate themes which best represented the participants' accounts. Under each

superordinate theme a supporting theme was listed alongside short quotations, page and line numbers (see Appendix 12). The first transcript was reviewed fully prior to moving on to the next, in line with the idiographic process. The above steps were repeated for each successive transcript and I aimed to bracket prior assumptions as much as possible in order to assess each participant's account fairly. This was difficult at times, as previous observations and themes formed whilst working through each account sometimes came to my attention (Willig, 2013). To counteract this, further digestion of the emerging data was engaged with.

2.7.7. Patterns Across Cases

As the data is assumed to be homogeneous, it was appropriate to look across the group as a whole for further understanding of the phenomenon (Willig, 2008) (see Appendix 13). A core approach was to regularly check themes which surfaced in later transcripts against earlier transcripts (Willig, 2008). This informed me of novel meanings and experiences and manifestations of old themes. I continued to utilise visual approaches such as writing themes on coloured sticky notepaper, which allowed me to more freely move themes between clusters as the analysis progressed.

Thus, to explore patterns across the interviews, I repeated the clustering processes described previously and reflected on the strengths of each theme. Smith et al. (2009) stated recurrence across cases to be significant when considering credibility of findings. They proposed that in a sample of seven or more, master themes can be present in at least a third but do not need to be present in all accounts. This was a helpful guide. Additional strengths were defined by the length of time participants spent focusing on particular topics, relevance to research, and originality of the theme in light of previous literature. This resulted in the identification of overall master themes, representing the experiences and meanings of the group (see Appendix 14). Thus, earlier themes disconnected to the final formation or lacking in evidence were excluded (Coolican, 2004). Moreover, care was taken to minimise researcher bias in the process of identifying themes for analysis (Brocki & Wearden, 2006). This integration led to the development of an inclusive list of four master themes each containing emergent themes. I then expanded the themes into a narrative account presented in the analysis section (Smith & Osborn, 2003). An audit trial is further evidenced in the appendices.

2.7.8. Evaluation of Research

Evaluating research typically involves measuring validity (the accuracy in which a phenomenon is measured) and reliability (the consistency and dependability) of the methods used to gather data (Coolican, 2009). Yardley (2000) stated that such measures are commonly used within quantitative research and less suitable for qualitative. Qualitative methods might not lend themselves well to empirical estimations but seek the same values through methods better suited to human matters (Brink, 1993). Qualitative researchers are more concerned with subjective beliefs, experiences and meanings than laws of causality and truths (Brink, 1993). In quantitative research, validity and reliability are commonly assessed by large representative samples; however, for qualitative research this may result in the depth of the data being sacrificed. Thus, Yardley (2000) proposed four broad values for qualitative research which the present research employed.

The first is *'sensitivity to context'* which requires research to be sufficiently grounded and contextualised in related theory and literature. The introduction chapter reviews the connections to existing research literature and the extent to which this impacts upon the present research is explored in the discussion. The methodology chapter reflects upon the philosophical values within the implementation of the research. I have further shown sensitivity to participants' perspectives through open-ended questions which encourage participants to express what is important to them. In addition, reflexivity and supervision allowed for scrutiny and for me to be mindful of preconceptions (Braun & Clarke, 2006).

The second criterion, *'commitment and rigour'*, refers to the thoroughness of the research and process. Yardley (2000) describes commitment as strongly engaging with the topic beyond the position of a researcher. I have worked professionally with people seeking support with depression and have a partial personal experience. These examples provided the opportunity to fully engage with**,** and gain a deeper understanding of, such worlds. In addition, spending considerable time embedded in the data assisted in gaining closeness to the participants' internal experiences. Yardley (2000) proposes rigour to be the robustness of the data collection, analysis and reporting of findings. I ensured that appropriate engagement and necessary skills were adequately used to competently assess the data. In addition, my counselling psychology training not only allowed me to maintain an empathic awareness towards the individual but also explore depth with an interpretative and curious focus. I further remained mindful of the individuality of the participants coupled with an appreciation for the wider themes within the sample as a whole. Supervision further helped ensure that the data analysed had depth and richness.

The third criterion is '*transparency and coherence'*. The research maintained transparency as I explicitly detail all aspects of the research process and have provided access through samples within the appendices for the reader to have clarity. Utilising a reflective diary allowed me to remain open and further reflect upon the impact of my own interpretations and observations on the data or vice versa. Coherence refers to the unity between the research question, philosophical position and approach taken. These aspects are congruent with each other and the rationales behind them are stated. All the stages involved in the research are documented. In addition, discussing the research with colleagues and in supervision helped me to explore areas which might not have been considered in isolation or which needed further clarity. Whilst these discussions were helpful, revisiting the raw data from the interviews to capture the nuances of what was expressed and of the interpretations made was useful at times where my understanding of what participants communicated differed from that of others (Willig, 2013).

The last criterion presented is the '*impact and importance'* of the research findings. One aspect of this is for the research to offer insight into alternative or novel ways of understanding a topic. The research hopes to offer useful insights for counselling psychologists who work with this client group and provide a voice for those who feel current standardised understandings of recovery from depression may not be representative of their subjective experiences. It is further hoped that the findings can empower those in recovery and enhance wellbeing. Ultimately this research can act as a platform to challenge attitudes and widen knowledge of recovery so as to develop more effective or new approaches towards this area, given the gap in research. The discussion chapter will more closely review the significance of the findings.

2.8. *Methodological Reflection*

Reflexivity is the analytic consideration of the researcher's role in the research process (Coolican, 2004). It involves awareness of what is influencing the researcher's responses, association to the topic area and participants (Coolican, 2004). It requires explicitly exploring how the researcher's own values, experiences, beliefs and wider life may influence the research (Willig, 2008). Reflexivity enables researchers to be mindful of not imposing their preconceptions upon the participants (Finlay, 2002). Moreover, the researcher's response to the data could further uncover useful insights (Willig, 2008). The following section reflects on researcher assumptions carried into the research process.

2.8.1.Academic and Occupational Influence

My initial motivation to undertake this research stemmed from my long-standing curiosity with depression. I conducted past academic research which focussed more on the relationships and effects of depression and I also work as a mental health assistant within psychiatric care. These experiences contributed to and stimulated my beliefs that there are multiple truths, understandings and experiences of 'distress' and multiple ways to approach and recover from 'this'. Nonetheless, I recognised that depression wore many faces and functions which were not always limited to pathology or standardised categorisations. It became clear that what depression meant for the individual experiencing it, as well as how they engaged with it, played a significant role in its process, thus heightening my interest in subjectivity.

My experiences advanced my belief in the complexity and uniqueness of human beings and the importance of integrating models to suit the individual where necessary. I felt able within my workplace to think about human experiences within, beyond and outside scientific observation and was often drawn to acknowledge and challenge normative thinking to identify alternative ways to help those who did not fit within this. Towards the latter end of my counselling psychology training, I felt I identified more as an integrative practitioner. Whilst I often first formulate within a psychodynamic approach, in that I take into account one's past history, I further pull on practical elements of Cognitive Behavioural Therapy (CBT) and utilise holistic values where needed. Although as a *trainee* I was able to engage entirely in one single modality if required, as a *person* I questioned whether one model would always be fitting for every individual. I remained aware of the tensions, but often found that focusing on what might be more useful for the client could help mitigate these conflicts. However, in retrospect, I wonder whether this impacted on my difficulties with being selective during the analysis as I perceived value in all the accounts, which may have made the process much longer than anticipated. It may have also contributed to some degree in the breadth of findings that emerged from the data.

2.8.2.Personal Influence

My interest in the specific focus of 'recovery' was unexpected and rooted in depression finding its way into my personal circle. I then realised that despite my clinical awareness of depression, a more intimate and deeper understanding of its recovery was missing in my knowledge. As I was now more personally close than my usual professional position, I came

against this *ambiguous* and *private wall* which often felt impenetrable. I have named the individual I reflect upon as 'Blue' for anonymity. In relation to this wall, I often thought "how could I help Blue out of this?". When I finally accepted the need to take a step back, I recognised that my fixation had been on *'coming out'* of depression and had not truly considered whether this was Blue's own way or whether *'out'* was even a destination of recovering from depression. However, what became clear was that recovery was more than my knowledge. There was an undisclosed insider relationship between depression and Blue which fuelled me to seek further understanding into the inner world of how people make sense of their recovery from depression.

Following Blue's recovery, I learned that for Blue, the turning point was reaching the absolute painful bottom of depression, wanting to shift this feeling and recognising a purpose in life to be integral for Blue's recovery. However, Blue still expressed some uncertainty within this personal understanding of recovery. Naturally, I am often curious to explore unknowns and complexities; therefore, this inspired me to learn more about this focus which could subsequently assist me in my intended position as a counselling psychologist. I struggled greatly with finding sufficient and specific literature focusing solely on my research topic, which confirmed the disparity between what was out there and what was needed, and emphasised the relevance of this research. Gaining understanding of recovery from depression beyond clinicians' perspectives might produce fuller insights into this experience and offer implications for practice and research.

2.8.3. Impact

In considering the above, I am aware that I bring some assumptions to the research. Brocki & Wearden (2006) reported that IPA acknowledges that preconceptions carried by researchers into the research process can influence the quality of the interview and the data gathered and selected. Although a long time had passed since my more personal involvement with depression, it had an impact on me, as I later became aware of my strong expectation that recovery would have an apparent turning point, as it had with Blue. Despite my awareness of multiple realities, I had anticipated this response and recalled feeling surprised when this was not the case. In addition, my epistemological and ontological position meant that I assumed personal meanings would vary and not necessarily be limited to standardised notions of recovery. Therefore, this may have drawn me into looking for the more complex and philosophical themes, possibly overlooking the plainer or more straightforward findings.

My assumptions may have shaped my interview questions and consequently, contributed to the experiences that participants chose to explore. An example of this can be evidenced in me questioning participants about how they viewed themselves following recovery. This assumed an 'after' period, which may have led participants to think about their sense of self post-recovery, even though this may not have been central to their experience. Perhaps asking a more general question about the impact of being recovered for example, and allowing the participants to reflect on what this meant for them may have allowed for broader insight. In addition, perceiving the possibility of recovery to be a profound experience may have led me to amplify the importance of a weighty world of recovery at the expense of other perhaps lighter aspects. This may have further influenced the decisions made regarding what to address in the interviews, the answers provided by participants, and how it was employed to interpret the findings (Finlay, 2002). However, the research advertisement was explicit in terms of its focus being on personal meaning and experience, which may have helped participants to feel better able to reveal their reflective and subjective experiences. It also may have assisted in establishing personal openness during the interviews and in the findings.

IPA acknowledges that researcher's preconceptions brought to the research process might have a potential impact on the quality of the interview and on the data the obtained (Brocki & Wearden, 2006). In relation to what further extent the interview questions impacted on the analysis, the interview schedule potentially encouraged participants to think more progressively. However, the interview schedule did not present a concrete list of questions and was not strictly followed. In addition, participants were not specifically asked to refer to specific stages of their experiences. However, potential prompts within the schedule associated with a sense of order, perhaps indicating my pre-existing assumption of recovery possibly involving some sense of process. Therefore, I might have been more inclined to notice data relevant to a beginning, middle and end for example. Nonetheless, prompts were only used for elaboration or clarity and prompts listed in the schedule were also reflections of curiosity and at times a note to myself. However, I recognise the potential for such prompts to subscribe the themes elicited in the analysis.

I remained aware of these preconceptions and reflected on them during the research process. I attempted to stay as faithful as possible to the participants' transcripts in relation to my interpretations. My sense of the participants experiencing some loose form of stages emerged from quotations such as, "that was the beginning of the journey back" (Darren 8,

180-182), which implies a starting point, as well as a sense of voyage. Another example can be observed in "when I was at the beginning of the journey I had absolutely no idea where the end was or what it was and it's only as you get through it, you realise…well it's not so much an end…it's a different way" (Linda 19, 666-669). Most participants, without prompting, seemed to convey a sense of course and how they themselves referred to the notion of an 'ending'. Some participants referred to experiences as 'towards the end of recovery', whilst others experienced otherwise. I interpreted that most seemed to refer to coming to a place identified as being recovered.

However, I recognise the interview schedule may have limited experiences shared, although remaining reflective and continuous checking of data helped to gain clarity. In addition, I was able to recognise conflicting aspects and disparities in the themes presented. Similarly, participants shared varied experiences despite the questions suggesting that I was open to responses which contradicted preconceptions. Moreover, I utilised broad questions such as '*tell me about your recovery experience'* which allowed participants space to reflect more openly. I recall a participant responding to this with "where would you like me to start" to which I responded along the lines of "*wherever you would like",* allowing for some flexibility. Therefore, my primary aim was for the participants to reflect on what was important for them, although most tended to refer to their 'beginnings' for example. Thus, whilst interview questions played a role, without prompting, the participants appeared to refer to what was interpreted as 'particular times' of their experiences. Therefore, their responses were reworked into themes, albeit with a sense of sequence.

Additionally, participants appeared to express a sense of travel or moving from circumstances, through to another, or from one way of being towards another. Presenting the analysis in this manner can be reflective of such transitions or loose stages which emerged from my interpretations of their accounts. Some participants described sequential experiences and other times they acknowledged deviating experiences. Nevertheless, a sense of direction, albeit an intricate one, was interpreted from their accounts. Linda's statement, "where is it and when am I going to get there" (Linda, 19, 678) suggests a sense of place or position to get to during recovery. Other quotes such as "I *was getting to that stage where I was close to recovery"* is suggestive of participants' experiences of phases. Whilst the findings are not intended to resemble fixed and exclusive stages, they portray the participants' possible sense of development and/or pathways. Furthermore, transitions can be argued to rather serve as a typology to better identify potential experiences involved in recovery (Ridge, 2009). However, upon reflection, my curiosity may have led me to draw

attention to the participants' expression of stages, or perhaps led them to focus on this. In addition, any empathic response to the participants could have eased the development of the interviews and allowed participants to share these thoughts. Thus, my interviewing style as well as my own subjective context within this topic can have an impact.

Conducting and analysing semi-structured interviews from a hermeneutic position means that I inevitably impact upon what emerges from the data**.** My motivations to give a voice to the participants and my perception of subjective experiences regarding the concept of recovery from the experience of depression being overlooked, may have led me to accentuate nuances and perhaps lean towards intra-psychic themes, potentially missing other insights. It might have further encouraged the type of questions participants responded to. Additionally, prompts regarding metaphorical reflection could be argued to have discouraged participants to reflect on more conventional experiences, therefore impacting the findings. However, I would argue that most participants willingly shared symbolical and unexpected insights. Therefore, having such findings emerge arguably suggests that I was able to be reflective and make sense beyond some of my biases.

Another potential understanding is to perhaps consider that the participants and I, as human beings, can often make-sense of things quite narratively, and potentially we are unable to separate ourselves from following this somewhat embedded approach. A packaged account is perhaps an aspect of reflection at times and sense-making can include creating some form of structure which presents a potential tension. Alternatively, I wonder whether there may have been a subconscious need from the participants and I to provide some sense of arrangement in what appeared a meaty experience of recovery. In retrospect, perhaps I was mirroring their conflict around the experiences of dynamic movement and loose stages. Nonetheless, participants appeared to give the impression of travelling, however this also seemed complex. Therefore, having the analysis present with what seemed novel insights can perhaps be suggestive of the flexibility within mine and the participants' engagement.

My nature and clinical training positioned me to respond empathetically to the participants, however, there were moments where I felt a pull to respond therapeutically and had to remind myself that I was intending to be a *naïve researcher* (Willig, 2008). At times I battled with not wanting to appear '*too understanding'* in order to gain depth, elaboration and insights not blunted by my own assumptions. However, finding a balance at times seemed difficult and initially resulted in me feeling unusually nervous and very formal at the beginning of the first interview. I later realised that I needed to stop over-thinking the

'researcher role' and just be with the experience whilst employing an inquisitive disposition. Once I literally relaxed back into my seat, participants mirrored me. Therefore my own behaviour may have influenced how participants responded to me and the research. As we all began to let go of this sense of restriction, a more organic and uninhibited engagement emerged, and this can perhaps be evidenced when a participant apologised for swearing as she had personally intended not to, yet in the moment forgot herself. More than anything I was pleased that she felt able to express herself freely and bring me further into her *felt sense.* Similarly, where participants felt they digressed this was still valuable for me as I felt I was learning about their characters and perhaps subconsciously they wanted me to know *'them'* as well as their recovery.

Another interesting observation was the unspoken positioning I felt participants might have imposed upon me during the interviews. Although I was an outsider, I felt that most positioned me alongside their experience. I felt from some a sense of curiosity as to whether I had a relationship with depression, as one participant warily enquired post interview. I further felt the '*trainee psychologist'* title made some perceive me as automatically understanding their experiences, which may have impacted on their openness and rapport. Once the interviews ended most were not in a hurry to leave and stayed in the space briefly. There was an after-sense of familiarity in our company, as if sharing their personal stories with me had perhaps resulted in a subtle bond by the end of the interview. This might have impacted on my difficulty to *let go* of some of the data and perhaps let go of this implicit union.

During this research I at times reflected upon which of my identities was engaging with the data. Was I interpreting as *Bridget*, *mental health assistant*, *trainee* or *researcher*? Even the order in which I unknowingly write these identities might be suggestive of how I may view the participants in that the *person comes first*, and may suggest a possible yielding towards the humanness in their accounts. Nevertheless, I recognise that each of these roles shapes how I made meaning of their experiences and that my worldview of people, being multidimensional, could dictate the orientation the study followed. However, I do not discard objective experiences of recovery and understand that these can also represent an individuals' personal experience or reality. Nonetheless, idiographic knowledge is also necessary alongside nomothetic evidence in providing a fuller representation of experiences. Willig (2013) emphasised the importance of remaining aware of preconceptions prior to conducting research and of those discovered during the course of the research. Every effort was made to acknowledge when interpretations were influenced by personal assumptions

and psychological knowledge by keeping a reflective diary throughout the research process and utilising supervision. Continuous returning to the original transcripts helped to ensure that I was capturing participants' experiences and not prioritising their experiences to fit my own perspective. My peers assisted with this as they shared thoughts on some of the data. This was helpful, and looking back, I would have liked to have done more of this. In addition, thinking critically against my interpretations helped with distancing and clarity.

Despite my best efforts, I acknowledge that I might not be fully aware of all my preconceptions in relation to the research and that more may be uncovered through the continued process (Willig, 2013). However, I acknowledge that my interpretations are also informed by my counselling psychology training and that this training could be considered a form of bias. Further, the present findings do not claim to be the true findings and rather are one of the many possible interpretations of recovery from depression.

3. Chapter Three: Analysis

This section outlines the four themes that emerged from an interpretative phenomenological analysis of participants' accounts about their recovery from depression: *Difficulty moving forward*; *Plunging in for change alongside struggle; Reconnecting body and mind*; and *The blemished trophy*. The master themes and contributing sub-themes are summarised below in Figure 1.

Master Themes:	**Difficulty moving forward**	**Plunging in for change alongside struggle**	**Reconnecting body and mind**	**The blemished trophy**
Sub-themes	*Travelling at a snail's pace*	*Holding on to life*	*Coming alive again*	*The mark of the journey*
	Snakes and ladders	*Choosing to move on*	*Overcome by the light*	*The transforming of me*
	Masking the pain	*Having support alongside me*	*Living not surviving*	
		Becoming aware		
		Removing the crutch		

Figure 1: Representation of master themes and emergent themes.

In addition, participants who best summarised (i.e. the most clearly or strongly) what others had also expressed were utilised and may appear more frequently because of this. Quotes from participants have been lightly edited to improve readability. Significant pauses are

identified by the word [pause] and more minor pauses are indicated using ellipses […]. The emerging themes were not always distinct, and overlaps were interpreted to display a complex and multifaceted recovery experience. Moreover, similarities and differences observed, amongst as well as within their accounts, potentially emphasised the intricacy and richness of their experiences, as well as the dynamic and, at times, paradoxical process of meaning making. Theoretical exploration will be reserved for the discussion chapter to keep the analysis closer to the participants' lived experiences.

Pseudonyms will be used throughout and any identifiable information has been changed to ensure anonymity.

3.1. *Master Theme One: Difficulty Moving Forward*

This first theme highlights how the participants realise their recovery experience is not as straightforward as they had assumed and wished it would be. The first sub-theme entitled *'Travelling at a snail's pace'* refers to a gradual pace where participants appear incapable to change this pace. The second sub-theme entitled *'Snakes and ladders'* describes a sense of disarray surrounding their experience. The third sub-theme entitled *'Masking the pain'* highlights the difficulty moving as not fully healed. These sub-themes offer a reflection of times where participants feel they have no control and feel the pace is largely leading them.

3.1.1. Sub-theme One: Travelling at a snail's pace

All participants describe experiencing an overall slow and somewhat monotonous pace to recovery. This lengthiness seems contrary to their initial expectations of recovery, and instead their accounts seem to embody a more arduous and all-consuming experience. Most participants appear concerned with the pace of their recovery. For Claire, who mentioned having a vibrant and eventful lifestyle in the past, this slow and tedious impression seems significant:

Recovery is so difficult to measure because it's so drawn out and because it's so sort of so drip fed […] I think maybe I knew that I was properly recovered when I started my relationship with my boyfriend […] because, I don't think I would have been able to do that if I hadn't been in a state of recovery. Because I wouldn't have had anything to give to another person because I wouldn't have had anything to give myself (Claire Pg. 14, 334-335)

Claire seeks to frame her sense of growth in the context of her ability to have a relationship, thus making recovery seem more tangible. Claire described depression as a barren situation

where she felt drained of life, energy and vigour. Therefore, 'drip-fed' metaphorically might also represent her gaining or receiving small and gradual amounts of some sort of sustenance to survive or her being fed some vitality which she regarded as previously being withheld.
Similarly, Darren recounts the pace he experienced and was frustrated at his slow progress:

I would go even for maybe weeks […] where I would think I was making progress […] or certainly made a little bit of progress and then other weeks where I felt I wasn't, that I was actually going backwards, you know. And that was partly maybe due to outside agencies that were supposed to be helping me, maybe frustration of things being too slow happening. Um, maybe my own kind of frustration at myself for not doing things um and letting things like slip […] the fact I wasn't feeling up to it then obviously they would slip, you know, so there was a lot of juggling going on really (Darren 330-341)

Darren had engaged with NHS services for psychological support whilst most of the other participants had utilised private care due to long waiting lists. Despite these differences, all participants seem to experience a struggle of slowness and not feeling as in control as they would like. My sense from most of the participants is that they find difficulty at times in feeling held back, almost as though slowness appears an indication that they are perhaps feeble. Darren's feelings of helplessness are perhaps intensified by his irritation towards operational factors, which he previously described as 'red-tape', impacting the pace, but there seems also a sense of personal blame. It seems Darren feels there were multiple things he had to balance to maintain his sense of progress.
Conversely, Elisha was more accepting of the slow pace of recovery. She had a long history of depression, unlike most of the other participants, and therefore seems more able to recognise the advantages of moving slowly:

"This last time I found it quite gradual. But because it was gradual, it felt more sustainable instead of having all that immediate […] instead of me putting all that immediate pressure on myself to do well tomorrow. It was like, actually, let's slowly work through this, let's see what I can do to make myself better and what I need to learn again". (Elisha. 30.647-653)

Elisha appears to gain a sense of stability in what seems like a sluggish experience and appears to deviate from an urgency to get 'better'. She appears reflective of the usefulness of taking her own time as it seemed to allow her to re-connect with herself and her needs. Elisha's previous history potentially provided her the opportunity to make more sense of her movement towards recovery.

Jacqueline, on the other hand, initially anticipated a more immediate improvement with her mental health, and felt great unease with the slow pace:

When I took the meds and the day after that and a few days after that it wasn't better, per se […] it was a bit complicated because I thought it didn't […] it wasn't working. (Jacqueline, 3, 76-79).

Jacqueline appears influenced by her conventional assumptions of medication and therefore seems left with a sense of disillusionment. Medication for Jacqueline was a last resort, something she was never comfortable with. She alludes to the medication failing, which perhaps was her also feeling a failing of herself to get better. Her struggle to get the words out perhaps embodied her experiencing obstacles or barriers in this experience.

There seems to be a sense of feeling somewhat defeated with some participants, to varying degrees, potentially suggesting an element of stigma or shame around how long it can take to feel better. It could be that the participants' initial needs to get better quickly might arise from potential western norms and expectations. However, Elisha summaries a uniqueness of this particular experience, also shared by some of the other participants:

It's perceived really badly because I mean especially with mental health, people automatically think of drug addicts connotations of the language and stuff like that, but I guess people haven't got the awareness or haven't experienced the situation of depression like clinical depression rather than everyday depression. I don't think they can fully comprehend or understand what recovery is and why it takes so long. If you had the flu you can have weeks and get better but you can have a breakdown or episode of depression and it can take years to get back from that, you know what I mean? There's no timescale or a box that someone can fit in to."- Elisha 7, 128-138.

There also seems a disapproval against the expectations of others to move more quickly and this may heighten the experience of slowness. Elisha seems to imply that it is more helpful to consider the impreciseness of this experience and normalise lengthy experiences.
Some participants described going through some form of stages rather than recovery happening all at once:

I'm a very sociable person and I love to give and very loving kind of person. So fortunately when I was unable to sustain those relationships they sustained themselves um throughout

my sort of black period. So when I was sort of able to come back, I was welcomed with open arms and you know, very supportive, which was lovely. And so that kind of recovered first. And then I had work, which in the beginning was very very difficult, but slowly but surely started to get a little bit better and I started to get a little bit more switched on with that. And then my relationship started, which was which was great but I think it kind of came in those, sort of, I guess […] in those kind of sort of stages. (Claire pg.16. 366-389).

Claire, who had described her experience of depression as 'dropping out of the world' seems to experience a phased arrival back into the many facets of her world which seem of value to her. Participants appear to experience different phases of development which are not fixed but feel personal to aspects of their lives, and shaped by their social and environmental circumstances. In the case of Claire, she describes her social life recovering first, as this was already intact and therefore felt less difficulty re-engaging with this aspect, in comparison to her employment, which had been strenuous for her and perhaps required more mental effort, which took time.

Overall, recovery does not appear to simply involve the absence of despair but possibly involves the salvaging of different aspects of lives, which was the case for all participants, and perhaps requires greater time and energy. There seems a progressive element to the participants' experiences which appears to add to their experience of lengthiness.

3.1.2.Sub-theme Two: Snakes and ladders

All participants describe degrees of fluctuation and many setbacks in times during their recovery. Like other participants, Darren appears to recognise that going forward also involves moving backward:

Occasionally during that recovery, um […] it's a bit like snakes and ladders. You sort of go forward three and you go back two […] you know. And you're just doing it in little bits, there's no kind of like straight path towards […] the top, you know, and yeah, it's not an easy […] it's not an easy journey. (Darren…)

I interpret Darren's association to '*snakes and ladders'* as a portrayal of experiencing both a sense of encouraging and disappointing fortune in what he, and others, allude to as an unconventional experience. Symbolically the *'snakes'* might represent a twisted side where a degree of threat and obstacles are painfully experienced within his recovery. Darren reported having to battle with feeling dispirited in mood and struggling to maintain a sense

of steady progress and control of his wellbeing. However, he also acknowledges only partly waning, possibly implying that despite fluctuations he still perceived himself as recovering. He does not seem completely discouraged by setbacks as his reference to a *'ladder'* perhaps depicts his sense of opportunity to escape or rise above his turmoil. The ladder seems pertinent for Darren as he referred to depression as being trapped underground, therefore to escape perhaps involves a difficult pursuit or climb. For the participants, it seems their sense of direction towards their sense of wellness is not without struggle.

Similarly, participants describe a sense of perplexity and messiness within their experience:

It feels like it's um [pause] it's a process, it's such a process, that you can't see when you are bad and when you are getting better because it's long. But at the same time there are moments when you know there was a […] a switch moment. There was this moment, and this moment and it's so I don't think it's linear, I think it's a lot of lines that intertwine themselves. (Jacqueline 14, 400-404).

Jacqueline seems to convey a sense of overwhelming chaos which seems to heighten a sense of ambivalence in the process of getting better. Jacqueline had described depression as obstructing her vision and taking over her thoughts. Perhaps this made it difficult for her to gain a sense of clarity. Whilst there seems a sense of helplessness, she also acknowledges experiencing fleeting and sudden glimpses of hope, but suggests a difficulty in holding on to hope. However, the excitement in her tone of her voice during this description seems to exemplify how meaningful these moments are. Participants suggest that getting better was a changeable and at times uncontrollable experience, that looking for a linear way forward, a destination or turning point, might not always be possible. My sense is that for these participants, getting better does not seem dichotomous and is largely emphasised as an ever-developing and all-encompassing experience.

Most of the participants seem to underline the unpredictability within their experiences, beautifully captured by Claire:

Recovery is never a straight line – it's going to wobble. It's gonna shift and it may take you in into directions that you were not expecting. (Claire 37,842-844).

Claire appears to suggest experiencing a greater complexity than she initially anticipated, and she wants to get this message across. Recovery might be experienced as something that cannot be entirely prepared for, and that accepting what seems like for her an inevitable

level of vulnerability perhaps is important. The uneasiness in her tone of voice further heightens her sense of emotion behind this realisation.
Whilst Claire describes what seems like a broad experience of instability, Linda refers more explicitly to experiencing emotional instability during her recovery and a sense of not trusting herself as well as her experience:

I could seem to be perfectly OK one day […] the next day I would be suicidal, that might last for a bit, then I would be in […] in a more positive frame of mind and literally but there was no pattern. (Linda, 4, 118-120).

The contrast between '*perfectly OK'* and '*suicidal'* feels particularly tormenting for Linda, and she gives an impression that feeling better may not necessarily always involve feeling safe. She describes her mind-frame as unpredictable as at times she feels in control of her life and other times feels hopeless. Her slightly flippant and contrasting *'that might last for a bit'* might be her attempt at normalising what seemed like an unsettling experience.
Linda highlights how the reaction of others can further heighten a sense of herself as unstable:

It was a really rocky journey and [pause] for the people working around me didn't understand my state of mind and what support I needed, and it made it just a horrible, horrible time. (Linda, 3, 103-105).

Linda reports a lack of support from her workplace at the time regarding her mental health and felt abandoned, judged and aggrieved. It is possible that she associates her experience within this context and therefore perceives her journey as un-containing. I wonder whether Linda also feels she abandoned herself, since she too did not know what help she needed, and this possibly felt frightening.

3.1.3.Sub-theme Three: Masking the pain

Some participants describe times during their recovery where they have to draw themselves back as they feel unable to fully engage themselves into the demands of life. Some recognise and accept that despite striving to move ahead they were still hobbled by a sense of pain, making it difficult to move through life:

It's like I built this sort of, ah I don't know, like this sort of mask, ah I don't know, thinking now sort of this suit, like a robotic suit, so that I could kind of walk through the world […]

again. It's something that would protect me and that I could sort of be amongst people again […] but I think more sort of inside I was still very raw and red […] and you know […] very vulnerable […] and very kinda fragile […] (Claire 9, 202-208).

Claire's metaphor of a robotic suit possibly portrays a desire to harden, protect and conceal her fragility. Claire mentioned feeling pressure in relation to her famillies expectations of her recovery, which is also shared by other participants. There seems an element of pretence or persona some feel they have to adopt to be perceived as 'recovered', despite times where they still feel bruised. Claire describes an internal *rawness* and *redness,* suggesting a painful tenderness, a seething from within, and possibly implies that she felt unhealed particularly in beginnings of recovery. The adjectives *'red'* and '*raw'* can depict a gory feeling of recovery and perhaps this is how she experienced herself at the time. She appears to describe a longing to be invincible. I felt a magical and idealised tone in her speech, perhaps implying that this is an unrealistic expectation of herself as she realises she cannot move far whilst wounded and it is to take some time.

Most of the participants initially attempt to keep up to pace with their worlds but keep falling behind and having to realise their limitations. However, Chantelle describes a cautiousness in relation to re-engaging back in her usual schedule and implies that she was learning to self-care.

I would have to be a bit careful with myself […] I was still quite fragile but […] and try to use my energy sparingly. (Chantelle, 20,621-62).

3.2. *Master Theme Two: Plunging in For Change Alongside Struggle*

This theme relates to the participants' descriptions of the various ways they attempt to delve into overcoming depression and speak of possible tensions coupled with this. The sub-theme entitled *'Holding on to life'* illustrates participants feeling they have to grapple with some challenges to get better. The sub-theme entitled *'Choosing to move on'* reflects participants' attempts to gain their own sense of power over their wellbeing. The sub-theme entitled *'Having support alongside me'* portrays a need for additional support in overcoming their distress. The sub-theme entitled *'Becoming aware'* describes participants gaining insight into themselves in relation to their mental health. Finally, the sub-theme entitled *'Removing the crutch'* describes participants connecting with rather than evading their sense of pain.

Overall, the themes offer an interpretation of the multiple means participants appear to seek change in their situation.

3.2.1.Sub-theme One: Holding on to life

Several participants seem to experience the testing of what appears to be their sense of endurance and perseverance:

Some days it was really, really tough. But the one thing I said to myself was: 'Just hang on in there'. […] You know, no matter how bad it gets, no matter, you know, how emotionally exhausted you feel, you want to just go into a corner and cry or whatever, just hang on, you know, tomorrow is a new day, you know, you never know what's going to come'. So that was sort of the one thing that was keeping me. (Darren, 11, 377-383)

Most of the participants give the impression of giving up on life during what seems like the depths of their distress. Darren's account seems to convey his mental and physical exertion and willpower to continue through his sense of emotional turmoil and temptation to withdraw from this, as he had done in the past. However, the sense of him *hanging* is significant as Darren, along with a few other participants, describe their experiences of depression as slipping further or falling further into darkness. Darren appears persistent in what seems like a fight for his sense of life, as letting his hold go perhaps would result in a collapse. Thus, hanging on appears to keep them at a distance from this sense of threat, perhaps for Darren, he was determined to no longer be intimidated by what seemed like the suspense of recovery. Darren seems to shift from hopelessness, something which was previously difficult for him to do and perhaps instead, experience a sense of hope in uncertainty. There was a sense of courage, passion and encouragement in Darren's tone and content. His repetition in speech brought to life a sense of intensity or perhaps the apprehension he experiences within this struggle. His shift to the present tense drew me in closer to his experience, and I recall getting goose pimples on my skin. When Darren changes from first person to the second person it seems like he wants to bring to life the mind-frame he connected with to reassure him of his certainty of survival. Interestingly, he then ends with uncertainty of what the future holds, perhaps portraying that he experiences both hope and doubt co-existing together. I feel both emotional and enthused by his response which leads me to wonder whether such feelings may have helped Darren ignite his determination. Linda further alluded to a sense of rebelliousness in her persistence against her struggle. Her account conveys her sense of endurance and recognition to work with the experience rather

than against it, which might be her way of accepting a degree of uncertainty and distress but refusing to be overpowered by it:

I'm probably quite stubborn and I just kept persevering and that no matter what shit was thrown at me, we dealt with it and moved on and there were times when I thought, I don't know how this is going to work out, I've just got to go with it. (Linda, 26, 934-939).

How participants seem to respond to their challenges seems significant, perhaps as participants allude to previously feeling engulfed and somewhat paralysed by what they experience as depression. Linda's account is evocative of her appearing to gain dominance over her experience and herself which also seemed reflected in her defiant and gritty tone. She further expresses having shit *thrown* at her, suggesting an aggressive struggle. Though the firmness of Linda's facial expression reiterates her personal grit, I could not help but wonder whether such sturdiness masks a sense of fear; a sense that was later confirmed when she expresses having periods of uncertainty and perhaps echoed a protective layer. However, despite this, she remains willing to get her hands dirty (*'shit'* in a sense) and graft to survive.

Conversely, Claire appears to suggest that she committed everything she had to understanding her recovery and this personal devotion made the difference for her:

I just committed to it wholeheartedly. I think I put in so much energy and time to thinking about it and wanting […] not necessarily wanting it, but wanting to try my best, to try my hardest, not for a fast recovery […] that was never the goal […] to do it in a certain time limit or anything like that […] to really understand recovery fully. I just committed so much time and energy to it I think that's really why I did. (Claire, 44, 1007-1014).

Claire's repetition of *'time and energy'* suggests how much she felt this experience needed and pulled from what seemed like all of her. It could be suggested that Claire perceives herself as giving her life, or perhaps her soul, in an exchange for something hopefully better than what she has been enduring. By *'wholeheartedly'* giving herself, she implies a need to be emotionally and compassionately open to this experience. Claire's account alludes to her seeking for what seems to be a more meaningful and deeper depth of recovery rather than what she considers to be superficial levels.

Whilst Claire seems to make sense of an emotional drive and potentially a level of faithfulness, Elisha addresses what seems like an intellectual self-conditioning to help motivate herself:

It had to be OK so it was like the other way round, so instead of it being kind of like, you know, that optimistic drive […] it was like […] there isn't any other option […] [laughs] ah, and [pause] yeah, no that was the only option. (Elisha 30, 848-851).

Unlike the other participants, Elisha seems to be convincing herself of the conclusiveness of getting better by seeming to enter an inflexible mind-set where doubt seems forbidden. Elisha alludes to being quite a methodical and somewhat pragmatic person and perhaps engaging in this mindset was reflective of her character. I also wonder whether her moment of pause was a slight questioning of this mind-frame.

3.2.2.Sub-theme Two: Choosing to move on

A profound theme amongst all participants seems to point towards a feeling of great responsibility and a sense of compulsion to take charge of their own wellbeing, and perceiving themselves as having the decisive role in this experience. That is, in some ways recovery from depression felt like a choice. All participants appear to express a desire to self-initiate change, particularly as most describe their experiences of depression to have weakened their sense of significance.

Chantelle appears to stress the importance of her own role, and a rejection or perhaps inadequacy of anyone other than themselves being able to make a change:

It has to come from you […] it has to […] no one else can get you better but yourself; you have to make the decision to want to get better. (Chantelle, 26, 833-835).

There seems such sturdiness and conviction in her tone of voice as she appears to emphasise this solitary experience, and perhaps it seems an experience she feels one cannot be passively engaged with. I recall feeling initially conflicted with this sense of pressure and ownership for getting oneself better. I wonder if this would become burdensome for those who may feel unable to independently help themselves. I sense a degree of harshness and forcefulness in her account, almost as though she was displaying tough love which may have been what she needed to perhaps fight through. As this theme continued to surface amongst others, I later interpreted that this adoption of assertiveness might be useful or needed for these individuals to motivate themselves to dig deep for something which, according to some accounts, seems described as 'within' the person at times. Perhaps attempting to take control of their own wellness is a way for participants to recognise their capabilities and self-

worth. Nonetheless, some participants give the impression that they experienced themselves as having a choice and the notion of mollycoddling oneself is not an option.
Gloria appears to contemplate the notion of '*wanting'* to get better and further alludes to an experience of choice:

I suppose wanting to get better […] if you didn't want it to happen then you would stay in that situation where you will be depressed all the time but, ah, I didn't want to be unhappy. (Gloria, 14, 440-44).

She implies there to be a possibility to have a slight preference and neediness for melancholy as opposed to recovery. Although this might feel initially contentious, I feel Gloria was rather hinting at what she might experience as the enticing or protective function of depression, perhaps becoming afraid to embrace recovery. For example, recovery for her and other participants, seems to involve facing something unfavourable and unfamiliar in comparison to the individual's intimacy with their experience of depression, which may be serving a personal purpose. Gloria's account could have been suggesting that change occurs when the pain of staying depressed becomes greater than the pain of recovery and/or change.
Whilst Gloria appears to make this *decision* with ease, a few others seem to experience this as more complicated and, feeling unable to assume such responsibility, some appear to understand this as a sense of personal inadequacy:

Because I would have thought that the problem with depression is that it's not that you can't get better, it's that you don't want to get better because it's too difficult and you're just so tired, it's just […] to get better you have to do something and the definition of depression is that you can't do anything, you just […] it's too difficult to do anything so I was feeling guilty because I knew that it was part of […] of my fault if I couldn't get better (Jacqueline, 6, 135-140).

Jacqueline captures the negative impact of this *wanting,* whereby feelings of blame and guilt towards herself for feeling unable to influence her ability to get better emerge. She perhaps challenges the notion of recovery as something strived for simply through personal action. For her, it seems more complicated. Her account depicts her experiencing personal struggle, contradiction and helplessness. She appears in turmoil with her subjective feelings and her understanding of perhaps the more pathological connotation of depression. Her description of exhaustion and repetition of '*difficulty'* and *'can't'* portrays a 'stuckness' and a challenge to gain what she seems to frame as inner strength and agency. I wonder whether Jacqueline

feels unable to do anything or whether she had adopted these thoughts because they were clinical definitions of what she *should* be feeling, particularly as she has an academic background which involved psychology. I interpret that the desire for her to take ownership of her wellbeing overall feels stressful, perhaps suggesting that it is not always possible.

3.2.3. Sub-theme Three: Having support alongside me

Whilst there seems a strong yearning from the participants to experience their own sense of power and responsibility, it also appears that this was difficult. Their sense of strength also appears to be influenced by experiences they perceive as being external to them.
A few participants share the desire to relinquish responsibility and pressure to the hands of what I interpret as a 'magical otherness' to anchor them so that they feel more secure in their attempts at 'getting better':

You want to get better, but you want someone else to get better for you. It's this kind of feeling like you want a fairy godmother to come around and just make you feel better. But you can't do the first steps, that's what I said to my doctor actually because he was feeling a bit worried about giving me medication. But I said to him 'Look, I know I could get better and if […] I'm […] if I'm standing up I could start running to get better but I need someone to take the first step for me because I can't do it for myself, I can't anymore' (Jacqueline, 6, 149-155).

Jacqueline describes desiring assistance or a greater influence to help empower herself in times where she is trying to overcome the struggle but feels she could not do so alone. Her yearning for someone to take the '*first steps'* or help her to *'stand'* alludes to her need for support or a kick-start. Perhaps she is afraid of falling back into what she experiences as dark days. This could also portray an inability to look after herself or take responsibility. Perhaps recovery for Jacqueline, and some of the other participants, seems to be about discovering autonomy and believing in oneself first. However, it can be interpreted that Jacqueline's feeling was that of personal failure. In this moment, I feel pulled to reassure her or perhaps 'lift her up' as she wanted, but I also recognised just how much personal mastery seems to mean for participants, and how much it appears to be embedded in how they perceive and experience themselves.
Most of the participants seem to experience this support within the context of having a sense of encouragement, something to help them feel able to push through. However, for a few others, this also came with a sense of dependence which felt disempowering.

Darren's account seems to encapsulate the power and experience of feeling cared for and not deserted, enabling him to feel safe enough to work through his difficulties. His account conveys a feeling of warmth and compassion which perhaps seems to soften his sense of struggle. This experience feels poignant for Darren, particularly as he had reported past experiences of isolation and bereavement. Darren's tone of voice is heartfelt; the support he received from his GP rouse a sense of self-worth, which seems to increase his belief in his ability to progress, and may have provided a secure foundation for him to move forward and heal:

The one thing I kind of […] I did realise was that I wasn't alone, you know. The fact that my GP actually cared, she used to call me up once a week if she hadn't seen me, you know, 'Are you OK? Where are you? You haven't been in […]'. She made sure that I was coming in every week to see her for an update and I was having the counselling so I felt, 'Well, actually I'm not alone in this, you know, there is somebody who actually gives a damn', and that actually I suppose gave me that little bit of optimism to […] to kind of work on, you know. (Darren 12, 328-332).

Recovering for these participants might involve a sense of belonging, connectedness or a need to feel a sense of solace in a space that can often feel quite unsafe. This sense of meaningful connection appears valuable to the participants, and particularly for Darren, who appears to need a compassionate relational encounter which would affirm him at a time where he had also felt abandoned by others in his life. Most of the participants find it difficult to speak to family and friends about their struggles, feeling there to also be a lack of understanding, therefore professional support seems to be another pathway.
Darren further refers to using a more spiritual stimulation where he connects with his father's voice, with whom Darren had been close until he passed away, to help motivate him recover:

I always had his voice in the back of my head, kind of pushing me on. (Darren, 38, 1026).

This again reiterates the idiosyncratic ways people might cope during recovery from depression, particularly as Darren mentions his disengagement with his church, and his feeling that the loss of his father and the circumstances around this sparked his anguish. Darren's account perhaps gives the impression that he needs some influence, something which feels meaningful to him and gives him a sense that someone was looking out for him, as he possibly feels unable to do this alone.

Elisha captures the experience of a mutual feeling of trust, whereby equality and humanness in the therapeutic relationship with her therapist appears to help her recognise her capability to recover:

She was really funny. She gave me some of the books that you would kind of like teach from and she said read these because I like to know the theory behind it […]. I liked that kind of like thing so she was really positive and worked really well with me. (Elisha, 44, 958-963).

Elisha smiles as she recalls this time, conveying a sense of warmth and contentment. It appears that the therapist's belief in Elisha and her ability to connect more personally to Elisha as a person seems integral to stimulating her recovery and sense of self. It can be suggested that perceiving and connecting to someone as a human being, and not simply a professional, seems important in the experience of moving forward for some of the participants. In addition, Elisha mentioned a resistance towards counselling or overly explorative therapies and sought a more personal supporter.

Whilst participants appear to seek engagement from professionals, some also indicate a need for individual differences to be recognised by professionals. Jacqueline highlights how support can also be experienced as a hindrance and for her it appears to perhaps be soul sinking, particularly where a professional's perception of recovery might not be synonymous with the individual's experience:

If a doctor or whoever, whomever in the health profession says to someone who has depression that they have to get better or they can't get better, it's another way to tell them that they're supposed to get better and they are not. So, yeah, every time for me, if every time I see you it's 'you are going to get better' and I wouldn't get better, I would just […] it would bury me even deeper. (Jacqueline, 36, 999-1005).

Jacqueline's account suggests that she experiences an overwhelming pressure to recover based on the professional's expectations and normative assumptions which do not appear to meet her experience. This appears to feel somewhat disheartening and unhelpful for her, since her own experience contrasted with their predictions. She refers to not meeting these expectations as being '*buried deeper',* perhaps alluding to a sinking feeling of hopelessness. Her account hints at the possible complexities between different understandings of recovery and further strengthens the importance of being in tune with, or perhaps beside, the individuals' subjective experiences.

Medication, which some participants consider as another form of support, seems to have a disempowering effect for some of the participants. The use of medication for these participants appears to threaten their perception of themselves and they seemed to experience a conflict, a sense of self-value diminishing:

I felt, well, if I did manage to get better, it wouldn't come from me so it wasn't a victory for me if I were better so it was very, it was very difficult. (Jacqueline 6, 160-162).

Jacqueline conveys experiencing feelings of defeat and pain, as well as resentment towards medication, which she seems to feel has confirmed her own personal inadequacy. It seems that for Jacqueline, she experiences medication as halting her from feeling worthy or triumphant in helping herself to get better, as she does not feel it is down to what she perceives as her personal and natural ability. I again wonder whether Jacqueline's academic background in psychology impacts on her difficulty to see herself as someone in need of clinical help rather than being the helper herself. In the past, Jacqueline has engaged in holistic or alternative therapies and resisted medicalised treatments, preferring what she perceives as natural resources and possibly less stigmatised. It can be assumed that for Jacqueline, a non-medical approach gives her a sense of power and perhaps shifts her from an illness narrative. According to Jacqueline, this conflict results in her initially not taking her medication, which she had previously reported as leading to further deterioration in her wellbeing.

However, later in the interview, she returns to contemplate whether medication had had a placebo effect, or whether it was through her own mental will that she became better:

It was knowing that I was taking […] something that was designed to make me feel better, it's scientifically proven that it would make me better so I'm not sure if it was the medication that worked […] or me knowing that I […] I will get better off it. (Jacqueline 26, 719-722).

Reframing medication seems to allow Jacqueline to feel secure and satisfied about her personal abilities and regard herself as having some power over her sense of wellness, perhaps soothing her sense of failure. Thus, I would speculate that it holds great meaning to her sense of being that she experiences recovery through what she experiences as her own mastery and 'intrinsic means'. By framing medication first, within a medical context, and then challenging this, perhaps suggests the potential tensions between different contexts. This seems pertinent for Jacqueline as someone with lived experience as well as someone who also seems influenced by her academic relationship with psychology and medicine.

Elisha reports similar conflicts however possibly within the context of having had a longer-term reliance with medication due to her experiencing what she referred to as a long history of depression:

Medication is one of those things where you have to take it when you can't do it by yourself, you know what I mean? There's that double-side edge, something that I'm really working on at the moment to kind of get out of that mind-set. (Elisha, 47, 1020-1023).

Her account appears to convey a sense of her surrendering and an acceptance of her perceived limitations in quite a matter-of-fact manner. Her reference to a '*double-side edge*' implies a painful downside regardless of whether she takes her medication or not, this seems an ongoing process to work through. I feel a sense of weightiness or difficultly with this acceptance.

3.2.4.Sub-theme Four: Becoming aware

Participants share that gaining insight about themselves and their circumstances as being pivotal in their experience of their recovery from depression.
Elisha seems to emphasise the gravity of gaining self-awareness and becoming conscious of what might be helpful or harmful to one's life and recovery:

Being aware of who you are and what's available to you and understanding fully what encompasses mental health issues really helps you understand how to get into recovery and be recovered. Because realistically, if you don't understand the things that you do that are linked to your mental health issue, you can't ever quite be recovered. (Elisha, 52, 126-136).

Elisha suggests a lack of self-awareness potentially leaves one vulnerable and makes sense of this as having a superficial or partial recovery. Her reference to *'getting into'* recovery may depict her experience of immersing or going towards the depths of what she regards as recovery, or perhaps having courage to look at her pain instead of waiting for the experience of recovery to welcome her in. She further seems to place value on what she perhaps perceives as an intimate knowing of oneself and the role 'you' play in your own mental health.
Most participants appear to frame their understanding in the context of discovering themselves for the first time in recovery. For example, Elisha implies a sense of starting from scratch:

A lot of it was about learning who I am and how I can […] what I can do to be the person that I want to be, instead of […]. Whereas someone that may have a good mental health for a long time is learning to go back to that - I didn't really have that to go back to […] umm] [laughs]. (Elisha, 704-70).

Elisha conveys a willingness to establish her understanding of what she considers as her identity and valued sense of self. That is, she is seeking the *'person'* beyond her mental health issues. For Elisha, recovery appears to involve self-development rather than a return to what once was, since she seems to be suggesting that, for her, there was no 'healthy past version of self' to retrieve. My sense was that for Elisha, in her past she never established a secure sense of herself. Her recovery experiences appear to involve what she seems to allude to as a search for an unknown or uncovered sense of self. However, Elisha's realisation of not having a returning point, and the subsequent impression of being lesser than those who do, conveys a subtle sadness as she pauses. The laughter that follows felt like an attempt to rescue herself from any despair or sense of failure this absence evoked in that moment. It could be assumed that for Elisha, this experience was about understanding a new way of being, rather than going back to how things were.

Jacqueline's account, in contrast, shows how her 'academic' understanding of depression possibly blinds her from recognising her own vulnerability:

It took me a while to notice because I […] I did psychology so I knew […] how it was going to happen and what were the signs. But it was like, um, there was a difference between knowing and knowing about myself. (Jacqueline, 1, 16-18).

Jacqueline's account suggests that from her experience, depression isn't simply a cluster of symptoms, but instead was fundamentally about her sense of self. The key within this context seems to be the idea of knowing herself personally, which she implies might have better protected her against her distress. I felt Jacqueline's reference to *'psychology'* might be her indirectly communicating or possibly warning *me* that we can all be stalled by theory or general knowledge about an experience. As such, knowing herself beyond theory and what distress personally means for her seems to facilitate her experience of recovery.

Interestingly, on a more emotional level, participants became more aware that self-care for them also involves sensitivity towards their suffering and themselves, which had, until that point, posed great difficulty across participants:

I'm trying to be nicer with myself because I think part of why […] why I felt so bad, why I felt […] I fall […] fell […] so quickly into depression was that I had so much expectation of myself. (Jacqueline, 33, 904-905).

The majority of participants understand that they need to learn self-compassion; a resource that appeared, by and large, unused and unknown up until then. Jacqueline captures willingness but also seems to struggle with being compassionate with herself, as though this is forced for her and requires effort. Her confusion of words *'felt', 'fall', and 'fell'* perhaps offer an insight into how she was negotiating between her present and past feelings of disintegration. The reference of *falling* into depression can convey her experience of a loss of balance with herself, but might also suggest a sense of hurt, unkindness and destruction. This paradoxical account of both kindness and harmfulness towards oneself portrays a sense of dualism in her experience, but might also depict the self-soothing of an inescapable pain. I also wonder whether the repetition of '*I*' implies her feeling responsible for what she experiences as her fall/breakdown and so now feels responsible for her self-healing, as Jacqueline had mentioned some personal guilt around how depression, financial costs for therapeutic support and the impact her distress had on others. Perhaps her account is suggestive of the possible underlying sense of guilt which can still be experienced whilst getting better, and the need for one to be nurturing and less punishing towards themselves. This narrative of compassion appears to be an act of healing for the participants.
Jacqueline later put into words what many of the other participants report to be feeling regarding becoming more compassionate with themselves:

It's like a cocoon for me because it's made me able to distance myself from guilt I can still feel sometimes. (Jacqueline, 34, 929-930).

A *'cocoon'* can capture a feeling of self-containment and reassurance, which possibly swaddles her and others against the difficult feelings that might resurface during recovery. Participants appear to be hinting at becoming more aware of, not necessarily painless, but healthier and more loving ways to regulate their affect. However, I also wonder whether the cocooned armoury portray the participants experiencing a part of themselves that want to remain naïve or oblivious to sufferings, whereby covering oneself away resulted in a degree of sightlessness, maybe avoidance. Since recovery, to some level, is understood by most of the participants as possibly leading to more pain and experiences of yet more complexity, perhaps there was also an element of fear involved. Nevertheless, gaining increased insight

into oneself appears to serve as a protective function against distress for the participants and seems to provide momentum for dealing with their recovery.
Participants appear to gain some sense of security which perhaps helps them move from a place of knowing to a place of deciphering their pain.

3.2.5.Sub-theme Five: Removing the crutch

Several participants describe ways of evading or disconnecting from their emotional pain in some form as a way of coping. However, as highlighted in the previous sub-themes, they realise that working through and reflecting upon their distress is needed. Thus, participants become more open to their pain and are aware that this suffering is a necessary part to getting better. Participants seem prepared to unpacking the depths of their distress, the perceived unknown of recovery and build emotional strength. They further describe pacing and slowing down themselves, perhaps to more fully experience and work through their pain.
Darren displays a sense of courage as he exposes himself to his pain; he gives the impression of feeling unarmed:

It was only after about sort of four or five weeks of taking the anti-depressants, and the counselling, that I just completely cut the alcohol out of the equation completely. Which was not easy to do […] because I didn't have that crutch anymore, you know. I had nothing to kind of ease the pain as it were, you know, take the edge off things (Darren, 7, 231-236).

For Darren, as for others, there is a sense of having to prepare and perhaps brace oneself to experience the fullness of their pain. His reference to *'cut the alcohol out'* gives the impression of Darren denying himself his previous weaponry of numbness. The absence of '*that crutch*' implies that Darren had nothing to alleviate pain or block it from his consciousness; in other words, being with and accepting the pain possibly was a form of healing. Although this might illustrate a sense of vulnerability, it also suggests a readiness to *cut off* his armoury and experience the pain in what he regards as its entirety. Perhaps this is a way for him and others to value their own self-protection and capabilities. A few of the participants do not feel strong enough to manage their difficulties without something to help numb the pain, such as over-eating or alcohol, although recognise that this, in the long-term, is detrimental.

Whilst Darren appears to go forward towards pain, Linda appears to decelerate and regress into her depths. Progression for Linda seems to entail going backwards first to advance her recovery. In fact, for many participants, making some sense of their distress, and not blindly going forward and perhaps shelving what some feel that they knew needed to be unpacked, feels pertinent:

It was interesting for me to understand […] and I can now see why I do certain things […]. It was psychodynamic, where you go back to what is the deep-seated problem, whereas some therapists don't cover that at all; you just move forwards. Um, but I suppose I felt there was something there, because of the history that I'd experienced (Linda, 31, 1082-1088).

Linda seeks to connect and explore her past, since this is where she felt her experience of distress and answers for concerning her wellbeing lay, reiterating the legitimacy of subjectivity.

Claire similarly recognises a need to go beyond what she perceives to be a superficial surface. She seems to experience a revelation regarding her needs when she places value on her own subjectivity. Such a breakthrough transcends what was suggested by her health professional - she needs to reach the depths rather than avoid it:

His [the doctor] solution was, umm, Citalopram *and, you know, just take this and take some time off and you will feel fine. Whereas in my mind I felt no, no, no, this runs deep […] this runs deep. I need to talk to somebody about this and I can't talk to my family. (Claire, 22, 501-506).*

There is certainty and conviction through her tone and repetition of *'no'* as she connects with what could be considered as her felt sense. Her reiteration of *'runs deep'* suggests an awareness of her own suppression and further portrays an ongoing gravity and a longstanding existence of what she seems to experience as an 'internal' distress. She alludes to the need to securely confront and voice her experiences rather than perhaps medicate or silence what she frames as some sort of internal heaviness, as she had previously described depression to mute her. There seems a need for some participants to ultimately experience and explore what they perhaps experience as deep-seated conflicts instead of avoiding the pain. For most of the participants, dialogue and making sense of their pain, not simply medicating it, seems integral. For Claire, and a few other participants, there was a sense of discord in the way others assumed what they needed, i.e. that masking the pain will be enough. My sense from Claire and others is that their pain is not to be stifled any longer, as

the participants perceive experiencing their pain is an important part of their recovery from depression.

Darren expands on pacing and alludes to being in the present moment. He refers to trusting the unknown and implies that too much anticipation protects one from a discomfort that needs facing and perhaps restricts what he regards as the spontaneous evolution of change:

Take it one day at a time, not to look too far down the road, maybe a week ahead, three or four days, but don't think too much of the bigger picture. In some of these cases, the bigger picture takes care of itself. You just have to get from where you are to there. And things happen along the way, which I said, might surprise you. But be open to it, because if you're open to it, it will come in […] and it can change things. If you're not open to it, you just completely shut yourself off; nothing's going to change. (Darren, 29, 992-1102).

He describes the necessity of being receptive to an unknown, to change that which might be frightening and shocking but needed. There is a sense from his account of allowing oneself to be vulnerable and further flexible to adapt to what feels like the unpredictability of recovery and perhaps life. His account and tone of voice is that of reassurance; perhaps he was advocating for trust in the recovering person and an ability to simply "be" in the experience.

3.3. ***Master Theme Three: Reconnecting Body and Mind***

In describing what it felt like to no longer endure what most construed as a vacuum or lifelessness, participants spoke about the beginnings of reconnecting back into aspects of their lives. From their accounts, there is a sense of regaining life, purpose and security in a world that previously felt barren and hopeless. Most participants had previously described feeling isolated, not able to connect or seeking to escape from the world. Overall there is a strong theme of aliveness and appreciation of life. A common experience for all participants seems an awakening and/or emancipation from the depths, which the sub-theme entitled *'Coming alive again'* portrays. The sub-theme entitled '*Overcome by the light*' further describes a release of burden and experience of joyousness. The final sub-theme *'Living not surviving'* describes the participants' sense of fulfilment and peace. As several participants previously felt increasingly cut off from their usual sources of vitality, this experience perhaps is made sense of as being more intense and rousing for the participants.

3.3.1.Sub-theme One: Coming alive again

Most of the participants mention descending into despair, which seems to contrast the sense of rising the participants experience as they begin to feel recovered. The majority describe or allude to a return to life following what seems like a deadness:

When I was lifting out of the […], the [.....], the ability to do anything, and I was kind of getting a little bit restless to me signalled recovery again. That feeling of restlessness, like wanting to go out and do something but not knowing what. (Claire, 32, 728-731).

Claire's account of *'lifting'* suggests the notion of her rising out of a lifeless state. Her *'restlessness'* possibly portrays what she regards as a sign of her consciousness returning. There is a feeling of excitement in her tone and repetition as she seeks to find the words to reflect the anticipation of becoming responsive and feeling recovered. I feel her account seemed symbolic of a soul rising out of a lifeless body, and finding its way into an alive and refreshed one in a sense.

Participants further express the idea of progressing from what seems like a physical wakeful state to recovering what seems like one's character:

I would start laughing again, in movies. I noticed that when I was in movies, it made me laugh and it didn't happen before. (Jacqueline, 3, 62-63).

Jacqueline describes how movies finally evoked a feeling of pleasure that had previously been absent during her depression. This reconnection to her emotions appears to reassure her that she was indeed on the road to recovery, as her sense of humanness was returning. This is also important for Jacqueline, as she was socialising again and able to be around others without feeling 'sad', which she had mentioned feeling guilty about.

Similarly, Elisha speaks of another type of shift and refers to experiencing a returning of physical senses, which for her seems to portray recovery of life:

I lost all taste of everything. I was an absolute state - drinking and smoking all the time, and not really eating much. And I had some chocolate, and I could taste. And was getting to that stage where I was close to recovery and I wanted to be able to taste chocolate, and that's what got me through. And so, you know, sometimes it can be bizarre things. (Elisha, 39, 851-85).

Elisha describes a longing to *'taste chocolate';* possibly a wish to re-experience pleasure or comforting feelings that was previously taken away from her in what could be interpreted as the blandness of her breakdown. Being recovered for Elisha means enjoying the simple pleasures again. Being able to *'taste'* and '*enjoy'* helps Elisha feel alive; she therefore utilises these markers to facilitate what she considered as progress with her mental health. She concludes by valuing her *'bizarreness'* as playing a worthy role, which perhaps emphasises the significance of individuality within recovery and perhaps the physical embodiment of depression for some of the participants. Perhaps Elisha is also implying that others would not perceive this as central to recovery from depression, however, for her, this is crucial, suggesting the stigma or lack of understanding from others.

Similarly, Jacqueline also describes a sense of being aware of physical sensations as part of her recovery from depression:

I think it's a feeling, for me it was like I could breathe again because that's what I used to say […] I couldn't breathe. (Jacqueline, 17, 439-440).

Jacqueline's reference to being unable to breathe suggests a previous feeling of suffocation and perhaps unconsciousness as life appears to be asphyxiated out of her. She refers to a revival of breath, which creates a sense of her being brought back to life and having another chance to live. My sense is that participants begin to experience life flowing back into their being. Ultimately, for her and others, this sense of revival appears to go beyond words and thoughts; it seems to be a felt embodiment.

Some participants find it difficult to convey the experience, but feel it important to try to explain to me in a way that I understood. For example, Claire uses an analogy of neck pain to try to convey what recovery is like for her:

If I take it back to the physical again, and I know I'm using a lot of physical analogy but [laughs]. But it was like, umm, when you hurt your neck or something. And then, you know, it's been sore. And gradually, gradually you start to get a little more mobility. And then one day it doesn't hurt and for a minute, you just think, hold on a minute - this doesn't hurt. And then you get on with it. (Claire, 17, 360-370).

Claire's account gives a strong impression of slowly gaining mobility, which perhaps relates to her previously feeling immobilised by pain. She suggests that the absence of pain and the presence of mobility signifies a shift in her health. Similar metaphors used by several

participants. I wonder whether Claire's utilisation of physical health analogies gives a close sense of her lived experience or whether some people are more accustomed to describing physical health sensations as opposed to finding language for more diverse experiences. However, referring to the body might also depict recovery. Her description is further suggestive of a physical felt sense and illustrates this *gradual* process of pain subsiding and the *suddenness* in realising its absence. Overall, some participants seem to perceive this experience as involving body and mind.

3.3.2.Sub-theme Two: Overcome by the light

Participants allude to being liberated from passivity and no longer being imprisoned but rather empowered to live as they withstood defeat from their anguish. They seem to position lightness as freedom from heaviness, darkness and burdening experiences. For most, this transition appears to mean that participants are feeling well, hopeful and strengthened.
Elisha described now feeling free since recovering:

It's that lightness instead of having me feeling overwhelmed and pushed down like the dark angel does. It's just like having a nice light one and it enables you to feel free and not realise what is going on around you. (Elisha 58, 1271-1274)

Her description of the angel as *'a nice light one'* suggests graciousness, serenity, and a sense of feeling lighter within herself. This is a significant transition from her reporting to have felt crippled by her dark self-consciousness. Elisha's metaphors of angels possibly illustrate the notion of a continued paradoxical element of recovery or perhaps symbolise her perception of having a darker side. However, this is now replaced by a *light angel,* which may represent what she perceives as her recovered sense of self and her now feeling safe and free. There is a sense of having higher energy and perhaps gaining an ability to protect over herself and an awakening of faith within herself. Her experiences of distress in this context seems to have lost a sense of power and there is a strong sense of weightlessness. It could also be assumed that feeling free was especially important for Elisha, who had reported having to hide aspects of her mental health, character and life from others in the past, due to judgement.
Another reflection of lightness seems to focus on relieving or perhaps unburdening oneself of an unwanted experience, as portrayed in Darren's use of the word '*dumped':*

I saw it like I carried the baggage. I dumped the baggage, I got rid of it and now I'm free from it. (Darren 2, 54-55).

Darren appears to hint at having now *rid* himself from past experiences and burden. One interpretation is that his disposal of his distress was perhaps his way of separating himself from an identity of depression that he felt emaciated him. I relate this to Darren's acknowledgement of his resentment against others in his past and having to work through letting this go.

Jacqueline elaborates on the colour and brightness of light:

It was bizarre – before I knew it wasn't anything amazing, it was just a normal day but to me it felt like the trees were beautiful and just outside it was so sunny and that was a good sign. And the […] just […] it was normal but to me, but it wasn't dark. So it […] it was sunshine […] it was sunshine days. That's how I saw it. (Jacqueline, 16, 409-413)

Jacqueline's repetition of *'sunshine days'* portrays powerful imagery and further suggests that being recovered for her perhaps is elating, warm and intense. There is also the impression that she is able to notice and appreciate the world around her, which seems to evoke a feeling of wellness and pleasure. Her account feels very passionate, possibly implying that being recovered feels rousing and special to her, and she becomes alive as she speaks about becoming alive. There is a harmonious sense that moves away from the earlier position of the uncertainty most participants had experienced. Perhaps Jacqueline now finds beauty in a life that had previously felt ugly or, like for most of the participants, felt hopeless. Most of the participants seem to be engaging with light rather than the absence of it, 'it' being their shared conceptualisation of darkness. It could be interpreted that participants are no longer overcome by their sense of darkness. At times, when participants reflect on what they regard as depression, they refer to a world which seems colourless and woeful. Conversely, most participants describe being recovered as an experience of bliss or an immersing into vividness. Darren's descriptive words such as *'It feels great, incredible really* (45, 959) and Gloria's '*blue sky with white clouds'* (18, 552) accentuate this sense of ecstasy of being-in-the-world again. Jacqueline relates her experience to a film where a character identified as depressed initially perceived his world as lifeless but once recovered begins to visualise vibrancy and life:

You see the colours, the colour, much brighter, much [more] vivid. Every moment when he takes it in, it just becomes […] everything; there is so much vibrance in it and it's interesting because that's what's happens (Jacqueline 26, 704-706)

Jacqueline's tone becomes animated as she associates her experience to this luminosity and wholeness, perhaps illustrating reaching a fullness of recovery and contrasting the beginning dullness. I feel completely absorbed into this imagination and enjoy where it takes me; I understand the excitement and stimulating vibes felt at this transformative shift.
Conversely, Linda suggests also experiencing a jaggedness. She seems to struggle in describing her experience, suggesting that she was not as far along the process of recovery as some of the other participants:

Um it […] it might not be so easy to actually put it into something […] Because it's not a big happy, shiny rainbow; it is day-to-day life, but it's a lot lighter than it is over there. A bit like you're walking away from something. (Linda, 33, 1157-1160)

Linda displays a slight irritation with romanticising recovery and also the expectation of it being an experience that can be summarised. Her reference to a '*rainbow*' possibly implies her feelings of the unlikeliness of experiencing such bliss in recovery. Linda's experience further seems to imply that being recovered for her involves a more moderate elation and normalises the experience by stating *'it is day to day life'.* Her account suggests that being recovered can also be ordinary and simple, and this is also meaningful. Linda states, '*walking away from something*', which presents recovery as a disengagement from *'something'*, indicating that she has not gained complete clarity.

3.3.3.Sub-theme Three: Living not surviving

This theme conveys the participants shifting from simply surviving to experiencing fulfilment in life. It seems that their recovery help them recognise what matters in life and experience a fuller sense of being-in-the-world as their surroundings no longer feel meaningless.
Elisha, like the others, seems to come to a place where being recovered as a pleasant and promising experience. She smiles as she reflects on what being recovered felt like for her. She alludes to progressing from a position of endurance and/or being restrained by depression, to a position where she is now living more freely in the world, which all participants identify with:

It feels really nice. It's nice to be able to kind of enjoy things again, and go out and just do things and not have to prepare for ages to do it or cancel because you know you can't cope with the situation. It just feels like you can live and instead […] it's always like my thing is, you know, when you are depressed you're surviving, you're literally just surviving. And being recovered, or in recovery - towards the end of recovery, you're living so kind of like that transition […] so what you want to do is to live; there's no point just surviving. (Elisha, 1247-1254)

Elisha appears to focus on living beyond mere existence. She gives the impression that life, now that she feels recovered, appears more meaningful and purposeful as she was living, enjoying and yearning for more experiences beyond her comfort zone. Interestingly, she shifts between recovered, recovery and end of recovery, suggesting that the process of recovery is fluid and ever-changing.
Elisha further describes feeling able to live safely in life, perhaps as opposed to her past suicidal ideation. She re-uses the analogy of angels, however not in a religious context:

It's just like being able to know that, you know what, you are actually safe and you can just enjoy and live. And again that survive to live [thing] is kind of like you've got that dark angel and you are surviving, and you got that light angel and you are living […] (Elisha, 59, 1279-1282)

Her '*light angel*' appears to symbolise life and appears to encourage her to live. As she makes this reference I feel excitement in her tone and she beams, almost as though this '*light angel*' is floating above her in the room.

Gloria describes not being held back by her experience of depression and achieving more functional aspirations:

I applied for a Master's course and that kind of thing. It's when […] you have goals or when you have something even though they are small goals at the beginning and big ones at the end, you know – that helps a lot (Gloria 14, 433-436)

Developing goals seems an important part of Gloria's perception of taking small steps forward and to look at achieving something that is not just surviving. This offers her purpose and her engagement in meaningful goals appears to restore her life again.

Once participants appear to self-identify as being what they regard as recovered, they give the impression that they are able to see the beauty of life again. Below, Jacqueline further metaphorically captures the beauty of living and being; she uses repetition to emphasise her feelings:

It's um walking the streets […] I like walking so it's walking and listening to music and seeing the trees and stopping because it's just very, very, very cheerful. And yesterday there was a squirrel […] a squirrel in the square and just […] it's just enjoying the little things. (Jacqueline, 24, 666-669)

Jacqueline portrays a picture of being present in life more as she appears to notice things whereas in the past she wouldn't have. Her reports of *'walking'* as opposed to her earlier description of constantly '*chasing things'* before recovery progressed implies that she is now able to slow down more and experience the joys of life. She refers to observing a '*squirrel in the square'*, which she was aware that I would be familiar with, as we are sat by the window overlooking the square. It feels as though she was inviting me into her experience with her, and we both glanced through the window. Her emphasis on *'cheerfulness'* perhaps conveys her feeling euphoric in mood and perhaps demonstrates that she, like the others, can experience happiness in their lives.

3.4. ***Master Theme Four: The Blemished Trophy***

This final theme conveys the participants' descriptions of what they potentially feel they inherit from overcoming depression. From the participants accounts, there is a strong co-existing sense of triumph and disillusionment. Despite self-identifying as recovered, participants seem not to experience themselves as unflawed or fixed, which the sub-theme *'The mark of the journey'* depicts. Participants appear to convey a paradoxical picture of recovery where they perceive themselves as both gaining and losing from this experience. All seem to suggest that they are able to find value in overcoming depression, and this is conveyed in sub-theme '*The transforming of me'*. Although participants speak about feeling more robust and enriched from their journey, they do not experience themselves as unmarked.

3.4.1.Sub-theme One: The mark of the journey

All participants seem to allude to experiencing a persistent gloominess and appear to describe how they experience themselves as having what I interpret as an everlasting vandalism upon their self-perception. Despite identifying as recovered, participants perceive themselves as being marred, which suggests their experiences of affliction to not entirely be erased from them. Whilst it appears helpful to assimilate their experiences into their lives, most of the participants express that they could never completely forget its presence:

Someone said to me you can't have an operation without a scar. You know, no matter how they do it, you're left with a scar, you know, no matter how small, it's there. To not have the scars I think would be […] would be wrong. It's not the right way to approach it. I know that if I didn't have the scars, I don't think that the experience would have actually done me any good. You have the scars to remind you of your […] vulnerabilities as a person, um, that you're human. (Darren, 34, 907-912)

Darren associates his recovery experience to an *'operation'*, which might allude, metaphorically to a physical embodiment of being *cut* into and *opened up* to potentially remove a damaged or poorly part of the body. It perhaps reflects the gravity of what he has endured and, further, the potential depths of healing required. Darren refers to being left with *scarring*, which can signify his engagement of trauma yet might also portray a healing. Nonetheless, the scarring can be interpreted as a permanent imprint upon himself, an engraving and writing of his journey. It might further suggest that Darren, like the others, experience a long-term presence of a sense of turmoil and bear the battle marks of its healing.

Nevertheless, the scars are understood to hold great value. Darren seems grateful as they appear to serve as a reminder that he is not indestructible, which is the caution Darren and others seem to need:

You've got to have some kind of trophy, if you like, even if it's gruesome, you know. It's a reminder of where you were; it's like a kind of a marking post, signpost on your journey, you know, that you never want to go back to. (Darren, 22, 755-768).

The experience of recovery is depicted to be both hideous and yet triumphant, and one that leaves painful mementos. Darren captures well the sense of paradox as his reference to a

'*gruesome trophy'* emphasises the sense of achievement and pride for what he regards as having recovered but not without having to acknowledge the ordeal he experienced. As Darren concludes, this badge of honour, if you like, feels like a solemn signifier of the ugliness he does not wish to return to. It could further be understood as a reminder of where he came from, to appreciate where he is today.

Whilst Darren conveys a sense of healing and/or closure, Jacqueline provides an insight into what seems like a more interminable experience and a further perception of being imperfect:

I think if you had depression all your life, you're going to be recovering and I don't think you're ever going to be recovered. But, I mean, in my […] I think that that's what happened. It's like a broken mirror, you can fix it but it's always going to have […] um to […] not look broken but it's going to […] you know it's […] it's had […] something happened to it so it's never going to be perfectly and mentally healthy every time. (Jacqueline, 22, 602-608)

Jacqueline appears to make sense of recovery as an enduring process, doubting whether completeness or complete emancipation from depression is ever achievable. The symbolism of *'broken mirror'* perhaps illustrates the notion of being patched back together to look the same but will always be cracked and flawed. There is a suggestion in her account that she recognises that she must accept what she perceives as lasting imperfections, which is echoed by others. As she speaks, I connect to a sense of sorrowfulness in her tone of voice and take this to mean that this is still something difficult to process. There is a sense of not always being able to feel 'recovered enough' and perhaps, at times, feeling worn down by her continued imperfections despite her experience of recovering.

Most participants describe experiencing a sense of loss, having recovered or a sense of things in their life which would never return. There seems to be a sense of a coldness for some, as indicated through Claire's shortness in speech, tone, and body language:

I was probably never gonna be the same again […] (Claire, 7, 153)

There seems a sadness with this realisation. Claire seems conflicted in whether it would be possible to live in the same way she had in the past. There was possibly a feeling of unfairness as she shakes her head slightly, giving the impression of disappointment.

Gloria expresses ambivalence in conveying a sense of disillusionment in being recovered:

Um [pause] I don't know […] I guess I miss the old me in a way because I was happier then. And umm, even though I'm happy now, so to speak, you know, I'm not um […] I don't know how to say it um [pause] I know I'm better than I was when I was depressed, but I'm not as happy as I was before all the stuff. (Gloria, 11, 323-326)

I believe it takes Gloria a lot to admit this sense of dissonance out loud, suggesting there to be some concealment and guilt in her being recovered. Overall, there are shades of grieving felt in her account. Although she describes experiencing a loss of herself, perhaps this notion of 'old me' is associated to the loss of her mother, which she earlier reported to have triggered her depression and refers to as 'stuff'. Gloria may have been mourning a loss of what she alludes to as a pre-bereaved and carefree life, which had not experienced any mental anguish. She appears to grapple with the notion of happiness once recovered and perhaps suggests that wellness did not always result in optimal happiness. For Gloria, she seems to imply that the comfortable world she knew has disappeared. Gloria is the only person who really expressed missing what she seems to frame as a 'former self'. Most of the participants express that prior to experiencing depression, there were things about themselves they were troubled by.

Linda also questions the meaning of being recovered and highlights that overcoming depression is not a return to 'normality':

It wasn't a normal progression back to normal (Linda, 291-292)

Linda seems to suggest that this experience is more complex than she assumed, something which most participants share. Perhaps she is suggesting that there are still struggles despite being recovered.

3.4.2.Sub-theme Two: The transforming of me

Participants seem to make sense of their experience as evoking a surprising yet welcome change with themselves and their outlook on life.

It's almost like an image change in a sense. Um it's like a makeover that you didn't ask for in a sense […] um. Some of the interests and things that I used to do back then I no longer have […]. I have a new set of interests, some new, some old […] um. The way I look, my perception of the world and life has changed. (Darren 30, 818-822)

Darren's use of *'makeover'* suggests that he experiences himself now as an improved individual. This sentiment also contrasts with his earlier description of *'operation',* which reiterated a sense of dualism within recovery. The excitement expressed in Darren's tone portrays an eagerness to taste life again, perhaps following what seems like the dimming or perhaps 'make-under' of depression upon himself.

Being recovered for some participants seems to have an impact upon many aspects of their lives; a sentiment that Darren particularly emphasises:

It's almost like I've completely grown up, almost, you know. It's like all the kind of childhood stuff and childish stuff has completely all gone, I now feel like I'm a proper adult […] You know, for some reason, and I don't know why, it's taken this long to feel like that, you know um […] I guess it's […] it's […]. Maybe this is the person I always wanted to be but I was scared to be it, or something like that (Darren, 20, 704-713)

Darren's recovery experience can be interpreted to have propelled him into adulthood, which he seems to associate with letting go of past conflicts and gaining psychological maturity and security. Thus, there is the impression that maturing is not only physical, it is felt to also be an emotional growth; hence, the length of time it took him to reach this place, perhaps. However, he contradicts with *'completely and almost',* perhaps implying that he feels whole but remains aware that there is room for improvement. There is a sense of him becoming fearless and trusting himself now that he has regarded himself as having recovered from his distress. It seemed important for Darren to perceive himself as discovering, poignantly, what he seemed to be framing as his 'authentic self'.
I suddenly feel quite emotional for Darren as he seems to realise recovery was about becoming a person, something he had perhaps longed to feel. I wait with him in this silence, as I recall him saying that he liked silence at times as it allowed him to just be; perhaps being in the present allowed him to feel connected with himself and his experience.

This sense of enlightenment varies across participants. It seems that, particularly, once participants self-identified as recovered, participants report gaining their own clarity on what they consider to be the function of their depression and it portray a shift in their initial punishing perception:

My belief is that depression […] for me is my body's way of telling me that something or some things in your life […] are not the way they should be and they're wrong for the type […] for who you are […] (Chantelle, 6, 168-172)

Chantelle seems to embody her experience as a distress signal, an unspoken dialogue between herself and distress. Claire expresses physically feeling pushed down by what she regards as the weight of depression; her experience seems largely connected through her body. My sense from Claire's accounts is that, for her, depression seems a personal source of protection, which perhaps alarms her of the dissonance in her life and that something needs to change.

Participants seem to make sense of depression as evolving from being the demise of their sense of self and life to being the catalyst for recognising life and one's purpose in it. Ultimately, I interpret that participants gain self-knowledge which shifts them from an estrangement of themselves to self-empowerment in the face of distress. Participants seem to suggest that self-awareness through their recovery seems to unearth an experience of self-acceptance and security amongst the participants, experiences which they suggest were previously neglected or absent in their lives:

It's like a sort of a big, sort-of warm armchair kind of thing now […] and I think that's really saying being comfortable in my own skin. (Claire, 42, 971-973)

Now identifying as recovered, Claire seems to embrace a sense of security and contentment with herself. A loving and comforting tone is conveyed through her description of a *'big warm armchair'* possibly depicting her compassionately holding and perhaps safeguarding herself sturdily as a way to self-sooth from distress. She has gone from what she initially described as a *'false robotic suit'*, which conveys a hard, unemotional stance, to a soft yet tough armchair, perhaps illustrating her transitioning. It seems that Claire now feels pride and ownership of her identity as she refers to *'my own skin'*, which was a significant progression as she had reported difficulties with body image, which she felt possibly contributed to her experience of depression. Perhaps Claire was implying that she had finally learned to love, accept, and appreciate all of herself, warts and all, which appears an integral purpose of recovery for the others.

Several participants allude to feeling insignificant, worthless and feeling as though they were strangers to themselves when they report to be living their experiences of depression.

However, participants give the impression that working through this seems to awaken qualities in the participants in which they considered absent:

I didn't have a voice or didn't have an opinion um. I was a very quiet person and I think what […] this transition has done is it has brought me out of my shell. (Darren, 20, 694-698)

There appears to be a growing recognition of self-worth and confidence. Interestingly, Darren previously described himself as an 'alien' during his depression, feeling no sense of belonging in the world. Darren's *'out of my shell'* symbolises the blossoming of a more robust, trusting and secure construction of self.

All participants express a readiness to be in-the-world and no longer hide behind their vulnerabilities. There is a strong suggestion from the participants that they perceive recovering from depression as getting another chance at life - a chance to be seen and become unmuted:

I'm stronger for this experience (Darren, 2, 38-41)

Ultimately, participants appear to feel that their experience of depression, and moving towards recovery, is not in vain. Their pain seems to be a powerful and valuable experience as participants feel they emerge stronger. The experience of emotional pain appears to be described as evoking a sense of growth. Participants emphasise a sense of experiencing weakness, which then appears to evolve into feeling empowered, proud and grateful for surviving, battling, and living. Alongside their wounds, participants feel strengthened; and it seems that this strengthening is largely what being recovered from depression embodies.

3.5. ***Summary***

The participants' accounts present richly textured ways of understanding recovery and the varying tensions experienced. For most of the participants, recovery is not simply experienced suddenly, neither is there a clear end; it instead seems marked by multiple transitions and struggles. Whilst their experiences feel arduous and denting, it could also be argued that what they regard as recovery also softens and strengthens them. Overall it seems not simply about becoming unflawed, but also having the courage to step into what they perceive as the unknown, and accept their capabilities, limitations and themselves. Their accounts of depression suggest them as missing in the world. It could be assumed that

participants perceive their recovery perhaps as an experience back into the world, living, but not unmarked and possibly forever changed.

4. *Chapter Four: Discussion*

Overview

This research aimed to explore seven individuals' experiences and meanings attributed to recovery from depression by employing interpretative phenomenological analysis. This chapter will draw upon the existing literature and further insights with a focus on broad themes selected to be unique, informative and stimulating in relation to the extant literature. The implications, strengths and limitations of the present study will be addressed, followed by suggestions for future investigation. Finally, this chapter offers a concluding personal reflection in relation to the research and training.

4.1. *Difficulty moving forward*

This section will draw on a few key findings in relation to the master theme 'difficulty moving-stuck' to convey experiences in which making sense of moving appear crucial for those overcoming depression.

Initial understandings involved assumptions of recovery being uncomplicated; however, as the participants gained experience, their beliefs changed. Diagnoses of depression can often be described in time-limited categories, such as depression lasting on average four to six months with expectation of complete recovery (NICE, 2018). Such prognoses and prescriptive language, typically used within clinical settings regarding timeframes and expectations, and with which these participants were familiar to some degree, potentially heightened their sensitivity to interpretations of slowness, boundlessness and unpredictability in the experience of recovery.

It can further be argued that, in some cultures, the notions of 'slowness' or 'irregularity' can seem undesirable, while 'good progress', particularly in mental health, may be associated with prompt wellness and potentially less stigmatising. One participant referred to her experience of not becoming better quickly enough with the assumption of 'something being wrong', illustrating the argument that medical and cultural narratives of illness remain embedded in these personal experiences of recovery.

However, as participants experienced recovery, they described an incongruence; they felt unable to fit into the normative objectification of timeframes. Instead, an overarching feeling was that of having to endure an uncertain pace. The *moving through* seemed challenging for various reasons. Such findings suggest that recovery from depression cannot be time-limited for all, which perhaps encourages us to explore current primary care systems and NHS

guidelines in the UK. The following section suggest a powerlessness in individuals' sense of *moving* in what could be described as a winding labyrinth.

4.1.1. The need for slowness at odds with our brief, time-limited interventions

Despite the varying spans of years that it took for the participants to self-identify as recovered, their experiences of pace, or perhaps lived time, in recovery all pointed towards feelings of slowness. These observations suggest that all participants largely experienced recovery as feeling drawn-out and gradual, which echoes Higginson and Mansell (2008) in relation to the gradual process of change.

A prominent discovery in the current study is an emphasis on a slow-moving and drawn-out experience that heightened participants' sense of an inability to accelerate their recovery. As they previously felt disconnected from their surroundings, perhaps they felt like they were moving slowly, out of time and unable to keep up with the world.

While this investigation's findings share similarities with Young and Ensing's (1999) of stuckness in recovery, the present participants placed greater emphasis on feeling hobbled by their weakness and lack of energy. They described a depletion of energy that seemed significant for their feelings of being paralysed in depression. Therefore, the capacity to 'move' in recovery seems to have become complicated for these individuals. Most appeared to attribute this to feeling drained of some 'inner' source of sustenance, implying recovery to require drawing on some source of power which, at times during recovery, seemed exhausting and difficult.

The sense of slowness may also have been heightened by participants' experiencing a heaviness or feeling of being weighed down in depression. Thus, slowness in recovery may be construed by these individuals as requiring energy to move with their sense of load. All of them seemed to share similarities in the ways in which they experienced and made sense of depression as some form of dominance when describing how they felt at a given time, and perhaps this contributed to their sense of feeling stuck. One participant believed that the structural delays within the mental health system exacerbated it, but largely attributed the pace to his own abilities. It can be argued that illness narratives regarding depression and individualistic ideology resonated with these participants, as at times the slowness was felt to be a fault of their own.

A contrasting finding relating to the gradual process is that of the participants recognising that recovery was not experienced all at once. Observations suggest that recovery went beyond the experience of depression subsiding and involved other areas of life also requiring

recovery. In line with other research (e.g. Price-Robertson, Obradovic & Morgan, 2016; Topor et al., 2011), this supports the argument that there is a relational sense of recovery and that helping individuals become aware of interconnectedness in overcoming depression may ameliorate feelings of personal inadequacy.

It is important to consider that the participants seemed unable to meet the demands of being in the world and moving at the fast pace they once did, which potentially heightened their sense of depleted energy. One participant mentioned an inability to give anything to anyone, let alone to themselves, implying that their lack of energy relates to being with others and meeting social expectations. It might be that this is experienced as draining for some in recovery from depression.

Furthermore, the findings suggest that participants' detachment from the world meant that recovery involved a gradual re-learning of being in their everyday lives. This resonates with the concept of recovery as a process involving a series of small steps (Deegan, 1988; Frese & Davis, 1997; Anthony, 1993; Jacobson & Curtis, 2000). It seemed that participants recognised the need to be patient with themselves, strengthening the argument that overcoming depression is not always instant or experienced all at once. However, this acceptance was initially difficult and recognition of the value of gradual healing appeared stronger after that they were recovered for those who had longer histories of depression.

A salient finding was that 'fast recovery' for these individuals felt superficial. For them, it meant that they appeared recovered but were masking their suffering. This implies that supporting people to overcome depression without time limitations may for some be less detrimental to their health and their sense of capability in recovery. This idea accords with Johnson et al. (2009) on concealment of feelings in recovery from depression and presents another dimension of the experience that clinicians might need to be aware of when working with those in recovery.

A potential understanding of these participants' emphasis on duration is found in their alignment with particular ideals of recovery potentially perpetuated by mental health systems. The participants were exposed to (DSM) categorisations, time-limited therapies and medicalised notions, all of which may have positioned them to focus on duration and tempo. Clinical expectations of recovery, in the context of depression as something treatable and quantifiable, potentially lead people to strive for promptness and experience their recovery as 'slow' though this is perhaps a healthy experience.

This study's participants expressed initially feeling discouraged, frustrated and that something was 'wrong' when they felt unable to speed recovery. Cultural norms suggest that

the experience of recovery from depression is not an isolated one and helping individuals recognise this may support them in their pace of recovery. From a psychological perspective, it also seems that recovering quickly gave some a sense of reassurance that they were not as 'unwell'. This implores clinicians to consider the function of this need to move quickly when working with clients. Furthermore, a few participants mentioned feeling like a burden, which further highlights interconnected issues regarding their sense of progress. Nonetheless, these observations suggest that there can be difficulty in being with slowness, potentially exacerbating powerlessness. They may imply that there is a mismatch between the lived experience of depression and the current emphasis on time-limited therapies, which may lead us to question whether we are setting people up for failure.

It might be suggested that some people need help to understand that 'slowing down' in recovery is not a defeat or failing of their own. This might rather be the new 'normal' in overcoming depression. The present findings highlight purposefulness in making sense of pace in that it allows us to go beyond the pathological sign of still being depressed and consider it part of recovery. Moreover, these observations are in line with those of Deegan (1998), who infers that recovery cannot be forced. Stigmatisation and normative views may have heightened these participants' sense of slowness and further indicate that evaluation of how they might be perceived in the world played a role in their experience of feeling stuck. This study draws attention to the delicacy of this experience and perhaps questions the effectiveness of short-term therapies typically offered by primary care services for those diagnosed with depression. It might be important to consider more deeply the gradual changes that those recovering from depression may undergo, which are both useful and challenging in recovery.

4.1.2. The elusiveness and fear of depression versus fear of recovery

The present findings are consistent with the conceptualisation of recovery as largely non-linear and fluctuating (Slade, 2009; Deegan, 1996; Schiff, 2004; Ridge, 2009; Anthony, 1996). Indeed, they go further, suggesting that it can at times feel turbulent; people may become entangled in multiple emotions and changeable experiences, which seem difficult to decipher and potentially heightens the awareness of vulnerability during recovery. These observations highlight that participants were not always able to trust the recovery process, as its unfamiliarity and their unawareness of what it means, or not knowing how to just be in the process, heightened a sense of threat in recovery. It can be argued that research has been able to address denial and confusion to some degree in the recovery literature

(Andresen et al., 2003; Young & Ensing, 1999) but that it has not explored more deeply the intimidating quality of the recovery experience in the context of depression.

From a clinical perspective, it can be argued that those with experiences of depression are seen to convey a loss of psychological flexibility (Kashdan, 2010). The ability to become open and go with what seemed like an 'unruly' process, according to the present research findings, might involve trusting in the process. This investigation shows some of the ways in which trusting recovery can be challenging. For example, the participants' experience of depression seemed to become almost a safe place, away from the world, which at the time appeared overwhelming. Depression, in contrast, offered a familiarity which seemed unchanging to them at the time. A potential insight is that mental distress can serve a compensatory purpose (Newman, 1994); therefore, recovery which requires change might induce vulnerability. The participants in this study indicated that overcoming depression can also be intimidating and that one can feel unprepared or perceive oneself as not strong enough for it.

However, this outcome could imply that the perceived 'unknown' is not necessarily an unknown but a sense of fear of what they suspected recovery to ask of them; for example, reconnection to an unexplored pain such as most described distancing themselves from. These findings suggest that the concept of recovery is not always thought of in encouraging ways and that the lack of such exploration hinders *moving through.* In many ways, it appeared that the idea of having to search through this path towards some sense of awareness or healing was challenging, as it seemed an uncharted path, which perhaps heightened their resistance.

These findings support the notion of recovery meaning multiple and varied things to different people (Jacobson, 2001; Ridge & Ziebland, 2006). In this investigation, observations conveyed a transition from fearing the 'unknown' to acceptance, which offers insight into how resistance to change may be experienced by those recovering from depression. A potential interpretation is that, when the fear of remaining 'depressed' became greater than the fear of recovery, participants experienced change.

Nonetheless, the experience of recovery as something potentially fearful and confusing deviates from its normative characterisation, suggesting that closer understanding of lived experience can help us to understand important or specific experiences more relevant to depression than others involving mental distress. Such evidence draws attention to potential barriers which clinicians and those seeking recovery might find important in the experience of *moving*.

However, a further key discovery of the present research is the value of trusting and surrendering to fluctuation, as it appeared pivotal in shifting participants from defenceless suffering to endurable suffering. While submitting in moments felt like defeat more strongly for participants who struggled with ideals of normality, overall, it also appeared to be a way of building resilience, awareness, and patience. These are qualities which most participants described themselves as lacking prior to their experience of depression. Fosha (2002) asserts the importance of survival during struggle; accordingly, the participants seemed able to develop qualities which they needed for further life struggles. This was pivotal for them, as most alluded to having felt indestructible in the past and lived life somewhat carelessly, free of trauma, perhaps having their qualities untested and underdeveloped. This insight might also heighten the sense of fragility they experienced in the process of recovery.

Furthermore, some participants described others as unaware of how to be with them in times of fluctuation, which seemed interconnected with their experiences. It is possible that contemporary western points of view, describing people with experiences of mental distress as 'vulnerable', add to this stigma. The present research also shares similarities and differences with previous investigations regarding concepts of hope and turning points. Ridge (2009) describes establishing turning points as crucial in overcoming depression. This study's findings imply that at times some participants found it difficult to distinguish depression from recovery. This salient discovery not only presents recovery as indefinable at times but offers a less pathological understanding of the participants' experience. This might offer reassurance for those who feel unable to fit into conventional standards of normality, supporting that this is not always possible in the context of depression. However, these observations may also reflect the participants' positions regarding normative assumptions about mental health, as most of them seemed somewhat rebellious against aspects of conformity to mental health stereotypes.

This study further suggests that, in depression, the experience of hope can be difficult at times. A few participants described times when hope was experienced as fleeting and distrusted, particularly when they were grappling with recovery. At these times, it seemed that to be hopeful was not enough or easier ignored, as its disappearance might be disheartening. Since hope is future-orientated (Schrank et al., 2011), it seems difficult in the context of depression for many reasons but particularly with respect to the notion of staying in the moment. Some participants spoke of taking one day at a time in recovery, not looking to the future. Therefore, withdrawing from hope, in this context, perhaps offered protection against disappointing setbacks. In the literature, it might be argued that hope is an

unquestionable concept in recovery. For these individuals, it appeared that the concept of hope felt more present as they experienced themselves becoming alive in the world. This could indicate that these participants needed to feel something more, but that it was at times challenged by their sense of stuckness.

4.2. *Plunging in for change alongside struggle*

Several studies emphasise agency and involvement in confronting challenges using a unique combination of strengths, vulnerabilities and available resources (Crowley, 2000; Deegan, 1996; Mead & Copeland, 2000; Smith, 2000).

Drawing from the theme 'plunging', the present findings suggest that participants sought active involvement in their recovery and appeared to make clear distinctions between their own personal efforts and those which they regarded as coming from outside themselves. Other research has also identified that personal agency and 'inner' resourcefulness appear important in recovery from depression (e.g. Cartwright et al., 2016; Grieken, 2013; Griffiths, 2015; Onken et al., 2007). Most of the participants described a sense of feeling stifled or worthless in relation to their experiences of depression. Perhaps this heightened their need to feel a sense of personal agency, although this seemed challenged by their conflicting need for support.

A significant observation was an emphasis on participants experiencing themselves as the 'ultimate' means for change. Despite all participants having engaged in therapy to varying degrees, they appeared to consider that, without their own efforts, recovery would be a greater challenge. What seemed important was a support person – someone who would be there while they went on an 'inner' journey.

4.2.1. Choosing to move on

These participants appeared to describe *perseverance*, *commitment,* and an *'inner' wanting* for recovery as greatly helping them to instigate action. This resonates with the empowerment model, in which an important aspect of recovery is the recognition that the individual is the author of their own recovery. It can be argued that the participants in the present research were in environments which supported their capacity to be agentic and make choices, such as their having the financial stability to access private therapy. Therefore, it is important to consider perception of recovery as largely self-authored in the context of individuals' situations, which may have sustained and inspired their determination. This insight points towards the relational model of recovery in that, although the participants

recognised their role in recovery, they were cushioned in some way, perhaps supporting this plunge into making sense of their distress.

Alternatively, the financial stability of most of the participants potentially heightened their sense of independence. It is proposed that our sense of free action is not something we experience primarily as internal to ourselves but something important to how we experience our surroundings (Ratcliffe, 2015). In this context, the participants' sense of will and independence seemed embedded in the opportunities with which they were presented. In addition, shifting from their sense of isolation may have helped to foster their determination.

Another consideration relates to the similarity among the participants in this study in terms of achievement and familiarity with having to persevere, as evidenced by their academic and vocational backgrounds. Duckworth et al. (2007) found perseverance to be linked to higher levels of educational attainment. Such experiences may have developed these individuals' senses of persistence, competence and ability to act.

However, these findings also draw attention to whether those 'more privileged' experience a degree of pressure to take ownership. There is an implication that, even with support systems in place, people still make sense of recovery as their own. Perhaps it is important to explore this from a psychological perspective, considering that it may hold some sense of power over their recovery, which participants feel they need to work through their mental distress. For these individuals, perceiving themselves as having strength and courage allowed them to reach a meaningful sense of themselves in the world as someone who is able and not inadequate, since some of them struggled with the clinical assumption that 'depression means you cannot do anything'. Thus, ownership may have been a way for some to challenge these assumptions.

These observations can offer insight into a strength-based approach which focuses on developing strengths as part of one's driving force to meet basic needs, such as autonomy, security, belonging, and finding meaning and purpose. Such an approach may help people to delve into their distress without necessarily knowing where the experience may lead. These participants described drawing on strengths which helped them persevere in difficult times. Their onus upon themselves further speaks to an approach in which one decides to let go of the crutch and work through mental distress, or perhaps avoid it.

4.2.2. Responsibility

While the recovery literature can often portray responsibility and control through action-oriented tasks and functional self-care (Griekan et al., 2013; Griffiths et al., 2015), the present findings go further and illustrate more closely the emotional and psychological meanings that pertain to overcoming depression. For these participants, gaining a sense of responsibility enabled them to feel to feel one of power. They described taking responsibility in different ways but most commonly there appeared to be a sense of taking responsibility to gain self-awareness. All participants seemed to suggest that recovery enabled to them understand themselves in the world as a person and in the context of their health, and that without this knowledge one could 'never quite be recovered'. These reports imply that taking responsibility to understand their depths as a person and in relation to their own well-being was necessary to get into recovery, be recovered and be aware of one's vulnerability.

It might be asserted that factors such as self-reliance, personal agency and responsibility are often emphasised by those from individualistic and egocentric cultures. It has been argued that some individuals from western backgrounds are often found to focus on their individuality and independence rather than interdependence in relation to their recovery experiences (Mezzina et al., 2006). However, what was prominent in this research was that most participants referred to feeling alone at times in their recovery, which may have heightened their sense of personal responsibility.

4.2.3. Wanting

A further complex finding was the notion of *wanting* to recover; wanting things to be different and willingness to go through what this may involve. From the participants' perspectives, it seemed that *wanting* to recover meant experiencing a further degree of pain. The overarching sense was of wanting to *fully* take the plunge to experience recovery and be vulnerable. Such observations resonate with research concerning ambivalence in letting go of mental distress, as this can be perceived as defence against further injury to one's sense of self (Veseth, et al., 2012; Ridgway, 2001; Mollon & Parry, 1984). This study's findings suggest that, for some participants, change was experienced when the pain of staying depressed became greater than perceived pain of recovery and/or change.

4.2.4.Reframing medication as a barrier to recovery

The current research suggests that, although participants appeared to place the onus on themselves and what they described as their own efforts, they also needed some form of anchor to help them take the plunge. This section highlights tensions in receiving support which participants described as being outside of themselves. It appears that the use of medication or antidepressants can be perceived as diminishing one's sense of personal effort and agency in relation to recovery from depression (Cartwright et al., 2016; Griffiths et al., 2015). The current findings go further and illuminate in more detail the emotional and psychological experiences which can surround the use of medication.

For a few of the participants, taking medication symbolised inadequacy and a powerlessness in themselves. This was felt to be because participants were not able to plunge directly into the depths, which is what was needed. Medication was considered a temporary fix that would help only partly in the process of recovery. These participants were typically those who seemed to perceive medication through more medicalised assumptions of personal insufficiency and helplessness. In addition, medication appeared to be a first-line approach among some health care professionals, and this relational experience further heightened clients' sense of being incapable.

Such observations are in line with Fullagar (2009), who found women to describe themselves as weak and flawed for their reliance on medication, which disrupted recovery. The participants in this study described medication as stripping away a sense of competence during recovery and retrospectively. Use of medication for some meant that it was not their own efforts that enable them to overcome depression. Instead, medication seemed to be a barrier between them and the feeling of personal responsibility for recovery.

Stigma in relation to medication remains prominent in particular cultures and in this study social and personal stigma was evident. It would be interesting to determine in a larger study whether this is something that is age- or culture-related. Such suggestions reflect fundamental tensions negotiated by those in recovery from depression as they attempt to reconcile conflicting feelings resulting from medical discourses, stigma and their expectations of themselves. These nuanced findings highlight the importance of phenomenological research in identifying these issues, which have direct relevance to supporting people through their depression experience.

In line with Ridge and Ziebland (2006), reframing medication in a less threatening manner seemed helpful to participants' experiences. The medical model construes recovery as tantamount to compliance with medication and symptom reduction. However, these

findings encourage a move towards understanding that medication may in fact be a barrier to recovery. Instead of blaming our patients for 'non-compliance', we can see that they are perhaps struggling to find their own way forward based upon their individual experience and position in the world. While there is great emphasis on the side effects of psychiatric medication, these findings suggest that the psychological experience of utilising medication is also important in our understanding of recovery.

4.2.5. Connectedness and social support

Therapeutic support was further revealed to be important, supporting research characterising recovery as a relational experience (Toper et al., 2011; Price-Robertson et al.,2016). However, participants in this study seemed to position this support as assistance alongside them rather than the primary source of recovery. It appears that what meant the most to them was a sense of humanity and individualised care, as opposed to therapy. Participants felt most supported by professionals whom they experienced as warm, empathetic, trusting, personable and providing a sense of unconditional care. In addition, clinicians were held in higher regard if participants found that they trusted and believed in their ability to recover in their own time, and were able to see them as a person.

These findings corroborate Clarkson (2003), who makes reference to the person-to-person relationship that participants described, and can further speak to Leamy et al.'s (2011) assertion of connectedness. Mancini (2005) further addresses the importance for some people in recovery of feeling as though they are collaborative partners in relation to health care professionals. However, for the majority of the participants, it appears that they responded with nurturing qualities. Corrigan and Phlean (2004) assert that intimacy is a nurturing quality in recovery experiences and important for overall health, sense of satisfaction and hope. These findings are in line with humanistic ideology, in which the warmth, and empathy of professionals are seen as integral to fostering change in individuals. Furthermore, humanistic paradigms involve considering the whole person, which for these clients seemed to be an important part of their ability to self-soothe.

Glove (2006) identifies balancing empathy and encouragement of self-care as paramount in recovery. In the present study, a sense of security and compassion from clinicians appeared to cultivate courage to plunge into exploration of participants' worlds and their distress. Relational engagement helped activate participants' sense of worth during recovery. Considering that most alluded to isolation from others during their experience of depression

and a harshness in the world, these human qualities might have been what they sought in their clinicians or responded to well, as most felt 'uncontained' in the past.

In addition, a further interpretation might suggest that recovering from depression also relates to aspects of attachment theory (Bowlby, 1969), whereby recovering involves developing a secure base in order to feel able to safely explore. This brings into question the attachment roles that clinicians play and perhaps what medication symbolises on a personal and meaningful level. Most participants described needing support as a kick start in times of difficulty. However, for some individuals this kick start might turn into longer-term aid. Therefore, helping people to find ways to manage this may be important for recovery from depression.

In contrast, spirituality did not appear prominently in this study, although a few participants mentioned a sense of a higher or magical otherness. For instance, wishing for a 'fairy godmother' or connecting with the comforting voice of someone who has passed away appeared to be ways in which participants sought reassurance in recovery. This implies that, for some recovering from depression, seeking and/or connecting with something that seems greater than the strength of the individual expresses how they may not always feel able to recover by themselves. In addition, the participants who referred to seeking this 'otherness' mentioned that people around them, in their social surroundings were less sensitive to their distress. Therefore, those who seek psychological support may require this because they do not have such support within their social network. Deegan (1994) proposed the notion of a 'surrogate hope' as a starting point for recovery, involving being held by someone else when a person feels they have lost all hope for themselves. This aligns with the impression of these participants seeking to be held as they begin to navigate through the abyss to make meaning of their recovery.

4.3. *Reconnecting body and mind through meaning-making*

Most of the participants initially sought to numb or alleviate themselves in the pain of their experiences of depression, whether with alcohol, overeating or even medication. Nonetheless, they all recognised that recovery required being with their sense of pain and learning how to accept it as part of their life, rather than removing or avoiding it. This section draws from subthemes 'coming alive again' and 'overcome by the light'.

Medical ideology often portrays a mechanical notion of recovery with associated terminology such as fixing, curing or reducing pain (Slade, 2009). However, this perspective

seemed somewhat secondary for most of the participants. It is arguable that the notions of being *fixed* and of a *return to normal* are perpetuated by cultural norms around mental illness and treatment. Meanwhile, the present findings point towards more embodied and existential experiences of 'getting better'. The salient finding was clients' realisation of a need to making meaning of pain, which was seen to help their sense of distress subside. Such insights diverge from the dominant narratives of fixing or curing pain, as the participants seemed instead to focus on accepting and exploring their pain. This realisation seemed to help participants move through their distress in a non-pathologising manner and offered a sense of reassurance. This challenges the view that recovery from depression is a reduction of symptoms or absence of illness. Instead, deriving meaning might also offer pathways for some individuals.

Healing can be associated with complexities of meaning and personal understanding (Egnew, 2005). This study indicates that recovery was experienced largely as a psychological engagement with healing. The findings suggest that exploration of pain rather than first seeking to mask or take the edge or it may be important for those overcoming depression and in working therapeutically with this client group. However, it is also important to consider that some of the participants felt it necessary to give voice to their pain, and therefore felt that therapy and not medication alone was needed. This study's findings imply that striving for a voice was important for these participants, as most felt stifled or muted by their depression. Obtaining meaning during recovery appeared to help facilitate the reconciliation of distress, particularly since in times of depression most reported a sense of void. From a clinical perspective, this encourages clinicians to think more about normalising pain and supporting clients to find their own meaning.

4.3.1. Emotional Healing

One of the ways in which participants seemed to move towards acceptance and personal meaning was by becoming self- compassionate. They described self-compassion as integral to their recovery and their interpretation of healing themselves. It has been asserted that emotional self-healing involves the full embrace of one's emotional pain with an open, compassionate and non-judgemental heart (Hammer & Hammer, 2015). Self-compassion was framed as a new experience for these individuals, as some mentioned typically being harsh towards themselves. This reinforces Westbrook, Kennerley and Kirk (2007), who assert that those diagnosed with depression can be excessively self-critical. Further, the findings suggest that self-compassion helped in the understanding of pain during recovery, agreeing

with Neff's (2003) claim that self-compassion is being moved by and open to suffering, not avoiding or disconnecting from it. Self-compassion additionally involves alleviating anguish through kindness, offering merciful understanding of one's own pain, limitations and failures so that one's experience is perceived as part of the larger human experience (Neff, 2003). This stance resonates strongly with these participants' experience, although they emphasised having to work hard to develop it. From a clinical perspective, such insights imply that compassion-focused therapy may be a useful approach in supporting people to overcome depression.

The participants implied that they became self-nurturing and kinder to themselves through the process of recovery. Such reflections are consistent with aspects of humanistic ideology, in which recovery can be experienced as a close meeting of higher-order needs such as love, empathy, esteem and self-actualisation (Maslow, 1987). Participants felt reassured by their ability to self-soothe. Another aspect of this understanding is that participants acknowledged pain as something that one can heal from and feel safe with. This can be related to Gilbert and Proctor's (2006) proposal of self-compassion feeding emotional resilience, as it regulates threats and activates the caregiving system associated with feelings of security.

Upon reflection, some participants made reference to personal insecurities. It might be reasonable to expect that these participants sought a sense of security within recovery. Moreover, forming meaning and connecting with pain helped these participants to develop acceptance, which appeared to contribute to the experience that pain subsided, although this was not immediately realised. They further provided an opportunity to develop as the individuals learned how to survive their pain. These findings support the usefulness of engaging in acceptance and commitment therapy (ACT) for those diagnosed with depression, as this focuses less on the elimination of unpleasant affect and more on being open to what life brings (Hayes, Pistorello & Levin, 2012). It may also be speculated that hurting can sometimes stimulate change and is therefore perhaps needed, as these participants suggested.

Another insightful finding was an inability to recognise objectively and immediately when clients' pain subsided, rather depicting more unconventional experiences of healing. In clinical terms, this reinforces the notion that recovery can feel indefinite and strengthens the argument that it is a process rather than an event. Thus, it appears hard to know when the journey is complete, as we are always moving. A possible interpretation could be that the interview provided a non-judgemental space for the participants to feel open enough to stimulate their less normative healing belief systems.

Participants seemingly referred to the idea of one's whole psyche healing, with some depicting experiences not typically consistent with an objective perspective. Some participants appeared to connect to an 'otherness' which offered a transcendent element to their accounts. Analogies such as 'light angel', 'deceased father's voice', and 'fairy godmother' give the impression of a personal, mystical and spiritual experience of feeling recovered. These analogies were further interpreted as motivational forces that encouraged participants to recognise the value of their lives and supported them in the struggle of recovery. Overall, these findings indicate that participants connected to personal sources of comfort, which most felt unable to do prior to their depression. These examples strengthen arguments for alternative and nuanced ways to help against difficult thoughts, worthlessness, or incommunicable experiences, encouraging individuals to develop and connect to their own methods and meaningful resources for aid in distress.

Slade (2009) further asserts that there is a need for individuals to feel something more powerful and personal to help their recovery. The current findings imply that healing after a diagnosis of depression can require different subjective and idiosyncratic sources of assistance beyond, for example, more traditional coping skills. Alternatively, they might show that something additional is sought in the individual, which they may be able to discover through exploration assisted by professionals. Thus, working with subjective recovery engagements might better tie in with the elusive qualities of recovery for healing. It may be seen that these insights are in accordance with those of Ventegodt, Andresen and Merrick (2003), who propose that human experience can be understood from the most abstract level of existence, which may be conscious, spiritual or soulful.

4.3.2. Physical Healing

In the interpretation of the participants' experiences, there seemed to be a focus on the embodiment of being recovered. However, it might be helpful to acknowledge that at times, when participants appeared uncertain of how to articulate and conceptualise the subsiding of their experiences of depression, they referred to the body. In particular, as participants felt closer to being recovered, a sense of hopefulness took precedence, encapsulated by a heightened physical awareness and connection to a felt bodily sense. Participants appeared to move between the mind and body to integrate their descriptions of feeling liberated from their pain. In relation to the body, the findings suggest an overall awakening from what seemed was interpreted as a sense of deadness.

Ratcliffe (2015) holds that the experiences of the body and the world are connected and that the ways in which we experience our body are at the same time ways of experiencing the world. The individuals in this research described their depression as a deadness or numbness which seemed heightened by their isolation from those around them and their usual engagements in the world. Some described experiencing others as demanding, in terms of seeking from them things they were not able to deliver with this heightened sense of heaviness. Most of all, it appeared that their re-engagement with their environments during recovery shifted their sense of numbness into a physical reawakening. The more they physically engaged with their surroundings, the more they seemed to experience wakefulness. This can be related to the research of Sutton et al. (2012) concerning the experience of engagement in recovery, which involved many layers of being and participants experiencing recovery as a development from numbness to an unconscious awakening of physical senses.

The present findings offer further detail for gaining a sense of this experience, as participants described breathing again and seemed to make sense of this as an experience of being resuscitated. They suggested that their recovery involved a physical feeling of elevation and weightlessness, which contrasts with their descriptions of the heaviness and lowness of depression.

Humanistic ideology asserts that recovery encompasses multiple, complex, dynamic imagery and felt sense (Gergen, 1996, as cited in Warmoth et al., 2001). Fullagar (2018) argues that recovery is more than a process of transforming thoughts, chemicals or interactions with the world, instead emphasising recovery as an intra-active, entangled process through which agency emerges in embodied multiplicity. In line with this study's findings, Fullagar's participants' embodied movement appeared to be co-implicated in the affective and entangled relationships which shape women's experiences of recovery. This process might be the same for men, as seen in the current study. Such insights together indicate that thinking beyond binary experiences of recovery is crucial to gain a closer sense of this experience.

The present findings further draw attention to the embodied distress of recovery and encourage us to incorporate ways of working which attend to individuals' bodily experiences in recovery and those of becoming 'alive'. They also suggest that hope is an embodied experience, as these bodily experiences appeared to mean for the participants that they were recovering. Therefore, understanding that perception of recovery is evoked in multiple ways, including as reconnection with both surroundings and bodily experiences, may be a

further dimension in the assessment of recovery. Moreover, these findings are congruent with mindfulness-based practices, in which the awareness of one's body is the focus for change.

Further findings convey present recovery in the context of regaining physical sensations, which varied among the participants. For example, one conceptualised the feeling of being recovered as visually regaining sight of the world and life, and visualising exuberance and blissfulness. This is in line with the notion of recovery involving a regaining (Young & Ensing, 1999), though it differs in its identification of what is regained, with an emphasis on visualisation of the world. A possible understanding of this finding is that, since participants had described a darkness with depression and the world feeling somewhat like an ugly place, as they re-engaged back into the world, their senses changed. The participants' senses were perhaps heightened and their experiences intensified, as most had described feeling isolated for some time, leading this spatial re-engagement to become magnified.

One participant commented on noticing minor things around them which perhaps would usually be ignored, while another mentioned becoming aware of the smaller things which would usually be taken for granted, describing these aspects of recovery as 'bizarre' things that hold much significance. There appeared to be an implication that, while we may consider these moments bizarre, for some they are central to recovery and potentially highlight a lack of understanding by others. What is more, these findings mirror the literature around recovery involving re-engagement and spatial connection (Sutton et al., 2011). Such findings strengthen arguments for remaining open to the nuanced ways in which people may experience their recovery from depression.

Findings of this exploration regarding restlessness, movement and returning humour all seem to reveal some form of embodied hope and healing for the participants. An insightful finding was the experience of recovery as striving to find pleasure in physical taste, and this returning. One participant described depression as leaving her without taste, stripping away flavour and perhaps life, while recovery was interpreted as reviving these senses. Such accounts emphasise how fundamental the personal intricacy and subjectivity of recovery might be and what could be understood as the metaphorical disarming of depression.

On the other hand, it is also important to consider the contextual factor that most of the participants described using food or some form of substance to numb themselves from feeling, which perhaps made them feel divided in some way from their senses. When they no longer engaged in these practices, they were perhaps then able to feel, and taste, for example, these senses was potentially heightened.

While it may be said that these reports, particularly in relation to one's senses, do not represent traditional measurements of recovery, still they signify for some participants that they had recovered. Re-experiencing these powerful sensations of wellness evoked positive feelings in participants, which stimulated their body language as they spoke, drawing further attention to their felt sense. This perhaps shows that assessing recovery goes beyond standardised scales, which for some feel unemotional, restricting and detaching. The reports provided a sense of fulfilment beyond societal perceptions of progress and, in some ways, verbal dialogue. Warmoth et al. (2001) finds recovery to surpass linguistics and enter the realm of dynamic imagery, experienced through all the senses, consistently with these phenomenological accounts.

The present findings are suggestive of the idea that the body remembers and possibly communicates when the mind is unable to, perhaps resonating with trauma narratives. They suggest that working with the body and mind is important for overcoming depression. The descriptions relating to physical embodiment offer therapeutic insights for clinical practice. They propose that approaches that focus only on the mind, such as talking therapies, may overlook the importance of integrating mind and body. Therefore, for those with experience of depression, it may be helpful to support approaches which can encourage connection with the physical, such as mindfulness, rather than talking therapies which focus on changing thoughts.

However, one may remain curious as to whether this physical expression is down to difficulties in finding suitable words to communicate a unique recovery experience. To elaborate, one of the participants referred to the body for shared and clearer understanding. There seemed an assumption that the researcher would automatically understand a physical manifestation, as perhaps culturally this is the predominant way of talking about recovery. This posits that physical analogies are more accessible, due to more frequent engagement or perhaps exposure to physical health connotations and language, than those of mental health for some participants.

Alternative understandings however came from another participant who challenged the more romanticised experience of recovery and offered a more mundane sense of healing. Such findings echo Davidson and Roe's (2007) characterisation of recovery as an everyday life experience. It suggests that being recovered is not always blissful for some and is rather an ordinary experience, perhaps indicating that clinicians need to be mindful of such contrasts.

4.4. *The Blemished Trophy*

Basset and Stickley (2010) reported identity to be paradoxically something permanent yet changing. Participants in the current study noted this paradox. Some participants described experiencing both a sense of disillusionment alongside feeling triumph for overcoming depression. Current literature on the recovery paradigm model often emphasises the transformation of a conceptualised self, typically in stages in relation to depression, with some studies acknowledging a conceptualised self that continues to identify with illness. The current findings challenge both the notions of 'returning back to normality' in a traditional sense and romanticised conceptualisations of self. The participants in the current study described how they felt stronger but they did not escape unscathed. It is acknowledged that most of the participants demonstrated an increased capacity to be introspective, which could have further heightened the findings that emerged.

4.4.1. The marking of the journey – remaining traces

Drawing from the theme entitled a marked journey, participants alluded to being marked in some way as though this seemed the price of surviving their distress, a perception of themselves as not coming away from this untouched.

The findings suggested that recovering from depression might leave a sense of an irreparable mark and a conscious awareness of no longer being the *same person.* Their experiences of themselves in the world had changed, whether it was through different friendship groups, professional care, or general awareness of mental health, and this potentially heightened their perception of themselves as a different person. Most described an everlasting feeling of imperfection engraved into their lives or the feeling of being left with the battle marks of their recovery. In line with Ridge and Ziebland (2006), depression was not necessarily banished but written into their lives and the turmoil experienced could not be forgotten. The findings suggested that the experience of depression remained with most of the participants in some capacity. Despite self-identifying as recovered, participants appeared to perceive themselves with some residual form of their pain that would remain with them forever. For most participants, this appeared to mark an imperfection as they had to accept that they did not seem to experience themselves in the same ways prior to this experience, and a sense of limitation remained.

Such findings can be argued to resonate with medicalised notions of instability and deficiency in relation to the experience of mental distress; perhaps these participants still struggled

between medicalised assumptions of normality and their subjective views. While the participants described feeling recovered and stronger, there still seemed to be a feeling of being marked. This might be heightened by their cultural and societal comparisons in that, in relation to these standards, they feel they will always be limited due to the stigma of mental illness. Therefore, while recovery of the self is based on meaning-making, the social context influences how participants perceive the progression of their recovery and, further, how they come to view themselves as recovered. As they are recovered and living in the world again, and engaging with their surroundings and others, this perhaps heightens their sense of difference. A few mentioned that they had felt, in the past, that previous friends were insensitive towards their distress and this in turn perhaps leaves one to feel like an un-person. Therefore, such findings support the literature asserting that recovery is also a social experience (Price-Robertson, 2016; Topor et al., 2011).

The findings suggest that although most seemed to want to rebel against ideals of normality, this might not always be possible in the context of depression. However, participants did not seem to refer to having remaining symptoms of depression; instead, a trace of vulnerability remained. This might be attributed to the stigma of mental illness, particularly in Western cultures, and how we speak about those with experiences of mental distress as 'vulnerable' people. These participants were potentially embedded in this concept of identity, possibly emphasised through their engagement in psychological and medical services and their own connotations of health.

However, the current findings shift from understanding this imperfection negatively, drawing attention to the various instructive and emotive meanings it has held for the individuals. These findings resonate with trauma narratives, which assert that there is no return to a former life (Davidson et al., 2005). The findings suggested that, for some, recovering from depression involved accepting a loss of the 'self' they had before. This differs from both the medical and recovery approach emphasis on a returning of a former self or former state. It is also important to note that some of the participants felt their lives before depression, retrospectively, were not healthy in some way. One participant reported that due to having a long history of depression, they almost did not have a former life to which to return. Therefore, a previous way of being for these participants did not appear desirable, and perhaps this emphasised the need to stay away from an old self or not see this return as a possibility. There can be an implication that they lost their sense of self and therefore it was difficult to go back to it. Such findings might also resonate with Veseth (2012), where recovery is experienced as something more than one's previous way of being.

Nonetheless, this realisation of loss evoked varying emotions; one striking finding was the undertone of mourning or missing aspects of life before depression. However, this varied between the participants and seemed specific to their personal circumstances, such as one participant missing her previous life as this was the life she shared with someone who had since passed away. Therefore, life before depression and perhaps before bereavement was less painful than life as recovered and without the loved one – *I am happy now but not as happy.* Such findings inform of the complexity in recovery and remind us of the nuances that may be overlooked in understanding what it might be like to be recovered.

These findings might point towards questions of how the expression of sadness in the context of recovery from depression is clinically perceived. It can be argued that a sense of sadness in recovering from depression is not simply a pathological 'low mood' as it can be a healthy response to a person's experience and perceptions of losses. Some participants initially seemed hesitant to describe the pitfalls of life as recovered, almost as though there is a cultural expectation that being recovered was assumed to mean no more difficulties – *happiness.* These findings suggest that more support is needed to normalise feelings of disillusionment in recovery, as this may be crucial for some in maintaining their well-being. Anthony (2000) proposed that recovery moves beyond illness and encompasses recovering from the effects of disruption upon the conception of self.

The findings suggested that being recovered did not mean being perfectly repaired or remaining completely broken. It seemed that participants were healed but retained lasting markings of their suffering. These markings were perceived by the participants as enduring, harmless and useful to their lives. The findings suggested that the markings reminded participants of their vulnerabilities as human beings, and a place to which they did not wish to return; the markings also reminded them to be self-compassionate and they acted as buffers to further challenges. It might be argued that helping people to 'change' what can be described as 'negative' perceptions of self might be detrimental to the purpose it might serve for the individual. Clinicians may need to be sensitive to this as what could be interpreted as residuals may also provide a unique and subjective sense of protection. In the context of being recovered, it seemed participants were able to make clearer sense of overcoming their distress and gain further understanding of their limits, rather than ignoring or being frightened by them, as would have been the case previously. Retrospectively, recovery was construed as a learning – learning to experience struggle as part of living and to accept that life and/or recovery was not absent of pain.

These findings suggested that overcoming depression seemed to leave a sense of incompleteness and their remained ambivalence as to whether a person can ever fully be recovered in the traditional sense. In line with Ridge and Ziebland (2006), being recovered seemed to involve accepting the experience of depression but not being defined by this experience. While this sense of marking or imperfection remained, it did not mean that one remained depressed or was not recovered; for these participants there were differences. In line with Davidson (2003), recovery seemed to be a way of working through and finding ways of living with difficulties and having an understanding in which distress is acceptable at times. A further argument is that seeking the personal meaning provides opportunity to consider their experiences outside of stigmatising narratives. It might also be argued that these findings resonate with aspects of humanistic ideology, which encourages facing suffering, as it informs us about our relationship with life and how the human condition has been disrupted, ultimately helping us to better recover ourselves (Schneider, 1990).

The findings further question medicalised expectations of a return to normality, and suggest that it might also be the changing of a person and the normalising of vulnerability that may continue in one's life, as opposed to remaining depressed. This might be enough for some to feel recovered. Recovery from depression may not be easily categorised due to such intricacies and this further supports some of the participants' reports of struggling to find a box to tick on clinical scales/questionnaires.

4.4.2. The Value of Recovery/Transforming.

An overarching finding among most of the participants was a sense of triumph and the perception of themselves as finally gaining or becoming 'the person' they always wanted to be. Most participants appeared to conceptualise this as their 'true' or 'authentic self', resonating with more humanistic narratives. The finding seemed to suggest that their conceptualisation of a true self, for most, represented their perception of who they always wanted to be but were afraid to be, or unsure of how to be. This seemed important, as a few of the participants mentioned in the past not having a voice; therefore, this overcoming or perhaps triumphing reassured them of their strength and, in turn, they felt able to be in this world without hiding and despite other expectations and ideals. The notion of 'knowing oneself' suggests using the 'self' to make sense and choices, further becoming an imperative perceptual, motivational and self-regulatory tool (Oyserman, Elmore & Smith, 2012). Gaining a sense of growth and transformation seemed integral to the participants' recovery experience. Andresen et al. (2003) proposed that reconnecting with oneself and life evokes

concepts of growth, change, development and transformation. This resonated with the current findings as participants described becoming stronger through overcoming depression. The findings were in line with transformative narratives of the concept of self (Andresen et al., 2003; Ridge & Ziebland, 2006; Young & Ensing, 1999). However, in this current study, there seemed to be an emphasis on the transformation of a self that had been perceived as neglected, and not necessarily a 'new self', as mostly seen in the literature.

Participants rather described recovery, upon reflection, to have unearthed personal qualities and allowed them to gain a sense of self-worth. The findings implied that participants experienced themselves to have blossomed, emerging with a more fulfilled, balanced and confident sense of self. Drawing from the relational and social models, re-engaging back into their social worlds, they seemed to feel a sense of purpose. The findings are in accordance with the literature, which finds recovering from depression to heighten self-awareness and evoke a clearer narrative of oneself (Davidson & Strauss, 1992; Ridge & Ziebland, 2006). This realisation seemed very moving and liberating for them and in some ways conveyed recovery as nurturing.

Further findings suggested that feeling more recovered helped gain clarity on what their depression meant for their lives. This might inform us that, during recovery, making sense of depression in less detrimental ways may be difficult and people need more support with this. Nonetheless, participants suggested that the experience of overcoming depression psychologically matured them, potentially heightening their meaning-making of their depression. Examples included depression being understood as the body's way of communicating that something about their lives was unhealthy and needed to change,or being reminded that they were capable of more in life. All examples were contextualised to the individual; however, overall, there was a shared sense of an edifying experience. These findings move away from normative perspectives and construe their experience of mental distress as some form of protector, which, although painful, ultimately saves them. Such findings are in line with Anthony's (1993) assertion of suffering being an instructive experience. The findings might offer insight into the psychological aspects of recovery, which perhaps encourages the need for psychological therapies alongside medical treatment in relation to depression. Ridge and Ziebland (2006) found that turning depression into a more manageable experience was crucial in recovery. The same was reflected in the present findings although there also remained a level of contradiction at times. However, the findings suggested that, while overall embracing what could be conceptualised as the chinks in one's armoury, they seemed enriched and more able to live comfortably with their imperfections

and the rising and falling of life. In line with Fosha (2002), healing and hurting was to be intertwined. Thus, the participants seemed to make sense of being recovered as both winning and losing, which perhaps reflects experiences of life and ultimately what it means to be recovered from depression. This is the paradox. Coming to this awareness may bring harmony and can potentially be a therapeutic aim for recovery.

4.5. *Evaluation of the Research*

This research offers rich and vivid interpretations that can inform us about the subjective experiences of recovery from depression, and the meanings attributed with being recovered. Overall the findings allow us to recognise that part of recovery seems to be about being unprepared in order to be prepared; the markings of recovery also seem to keep the participants aware of the self-care that they reported lacking. Further key findings involved the tensions between receiving support and a need to be independent, which have important implications in the ways we work towards fostering recovery. Therefore, providing a holding space and allowing recovery to evolve and not be forced is another central finding, particularly in relation to the time frames we work within in clinical practices. In addition, we learn that there can also be a conflict between cultural expectations of recovery and lived experiences of recovery from depression, which continue to seem difficult for people even as recovered. Alternatively, the findings further offer a sense of the relational, albeit largely the psychological experiences of recovery and the notion of fearing recovery, which can seem limited in the data but can make the difference in how people may approach recovery. The research further suggests that there might be a need to develop a psychological empirical framework towards the concept of recovery that can help anchor people in their exploration of mental distress and recovery. While an understanding of recovery seemed to involve gaining strengths it also involves accepting vulnerability and uncertainty.

The research contributes to the empirical gap in the literature on the lived experiences of recovery from depression by highlighting that participants experienced recovery to be, overall, a gradual experience that involves varying meanings – yet ultimately understanding the paradox that to be recovered is to be imperfect. The participants' descriptions highlight the complexities involved in the experience of recovery from depression. The current study builds upon valuable insights raised in Davidson and Roe (2007) relating to the co-existing paradigms that can remain in the experience of recovery and further suggests that perhaps models and frameworks might benefit from more interpretative-phenomenological research to capture this diverse experience. Furthermore, the findings suggest that this experience

may not be easily modelled and perhaps this points towards the difficulty with establishing an agreed paradigm for recovery. However, the multiplicity of assumptions, meanings and experiences regarding recovery in the context of depression pertains to the wide-ranging scope of Counselling Psychology.

The findings from the research highlight areas for further exploration into the extent to which the concept of recovery as we understand it relates well to those with experiences of depression. For example, the notion that, to recover, the fear of staying depressed needs to become greater than the fear of recovery is a key finding to explore in consideration to barriers that clinicians may be unaware of in relation to recovery or the idea of 'stuckness' (lack of progress). We learn that there can also be resistance in seeking wellness and a sense of disillusionment that can also be experienced. A further finding was the implication that participants made sense of recovery in ways that are not consistent with the diagnostical framework. The research further draws attention to the depths of ways in which overcoming depression can be communicated. Moreover, the current study highlights the necessity of valuing subjective data, which can provide useful recommendations for pathways of recovery from depression and assist in the development of theory and practice.

Qualitative research offers a channel for the scientific analysis of subjective experiences of recovery (Lewis, 1995). The IPA research provides a qualitative science that offers primacy to meaning and experiences and further offer insights from the perspectives of those with lived experiences. It allowed the research to remain close to the individuals' experiences and therefore strengthen the credibility of the findings. Additionally, the interpretive element provides further psychological, metaphorical, and implicit depth to the findings (Willig, 2013). Further evaluation of contributions, implications, limitations, and future recommendations are considered below.

4.6. *Contribution to Counselling Psychology*

While Counselling Psychology acknowledges the nature of scientific enquiry, it remains pluralistic, which seems to parallel the process of recovering from depression. It further supports the research in recognising the possibility of a multiplicity of ideas of personal, emotional and psychological experiences (Walsh, 1999). Thus, counselling psychologists are well positioned to negotiate within the range of ways human experience can be approached and made sense of (Strawbridge & Woolfe, 2003).

Counselling psychology is often understood to have broad shoulders that can hold the complexities, contradictions, and ambiguities often association with human experience

(Strawbridge & Woolfe, 2010). Therefore, exploring a concept such as recovery speaks to the interests of counselling psychologists who, while able to recognise the social and political context, can further challenge the societal and dominant assumptions surrounding the existing concept of recovery. Simultaneously, counselling psychologists are well positioned to embrace the first-person account as valuable knowledge. Therefore, there remains an interest towards some key concepts of the current research such as meaning-making, self and other intra-psychic matters. However, counselling psychology further draws attention to the context, interpersonal dynamics and other broader relational factors in which people's experiences remain embedded in and can be central to understanding the recovery experience.

Attempting to understand recovery might involve drawing from a wide range of perspectives and this can assist counselling psychologists in building the recovery agenda. Both counselling psychology and interpretations of recovery can be perceived to straddle the tensions between humanistic and traditional values. This can further allow for investigation into qualitative measures that can meet operational needs without neglecting personal meaning and critically engage in discussions regarding pathology and recovery. Anthony (2000) argued that consumers hold the key to their own recovery and the role of professionals is to facilitate this. Collaboratively exploring lived experiences opens a conceptual space in which different understandings can co-exist (Martin, 2010). Explorative research is pertinent to the phenomenological compass of counselling psychology training and practice (Martin, 2010). However, embracing elements of both a scientific practitioner and reflective practitioner approach is fundamental (ibid.).

In relation to understanding, counselling psychologists assist people in making sense of their own experiences and honour subjectivity and individuality, which is key to the present research. Exploring subjectivity can be an influential resource to enable different ways of thinking about well-being and recovery (Fullagar & O'Brien, 2012). With the present research focused on individual experience, professionals can gain insight into what might be most helpful for those recovering and how best to meet needs from an individual perspective. A deeper and fuller understanding can inform clinicians and researchers on how to further publicise recovery (Lafrance & Stoppard, 2006). The findings potentially enhance psychological practice and encourage professionals to think beyond treatment, causality, compliance and illness (White, 2007, as cited in Fullagar & O'Brien, 2012). As counselling

psychology seeks to establish the latest research to inform practice, this research offers new insights into guiding suitable interventions and knowledge for those with depression.

Recovery centres largely on fostering optimal well-being, which is integral to therapeutic practice and draws upon counselling psychology foundations (Strawbridge & Woolfe, 2003). Counselling psychology further perceives clients as active beings able to utilise resources accessible to them in order to construct a more satisfying life (Bohart & Tallmann, 2009). This has further been found in the present findings where participants felt able to utilise their strengths and sense-making to progress their recovery and growth. Ridge (2009) describes individuals as being meaning-makers, creating narratives about their lives and difficulties. This speaks to counselling psychology's humanistic foundations, which value meaning (Magyar-Moe, Owens & Conoley, 2015). Magyar-Moe et al. (2015) proposed that meaning embodied motivation and passion for aims in life. It can, therefore, facilitate recovery from distress, despite meanings not always leading to positive interpretations (Kamijo & Yukawa, 2014). Clinicians can ensure that people have opportunities to gain awareness of their ability to influence their distress, regain authorship of their recovery and appreciate their personal efforts of 'self-righting' (Amering & Schmolke, 2007). The research findings might further encourage fresh and innovative ways of supporting those in recovery from depression and assist in the promotion of building personal resilience and meaning, alongside managing symptoms. The research findings can be suggested to resonate with the holistic perspective on mental distress, which tends to focus on the person and not simply their diagnostic symptoms.

Moreover, this research contributes to counselling psychology as hitherto there has been limited empirical research in this area. Its findings can strengthen this area and compensate for the limited conceptual and phenomenological inspired development in personal recovery from depression. It is essential for counselling psychologists to communicate an understanding of individuals' experiences and help people name and understand their own recovery. Therefore, this research in line with Glover (2006), where providing insight into how individuals can be engaged in their recovery and how clinicians can move with them by providing adequate environments for support is important. It is a further chance to seek out the lived knowledge and validate personal experiences.

Although depression is under the umbrella of mental distress, it can stand alone and have multiple meanings impacting recovery. Therefore, the current study aims to offer reflections for the existing debates that remain around the concept of recovery, albeit with a greater

relevance to those with experiences of depression and expectations of recovery. Ultimately, this can help us to offer a better quality of care for those in recovery and further draw attention to those who self-identify as recovered. Furthermore, this knowledge can assist in developing the UK's recovery vision as personal recovery literature in the UK can appear less developed than literature conducted in other Western countries such as the United States of America and Australia. Nonetheless, in line with Starnino (2009), enhancing standardised recovery concepts and offering a clarity of personal components that can be encompassed into a framework that allows for consideration of all contributing ideological positions suitable for the individual may be a crucial development.

4.7. *Implications and suggestions for clinical practice*

Various implications can be drawn from this research for psychological and mental health services. Approaches within psychology and psychiatry can be criticised for overlooking subjective well-being: the findings illustrate the importance of including this knowledge to better understand recovery from depression.

4.7.1. The power of meaning

The findings have shown a range of meanings which seem to aid participants in their experiences of recovery. For example, the research suggests that recovery can appear for some to be an intimidating experience, in some ways perhaps more intimidating than depression and possibly from the perspective of the unfamiliarity of the experience. Such findings draw attention to potential barriers which may not be shared with clinicians or those attempting to support recovery. Thus, the insights encourage us not only to think about how people might recover or what the goals for recovery could be, but perhaps first also to understand how the clients themselves perceive the experience of recovery. The participants in this research highlighted that initial expectations of recovery, for example as a straightforward process, differed from their lived experiences and therefore in some ways heightened their sense of struggle. Such findings can point towards different ways of thinking about the assessment of goals of treatment or therapy: it might also be helpful to start with the meanings individuals (clients) attach to recovery and to engage them with this throughout the process. Building meaning-making into the therapy process, together with clients the patient, can help to stimulate further insights, as appeared to be shown in the interviews with the participants in this research.

I have further interpreted that loss of personal meaning might be a barrier in recovery and living their lives. It might be productive for clinicians to encourage people to explore their understandings of recovery to make sense of their circumstances. Facilitating people's quest to understand their experience of depression in less destructive ways, alongside other interventions, might be essential for recovery with this client group. Furthermore, the range of findings supports the possibility of multiple realities and worlds that people can experience. Clinicians should be aware of these multitudes and provide appropriate assessments to help individuals receive adequate support. Understanding that it might be important to find a purpose and to make sense of recovery in ways relevant to clients' relational lives could potentially help to facilitate and encourage other cultures of healing.

4.7.2. The length of recovery

An imperative consideration that emerged in the analysis was to interpret enduring, indeterminate and unpredictable experiences of recovery from depression. These findings suggest longitudinal studies as another way to approach emerging experiences of recovery and thus potentially to provide more in-depth and fuller insights. A key finding of this research can further challenge the current focus on brief or time-limited therapies that predominate in mental health services in the UK and other western countries: it seems that such therapies may not necessarily be helpful to people with experiences of depression. This encourages us to think about the flexibility of our approach to practice and in relation to policy. The culture of 'quick fix' therapy or cultural norms suggesting that depression is something one might simply 'snap out of' which can heighten stigmatisation and draw less attention to the complexity of peoples' experiences. The current research findings can help to normalise the experience of lengthiness or timelessness which some may experience in recovery and in turn educate those who lack awareness. Clinicians might need to reinforce the notion of variability to reassure people that lengthy or changeable recoveries are not atypical. From a service perspective, these findings can shed light on the extent to which short-term therapy typically offered within the NHS is sufficient in working with the potentially evolving process of recovery from depression. It might further offer critical insights into re-admissions, re-referrals and relapses. Broadening our knowledge of recovery and the potential inter-subjective elements may be helpful in guiding those who continue to struggle.

4.7.3. The embodiment of recovery

The research findings further resonate with notions of embodiment illustrated in descriptions of participants' bodily felt sense of recovery. Participants utilised bodily and physical metaphors to communicate experiences that appeared inaccessible or difficult to verbalise with existing and perhaps normative terminology. The findings further demonstrate that recovery from depression might involve a dual process involving both the mind and the body. This could encourage clinicians to be more curious and explore how depression and recovery may be contained and made sense of in the body. For example, being able to breathe again, the subsiding of numbness or a returning sense of feeling are experiences which help people engage in and understand their recovery. Such interpretations already enact a shift from a sense of pathology, which some individuals struggle with in their recovery experiences. There may be a need to better engage this group in therapeutic work pertaining to individuals' connection with their bodies. Also, techniques that aim to connect the mind and body, such as mindfulness, are likely to be important during this stage of recovery from depression. Further, self-compassion played an integral role for these participants, self-soothing responses towards the emotional struggle they experienced in body and mind seemed helpful in recovery. From a clinical perspective, a greater focus on approaches that encourage self-soothing could be warranted here. Compassion-focused work (Gilbert, 2010) and acceptance commitment therapy (ACT) may be effective ways of working with depression, specifically where feelings of self-worth, self-evaluation and affect regulation are challenged.

4.7.4. Communicating recovery

Participants often struggled to articulate their experience of recovery – they struggled to find suitable words or easily express their experiences. It can be argued that this suggests a potential limitation in the language of recovery: people may feel more able to describe experiences of depression using terms such as 'blackness', 'deadness'. It could be helpful to consider how much existing language might shape or conflict with meanings and experiences of recovery. The research findings appear imply that work is needed to illuminate, strengthen and make accessible 'personal recovery' vocabulary.

Metaphors and imagery appeared to unpack and communicate what were considered profound experiences,and were used by participants to try to convey their felt sense. This was especially noticeable where they were connecting mind and body. Suggestions for

therapy include using personalised metaphors based upon the person's own life; this seems to be a powerful way to help people connect mind and body, facilitating the process of recovery. Metaphors were not the only forms of communication: some participants utilised more unassuming language, e.g., 'really, really nice', 'lovely'. Such simple expressions were also meaningful in the context and perhaps highlighted the importance of ordinary, less romanticised and humble ways of communicating with people experiencing recovery from depression. This also connects with the importance of being accepting and present, as expressed earlier. Therefore, there is a need to be open to all communications when exploring recovery, rather than privileging certain expressions. Recovery was articulated in a variety of ways and involved personal, abstract and numinous expressions, and further exploration of these areas could help to draw out deeper meanings. Exploring personal aesthetic and ordinary communications can assist participants to explore and express their felt sense in ways that feel more grounded in their experiences (Todres, 2007 as cited in Boden & Virginia, 2014).

4.7.5. The concept of self

There may be a further need to consider existing models of identity, such as the social model, to expand and guide practices promoting recovery from depression to include conceptualisations of the self, as this seems to be an important tool for making sense of mental distress. The participants in the current study appeared to experience a sense of a permanent 'engraving' of their journey and sense of loss, which they made sense of as 'self-discovery'. Additionally, the findings place an emphasis on 'inner power' and personal mastery; such meaning-making seemed to strengthen the participants' sense of self-worth. However, conversely, it can be noted that 'recovery' also threatened their sense of self and ability to feel victorious, particularly in relation to the use of medication. Reframing medication as an adjunct to recovery, rather than as a weakness, may help to avoid feelings of inadequacy for some, allowing them to still claim self-responsibility for their recovery.

In addition, after recovery, the interpretation of an enduring sense of vulnerability and loss suggests that this client group may benefit from working through a sense of mourning and acceptance. Therapeutic work can support people by, instead of neglecting their difficult and conflicting interpretations, making sense of them in ways that can make them seem less pathological. Clinicians' awareness of people's potential conceptualisations of themselves – for example as eternally broken – might help to support clients in their integration and making sense of themselves in less damaging ways. To summarise, powerlessness is not

exclusive to medical ideologies, as it can emerge from meanings influenced by multiple circumstances. Such findings highlight the usefulness of psychological support to help navigate between potential barriers, tensions and meanings within recovery from depression.

4.7.6. The sense of agency

The findings appear to convey a sense of individuality within the descriptions of recovery from depression and perhaps challenge cultural norms regarding passivity in relation to 'mental illness'. The findings further imply that participants were helped by having the opportunity to recover by themselves, in their own ways – clinicians might also need to be supportive here. Professionals might need to be more empowering with some individuals, while remaining aware of the balance of support. The main themes of the current study suggest that participants need some sense of ownership in their recovery, rather than feeling as though professional, medical or other support agents have contributed entirely to their sense of wellness. Without this strong sense of personal mastery, recovery appeared challenging for most of the participants. However, the current participants were those who valued self-reliance and responsibility therefore other populations may not strive for these ideal in recovery. Nonetheless, from the current findings, self-mastery could be an essential foundation for therapeutic and clinical practice, and professionals should remember that we do not simply make people recover; rather, people can also feel that they are able to recover by themselves, and we need to help them identify their strengths. Therefore, working collaboratively and providing a supportive but not overpowering base to facilitate recovery might be integral to successful promotion of autonomy, self-worth and agency in recovery from depression. Moreover, what appeared most impactful regarding professional care in this research were displays of compassion, humanity and trust. These factors appeared to enable participants to feel deserving of their recovery and instilled faith in their sense of self, suggesting that recovery involves more than treatment or therapy. One interpretation of participants' accounts is that a sense of the *person* and/or humanity of both the individual and the professional is needed for recovery.

4.7.7.Conceptual connotations

Although measuring outcomes is an integral part of clinical care, outcomes alone may not be adequate for recovery treatments (Atterbury, 2014). It is possible that physical symptoms during the recovery journey, for example when the mind and body are reconnected, may

indeed increase through increased awareness. The themes which reflect such patients' lived experience perhaps call for notions of recovery to be more inclusive of humanistic and existential concepts as recovery outcomes. Standardised practices may be insufficient in capturing the human experiences evidenced in the research, such as the contradictory and dualistic experiences of recovery. These concepts are applicable to clinical practice and can be considered in the training of counselling psychologists, widening our analytical and philosophical thinking. Counselling psychologists can help establish and build upon these personal experiences, particularly for those in recovery who struggle to categorise their experience into existing outcomes. The findings can be influential in making valuable changes to how professionals, stakeholders, organisations and the public understand recovery, and help to humanise this process. The findings might further suggest a need for integrative approaches to more effectively work with the complexities of recovery from depression, as opposed to pure symptom reduction. Perhaps clinicians should be encouraging clients to explore and work with their experiential processes and the human dimensions of distress and healing (Todres et al., 2009; Young, 2010;).

4.8. *Strengths and limitations of the research*

An underlying strength of the research is the qualitative and interpretative-phenomenological approach taken, which offered access to many levels of the participants' experience and illuminated the complexities and nuances of recovery from depression. In-depth interviews and detailed analysis, with the small sample size of seven individuals, allowed exploration of these rich experiences and themes. Another important strength is the study's focus on conceptualisations of recovery from the lived perspective and not simply clinical and professional perspectives. The present research differs further from many previous studies in remaining specific to depression as opposed to mental distress more broadly. Furthermore, the research goes beyond treatment and causality, which can seem the conventional ways of making sense of health. The findings can address particularities when working with this client group which however also considering context. To my knowledge, the current study is so far the only one to solely explore personal recovery from depression using interpretative phenomenological analysis (IPA) to explore from the individuals' frame of reference. Existing qualitative literature tends to focus more on social constructs, gendered experiences or mental illness. The present research further contributes to the phenomenological literature on recovery in British populations, but also highlights the need to conduct both quantitative and qualitative research into personal recovery. It is

hoped that those seeking recovery, as well as the relevant clinicians, will remain open-minded and reflect on how they make sense of recovering from depression.

In light of the depth of what we have learned through using IPA in this research, there are limitations. An effort was made to provide a more nuanced insight into the lived experience of recovery from depression; however, these findings are therefore likely to be specific to each participant's distinctive experience and worldview. Qualitative research does not seek to generalise findings in the same ways as quantitative research; however, it is still important to consider the findings considering those who participated (Willig, 2013).

Although more women in comparison to men responded to the research advertisement, the recruitment indicated that there are men willing to share their personal experiences, and perhaps future research could focus more on a mixed-gender sample or only on men, as there is ample data on the female population. In the current study there was only one male participant. Despite the imbalance, commonalities were seen throughout the analysis. Further, all participants were of English or European ethnicity; considering the findings across more diverse populations could enhance our understanding and offer deeper insights. Therefore, it may be useful to explore on a more diverse scale using other methodologies that allow for more generalisation of the findings, factoring in ethnic, cultural and socio-demographic factors to ascertain how such variables might affect recovery from depression. Another possible limitation could be the use of a single interview for data collection. A follow-up interview might have allowed the participants an opportunity to reflect on what appeared to be an emerging experience and offer additional insights into further changes.

It was deemed important for this research to recruit participants who would refer to their subjective experiences of recovery. However, it might have been useful to consider other ways of exploring these experiences without the use of the term 'recovery'. Nonetheless, the research acknowledges that finding a term which is not value-laden is impossible; difficulties remain even with terms such as 'healing', 'moving through life'. Similarly, the emphasis on sharing one's personal experiences may have influenced a sameness in the findings regarding individuality and autonomy, instead of more diverse realities. However, the relativist position of the research might also have enabled more marginalised experiences of recovery to emerge.

My own understanding of recovery from depression and my experience as a mental health worker may have directly influenced the development of the research themes. In IPA, this is explicitly acknowledged, as there is a double hermeneutic where the development of themes are based upon my interpretation of the participants' interpretation of their experience.

Reflexivity aims to ensure that these interpretations are made explicit. It is possible that the sense of sameness shared with my participants, in terms of our similar views on mental health, also contributed to deepening some psychological and individualistic reflections: there seemed a mutual understanding between researcher and participants that those with mental distress can feel like their individual experiences are less valued. My engagement in the research themes may have unintentionally communicated my personal positions; however, I remained conscious of this potential throughout the research. As previously mentioned, in the methodology section, there seemed an assumption on the part of some participants that, as a counselling psychology trainee with an interest in depression, I shared certain characteristics with them and therefore would understand their experiences. Therefore, it is possible that participants may not have expressed aspects of their experience in as great detail as they might have done otherwise. Conversely, this sense of familiarity might also suggest a level of comfort among the participants in the interviews, which possibly allowed them to feel more able to open up to me on an emotional level. However, it is important to add that the participants seemed able to reflect upon their experiences in similar ways such as straddling between norms of normality and psychological experiences. similarities might yield limited opportunities to gain a broader understanding and might have impacted on the data and the analysis.

Further limitations might include the recruitment process, which seemed to attract a more middle-class demographic. The findings may therefore reflect a more privileged group of individuals with better access to educational, occupational and social opportunity; this group's experiences of recovery may differ from those of other groups. Recruiting individuals through the mental health charity SANE and university resources may have enabled participants to feel more confident in entering into a one-on-one encounter with someone perceived to be of a professional background. However, there was the potential to overlook individuals with limited access to resources, or those who may have felt intimidated by face-to-face interviews.

4.9. *Research Reflections*

Inter-subjectivity recognises that meaning is based on one's position of reference and is socially influenced (Given, 2008).

Recognising that experience is inter-subjective suggests that people's interpretations cannot be exclusively idiosyncratic or free-floating (Willig, 2013). From this perspective, the current research findings are not personal in that their understanding of experiences emerges from

within the participants, uninfluenced by their interactions with the researcher. However, the research is considered personal as it is interested in how individuals perceive the world and their subjective experiences. This double hermeneutic highlight the importance of reflexivity – that is, the researcher's being aware of their own biases and influences. It recognises that a complete study of subjectivity is impossible.

It is important to acknowledge that some aspects of the participants' demographics closely resonated with my own in relation to gender, education and in some ways aspirations. Further to this, I was of a similar age to at least half of the participants; these elements acted as a means of connection and perhaps reduced the level of suspicion or mistrust. Such familiarity or sameness may have facilitated the process of research. Interestingly, while there was only one male participant, I noticed an ease of communication with him and recall being particularly drawn by the profound ways he interpreted his experiences, which in some ways felt particularly resonant with my own. Bowleg (2008) asserts that social identities are more complex than merely the sum of their constituent parts. These elements can be understood to have had a significant influence on the ways we communicated during the interviews and how I interpreted the findings.

Most of all, my background in psychiatric mental health care perhaps played an important role in my understanding of the participants' experiences. Whilst this information was not shared with them directly, it did not escape me that most of the participants, particularly those who were recruited from the mental health charity (SANE) or shared some interest in in psychology, made sense of their experiences in ways that seemed familiar to me. This perhaps led us to draw on themes such as concepts of self, individual experience, felt sense and other. Further to this, most of the participants were aware to some degree of the concept of recovery as applied to 'mental illness' and some of the tensions, therefore we were already engaged in a shared understanding to some degree.

Most of the participants appeared at times to visibly enjoy engaging in symbolic descriptions and reflecting on their experiences in ways that also challenged standardised notions. This also echoed the argument that people diagnosed with depression can make sense of their recovery which are not always consistent with medical narratives. Thus, in some ways, my position as a mental health worker allowed me to be sensitive to similar views in the participants, and to pick up on conflicts in which I, too, was engaged. One further point to briefly consider is that individuals offered descriptions of care, empathy and humanity as important therapeutic concepts which I share, and perhaps in conducting this research there was an understanding that recovery can be a delicate experience. Furthermore, gaining

awareness and developing strengths, alongside potential limitations, were perhaps concepts that the participants and I understood mutually to be valuable.

Overall, the engagement with and discussion around the topic during the research interviews seemed to allow the participants to gain further, shared insights of their experiences, Therefore, through our interactions participants were able to become more self-aware in relation to their recovery experiences, which perhaps illustrates the importance of interpersonal processes in relation to making sense of personal recovery.

4.10. *Future research suggestions*

This research offers insights that could enhance the psychological understanding of recovering from depression. These could further understanding of what people believe themselves to be recovering from and inform professionals as to how best to perform therapeutic practice. The conception of self was a theme that emerged throughout the findings; therefore, it would be useful to explore the change process of how patients may perceive themselves in recovery and the threats they experience to their sense of self. This can provide knowledge on psychological experiences of recovery and what practitioners might need to consider when working with this client group. The concept of self as recovered is another area in need of further exploration, as the current findings illustrate that there can also be a feeling of disillusionment and loss which may be crucial in our understanding of this experience.

The meanings and experiences of recovery for the individual were broad yet distinctive in this research and seemed to evolve as recovery developed. Therefore, future research into whether the process to recovery is conclusive or ongoing, or whether there are other meaningful ways of defining recovery, may further promote clinical theory and practice. As stated earlier, a longitudinal approach for gathering data may allow practitioners to gain a fuller understanding, which can further assist in developing the recovery agenda. Similarly, the linguistics of recovery might be developed using the phenomenologically inspired data, grounding a relatable language in which to communicate recovery from depression.

Finally, it may also be useful to conduct research on people who have recovered without the aid of psychological or professional support and explore whether their experiences and meanings contradict or support the findings. Such information, alongside the present findings, can provide other insights and be useful to those who may not be able to access professional support. There are many pathways for exploring recovery which may advance our knowledge of the power and resilience of individuals. These findings might resonate with

aspects of resilience, in that participants, despite difficulties, can be able to respond and heal (Harper & Speed, 2012). Perhaps future research into this area can add a further dimension.

4.11. *Conclusion*

A salient contribution of this research is the suggestion that recovering from depression has multiple, often contradictory meanings that can at times seem difficult to reconcile and to depict a paradoxical experience. The process of recovery appears to involve a difficulty in moving forward, plunging in for change, reconnecting to body and mind and a blemished trophy. Discussing what recovery means to individuals and gaining a sense of how they experience this process will help develop a shared understanding and overcome barriers in facilitating recovery. It would seem that defining experiences in ways meaningful to them possibly enabled participants to build courage in facing up to their suffering to emerge as an evolved individual. In many ways, the findings imply that the recovery experience appeared to offer an opportunity to transform their pain into something valuable for their lives. A pivotal interpretation was that vulnerability and imperfection were ultimately inescapable life experiences, rather than simply pathological signs of abnormality or deterioration in well-being. Thus, it might be argued that the findings go beyond over-simplification of symptomology and potentially offer a more grounded, complex and humanising understanding of recovery from depression. It can further be suggested that retrospectively, depression seemed to serve a personal purpose in participants lives, beyond destruction. One salient finding is that the participants suggested that recovering from depression 'unearthed' and nurtured human qualities needed for them to live well and feel secure. If recovery is embodied within personal context, healing may be broader, more meaningful and more in unity with the complexities and quality of one's well-being (Todres et al., 2009). Overall, in this research, the experience of recovery was largely an experience involving multiple 'discoveries' for the participants.

The current research findings continue to appeal for a revolutionary change in how depression recovery is conceptualised. It would seem helpful for some if conceptualisations of recovery could perhaps exceed medical ideologies and embrace philosophical, holistic, psychological and other integrated perspectives of human science. These positions could be considered as potentially useful for theorising recovery. Furthermore, this research illuminated the voice of experience and credited subjectivity, devoting attention to how individuals might address their own recovery, as opposed to only or predominantly focusing on clinicians' accounts of an experience. We as clinicians need to be more perceptive of what

individuals themselves describe as personal qualities of recovery from depression, and remain aware of the potential tensions in their experiences. Perhaps the findings call for people to appreciate both the beauty and ugliness of recovery from depression.

5. Chapter Five: References

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6. Chapter Six: Appendices

6.1. *Appendix 1: Interview Schedule*

To note: These questions and prompts will act as a guide as the interview is semi-structured. Schedule and order will also be guided by the participants' responses.

Briefly address depression to get a sense of their experience.

- Can you briefly summarise your personal experience with depression.

Part A: Process

- **Tell me about your personal experience of recovery**
  Prompts:

  - How and when did it begin?

  -What did it feel like?

  - How and when did you feel that you were recovering?

  -Did you recognise your recovery or someone else?

  ***-**Contributions and hindrances*

  ***-**What Impact did it have?*

  ***-** Beginning, during and ending.*

- **Could you describe what feelings you experienced in your recovery?**
  Prompts

  - Throughout

  -Physically, emotionally, psychologically, metaphorically

Part B: Meaning

- **What is your general understanding of the word recovery?**
  -wonder if this is different from personal understanding
- **If you had to describe what recovery from depression means to you, what would you say?**
  -What words come to mind?

  -What images come to mind?

  -Nicknames/metaphors?

  -Do you think these meanings impacted on your recovery?

  -Has your own personal meaning of recovery changed following your experience with depression?

Part C: Perception

- **Was there a place you personally had to reach or develop for recovery and why?**
  -Frame of mind?

  -Feeling?

  -Turning point, stage, gradual?

- **Were there any other personal supportive measures you engaged in/employed from a personal standpoint which aided your recovery?**
  -internal/personal (personal qualities)

  -external, medical, psychological

  -How did this impact on your recovery

  -Were there any difficulties/challenges with the support meeting your needs?

Part D: Latter/Post

- **How does it/did it feel to have recovered?**
  -Do you feel any different or have you changed in anyway?

  - (Before & after self)

  -How do you feel about yourself now?

- **Why do you think you in particular/personally were able to recover?**
- **If you could think of a metaphor, shape or image that best describes your recovery experience what would it be and why?**
- ***What does it mean to have recovered?***

Part E: Closing Question

- **Is there anything else you would like to add about your experience or any messages for others trying to recover?**

General prompts if needed

-Can you tell me more about?

-Can you recall the feeling?

-What did that look like?

-What was your own understanding of?

6.2. *Appendix 2: Demographics Form*

<table>
<tr><td colspan="2">NAME</td><td colspan="4"></td></tr>
<tr><td colspan="2">DATE</td><td colspan="4"></td></tr>
<tr><td>AGE</td><td></td><td>DATE of BIRTH</td><td></td><td>MALE ❒</td><td>FEMALE ❒</td></tr>
<tr><td colspan="3">WHAT IS YOUR ETHNIC GROUP?
Choose one section from (a) to (e) and tick the appropriate box to indicate your cultural background</td><td colspan="3"></td></tr>
<tr><td colspan="3">(a) WHITE
❒ British
❒ Irish
❒ Any other White background
please write in below
……</td><td colspan="3">(b) BLACK or BLACK BRITISH
❒ Caribbean
❒ African
❒ Any other Black background
please write in below
…….</td></tr>
<tr><td colspan="3">(c) ASIAN or ASIAN BRITISH
❒ Indian
❒ Pakistani
❒ Bangladeshi
❒ Any other Asian background
please write in below
……..</td><td colspan="3">(d) MIXED BACKGROUND
Please write in below
……</td></tr>
<tr><td colspan="3">(e) CHINESE or OTHER ETHNIC GROUP
❒ Chinese
❒ Any other Mixed background
please write: .....</td><td colspan="3">(F) MARITAL STATUS
Please write in below
……</td></tr>
</table>

6.3. *Appendix 3: Ethics Release Form*

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor**, together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ↑ M.Phil ↑ M.Sc ↑ **D.Psych** ↑ n/a ↑

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

'An exploration into the experiences and meanings attributed to recovery following a diagnosis of depression'

2. Name of student researcher (please include contact address and telephone number)

Bridget Badu-Poku
Address removed

3. Name of research supervisor

4. Is a research proposal appended to this ethics release form? **Yes** No

5. Does the research involve the use of human subjects/participants? **Yes** No

If yes,

6-8

a. Approximately how many are planned to be involved?

6-8

b. How will you recruit them?

I aim to recruit participants in London due to practicalities of the research. I will recruit through personal contact and advertisements posted via the internet, newsletters, voluntary organisations where such issues are explored and within universities. I further intend to visit community open groups and charities where I could meet with people and inform them of the research in hope to find people that would be interested and suitable in partaking in the research

c. What are your recruitment criteria?

(*Please append your recruitment material/advertisement/flyer)*

Participants will be volunteers who have been given a diagnosis of depression and currently regard themselves as having recovered or in recovery. Those who are currently struggling with depression or present to be unwell/not recovered would not partake in the research. This will be monitored through careful wording on advertisements and an initial telephone screening with the researcher. The participants will be of adult age therefore 18 years and above is the age requirement for participation. There will be no gender, race or socio-

economic criteria within this study as these factors are not being explored. Some form of purposive sampling will be administered.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? Yes **No**

d1. If yes, will signed parental/carer consent be obtained? Yes **No**

d2. If yes, has a CRB check been obtained? Yes **No**
(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

An individual semi-structured interview will be conducted for participants to respond to where able to and lasting for approximately 90 minutes. The interview will be face to face with the researcher and further be audio recorded to maintain its original form of meaning. Prior to the interview, participants would be asked to give written informed consent.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes No

If yes,

a. Please detail the possible harm

The researcher will be aware of any emotional distress or discomfort which may unexpectedly surface within the interview on exploring the sensitive topic of depression. Nevertheless, the researcher will ensure participants do not suffer unduly or unnecessarily risks within this study

b. How can this be justified?

The research does not intentionally set out to present any risks to participants however the topic area of depression and recovery can be a sensitive area to explore and may unexpectedly evoke difficult emotions for some in normal circumstances.

c. What precautions are you taking to address the risks posed?

Prior to recruitment an initial telephone screening will be administered once interest is expressed in order to verify that participants meet the research criteria; this would further entail that they are adequately robust to participate in the research without markedly becoming distressed.

Participants will be informed that they are able to withdraw without explanation needed or take a break from the interview if things become too distressing. Participants will be provided with a list of contactable counselling and supportive services for additional advice and support. Appropriate use of supervision and personal therapy for the researcher will further act as a safe-guard to unexpected emotional response and further the use of personal and formal networks. All relevant contact details will further be available and data collected will be password protected and destroyed once requirements have been fulfilled.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research the research, as well as providing researcher and supervisor contact details?

Yes No

Information will be given to participants

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes **No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers) . See Appendix B

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Audio recordings, research notes and transcripts will be securely kept until fulfilment of research is required.

12. What provision will there be for the safe-keeping of these records?

All records will be kept confidential to protect anonymity. Identifiable information would be protected by pseudonyms and recordings and transcripts will be kept in a secure location and on a password protected computer to be destroyed once requirements are fulfilled

13. What will happen to the records at the end of the project?

At the end of the project all records will be destroyed.
Most scientific journals require original data which include videos, audios and transcripts to be kept for five years if research is to be published. However if research it is not to be published then the data will be kept for 1 year (British Psychological Society, 2005).

14. How will you protect the anonymity of the subjects/participants?

Identifiable information would be protected by pseudonyms and recordings and transcripts will be kept in a secure and password protected location.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

A full debrief will be given and an opportunity for questions or feedback. In addition they will be given a list of contactable counselling and supportive services for additional advice and support.

(*Please append any de-brief information sheets or resource lists detailing possible support options).*
Attached

If you have circled an item in **<u>underlined bold</u>** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher: Bridget Badu-Poku
Date:21/03/14

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal	↑
Recruitment Material	↑
Information Sheet	↑
Consent Form	↑
De-brief Information	↑

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes No
If yes,

a. Please detail possible harm?

No, however if any unexpected distress surfaces for the researcher then the use of supervision and personal therapy can aid this. In addition, personal and formal networks are further available to explore any issues should they arise. Researcher will not be placed in any greater risk than would have been in normal life.

b. How can this be justified?

Same as stated above; depression is an area that can evoke difficult emotions even under usual circumstances. Though with the precautions below all should be managed appropriately.

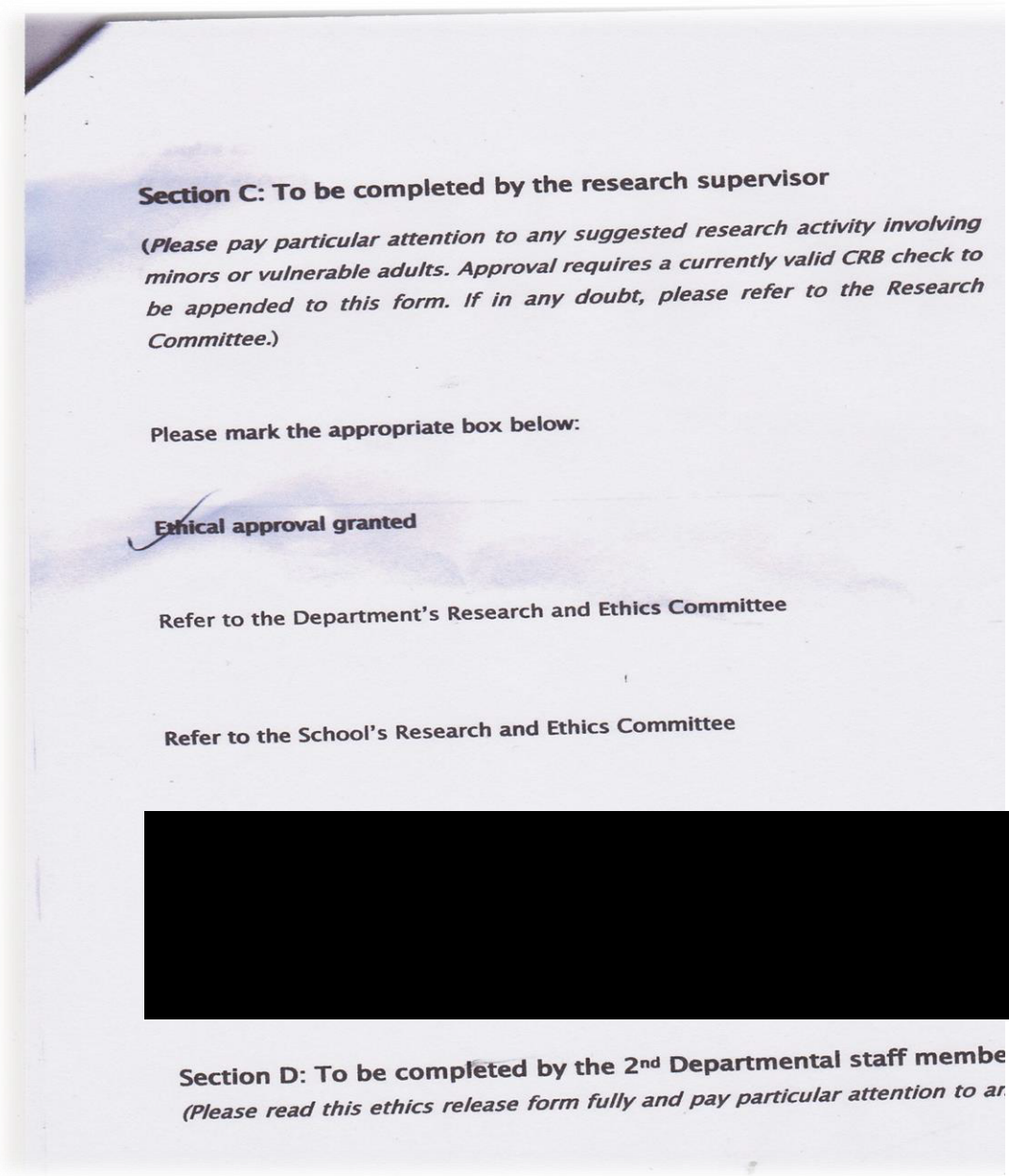
c. What precautions are to be taken to address the risks posed?

Good and frequent use of supervision and personal therapy. Other support groups and personal networks will be utilised if more support was needed. In addition keeping a reflective journal would also be beneficial in containing feelings around this

Section C: To be completed by the research supervisor

(*Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.*)

Section C of Ethics Release Form



Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

[redacted]

Section D: To be completed by the 2nd Departmental staff membe

(Please read this ethics release form fully and pay particular attention to ar

Section D of Ethics Release Form

*answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

6.4. *Appendix 4: Interview screening*

Telephone Screening Questions/Schedule

General Basics

- Are you still interested in partaking in the research?
- Please can you confirm your age?
- Are you located within London?
- Are you able to meet for a face to face interview in London?

Depression

- Were you given a diagnosis of depression, if so by which professional?
- Would you say you have a history of depression?
- Were you given a specific diagnosis of depression?
- How long did you experience your depression?

Recovery

- Do you consider yourself as recovered?
- Are you experiencing any depressive symptoms currently?
- How long would you say you have been recovered for?
- Would you feel comfortable in talking about your experiences?

If criteria is met

- Participant is thanked and arrangement of a suitable time and date for the interview is discussed. Location is further addressed and all further interview information will later be confirmed via email.

If criteria is not met

- Discuss the reasons why they are regrettably unsuitable for the research having not met the criteria and ascertain if they have understood. Apologies are given and the participant is thanked for their time and expressed interest.

6.5. *Appendix 5: Consent Sheet*

CITY UNIVERSITY LONDON

Title of Study: **An exploration into the experiences and meanings attributed to recovery following a diagnosis of depression.**

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve Being interviewed by the researcher Allowing the interview to be audio-taped Making myself available for approximately 90minutes for the interview to take place.	
2.	This information will be held and processed for the following purpose(s): -To highlight the ways in which people perceive the process of recovery from depression. -To assist in the promotion of recovery following a diagnosis of depression. -To motivate others with depression have hope of recovery and to explore alternative ways to facilitate recovery. -To explore how recovery and the experience of depression is unique to each individual. -To contribute to the knowledge of health care professionals who can explore and develop more effective ways to help enable recovery following depression. - To contribute to the limited psychological research regarding lived experiences of recovery and depression. I understand that any information I provide will remain confidential. No data that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No	

	identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part of or the entire project. I can further withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____ _____

Name of Participant Signature Date

_____ _____

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

6.6. *Appendix 6: Debriefing Form*

Title of research Study: 'An exploration into the experiences and meanings attributed to recovery following a diagnosis of depression'.

The purpose of this research was to explore how people experience their own personal recovery following a diagnosis of depression. I was further interested in how personal meaning of recovery can impact on the experience of recovery and vice versa. A wide range of research within mental health issues can present recovery in a conventional style and therefore limit the acknowledgement of complexities and variations in which mental health issues contain. Depression is widely known as a prevalent mental health issue and research into recovery focuses mainly on the absence of depressive symptoms and as an end state.

However there is limited research into recovery being experienced as a process, or a changeable experience.

Nevertheless, different people will experience things differently and therefore this should be explored to have a better and clearer understanding of recovery following a diagnosis of depression. As people are 'whole beings' an emphasis to explore people holistically (integrating all parts of self rather than separating parts of the self) may be essential for our understanding of depression and recovery. Hence this research aimed to access the personal accounts of how people experienced, understood and attempted to recover from depression. The uniqueness of peoples experience can not only encourage those struggling with depression but further have an impact on the understanding health care professionals have regarding this topic area. Thus, such research can assist in the development of effective and adaptable ways to promote, facilitate and help people achieve recovery. Consequently this could have a positive impact on intervention and treatment highlighting both strengths and limitations with current recovery approaches within psychological services.

Please feel free to ask any questions and comment on how this experience was for you. You will not be judged and will be treated fairly. Confidentiality will be upheld and only breached if a risk to harm self or others is presented.

However, if you feel this research has affected you in anyway and you would like to speak to someone about it or seek emotional support, please do not hesitate to contact the services on the following page.

If you wish to withdraw from this study or have any additional queries, please do contact me via email: [redacted]

If you need any additional needs in regard to the study you can also contact my supervisor: [redacted]

Thank you very much for your participation in this research, it is greatly appreciated.

6.7. *Appendix 7: Contact Information*

To receive emotional support, please see the contact support information sheet

This sheet is for you to keep

Contact support information

Depression Alliance: 0845 123 2320, email information@depressionalliance.org, www.depressionalliance.org - Confidential listening and support service. Also offer a range of information on depression and treatment options. National network of self help groups for people experiencing depression. National pen friend scheme offers support and fellowship to people with depression and their careers. Quarterly newsletter, booklets and leaflets on depression.

Samaritans: 08457 90 90 90, email jo@samaitans.org. www.samaitans.org. Samaritans provides confidential non-judgemental support, 24 hours a day for people experiencing feelings of distress or despair, including those which could lead to suicide.

Rethink: 0208 974 6814 (Monday, Wednesday, Friday, 10:00am-3:00pm and Tuesday and Thursday, 10:00am-1:00pm). Works to help everyone affected by severe mental illness recover a better quality of life. **Email:** advice@rethink.org **Website:** www.rethink.org

Mood Swings:

Helpline: 0161 832 3736

www.moodswings.org.uk

National Helpline and online support providing free and confidential information, advice and support to people with mood disorders, family, friends and health and social care professionals.

Useful Websites

www.mindingyourhead.info

Information relating to mental health, depression, stress and anxiety

www.moodgym.anu.edu.au – Online training programme using cognitive behavioural therapy for preventing depression

www.need-help.info – aim to help people with concerns, give support and understanding and information relating to other resources providing support.

www.overcomedepression.co.uk - Depression help and advice

www.patient.co.uk - Self help guides under mental health leaflets on depression.

You are also advised to contact your GP if you continue to experience distress as they can provide you with more immediate support.

6.8. *Appendix 8: Transcription Confidentiality Agreement*

Confidentiality Agreement - Transcription Services

[redacted]

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.

2. To not make copies of any audiotapes or computerised files of the transcribed interview texts, unless specifically requested to do so by [your full name].

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession.

4. To return all work to Bridget Badu-Poku in a complete and timely manner.

5. to delete all electronic files containing study related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement and for any harm incurred by individuals if I disclose identifiable information contained in the audio tapes and/or files to which I will have access

Transcriber's name: [redacted]

Transcriber's signature: [redacted]

Date: 2nd October 2015

6.9. *Appendix 9 : Recruitment Advertisement*

CITY UNIVERSITY LONDON

Department of Psychology

City University London

PARTICIPANTS NEEDED FOR

RESEARCH INTO RECOVERY FOLLOWING DEPRESSION.

This study will explore the personal experiences and meanings attributed to recovery following a diagnosis of depression.

WHAT IS REQUIRED:

-To be aged 18 and above

-To have experienced a diagnosis of depression

-Regard yourself as recovered or in recovery

-An initial telephone screening to verify suitability for the research

WHAT IT INVOLVES

-Approximately 60-90 minutes of your time.

-Participation in a semi-structured interview with the researcher.

-£15 cash in appreciation of your time.

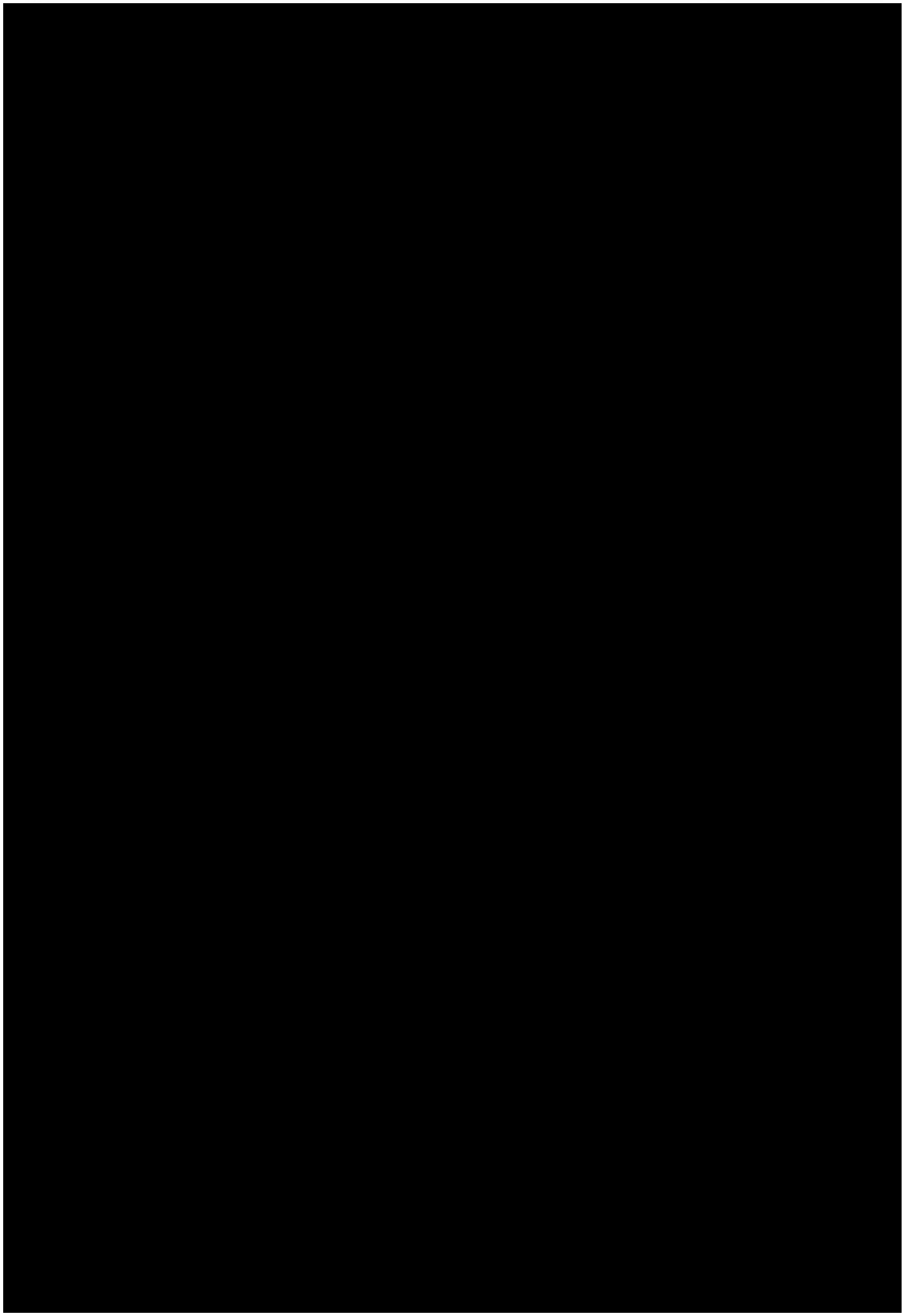
For more information about this study, or to take part, please contact:

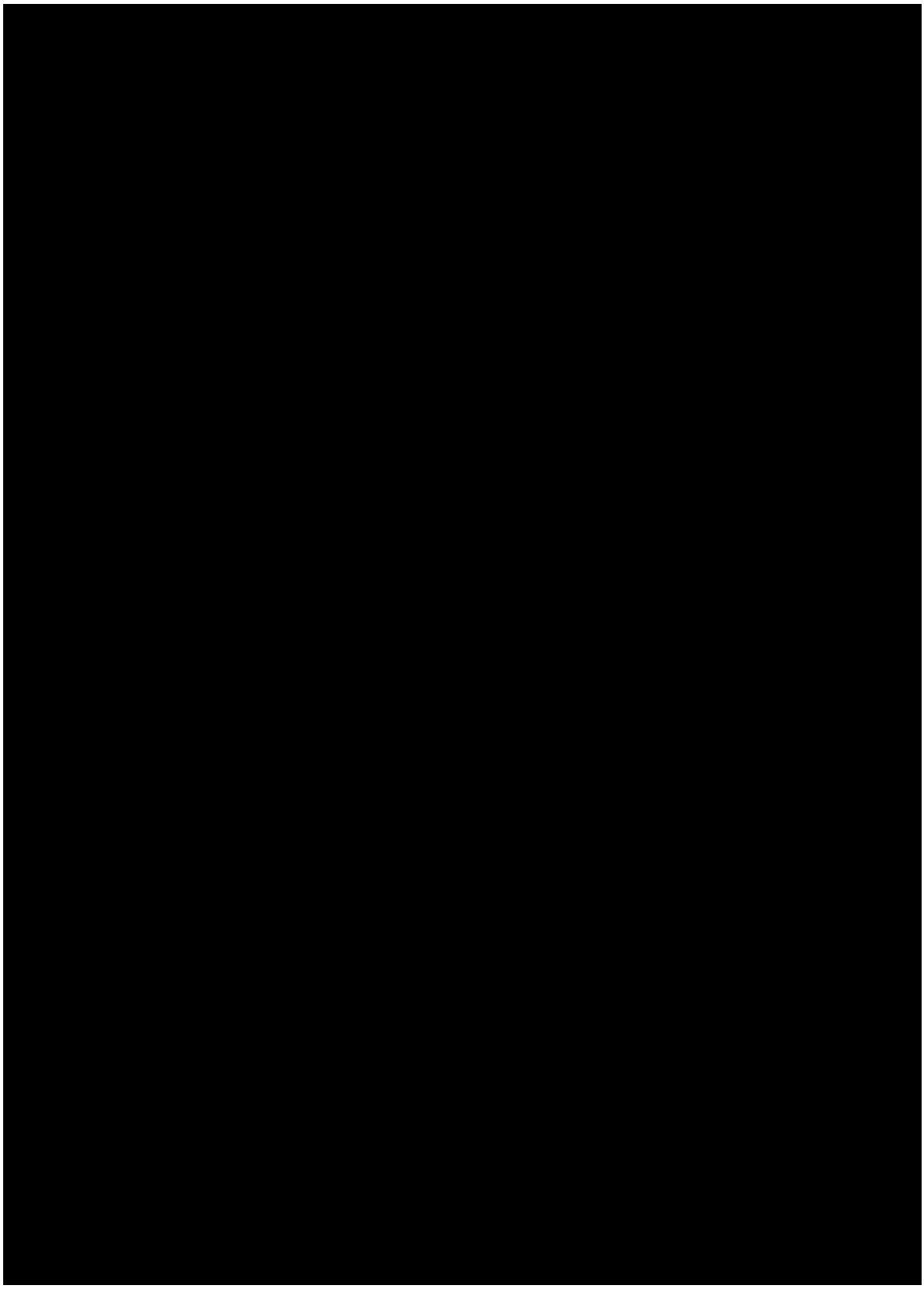
Researcher: [redacted]

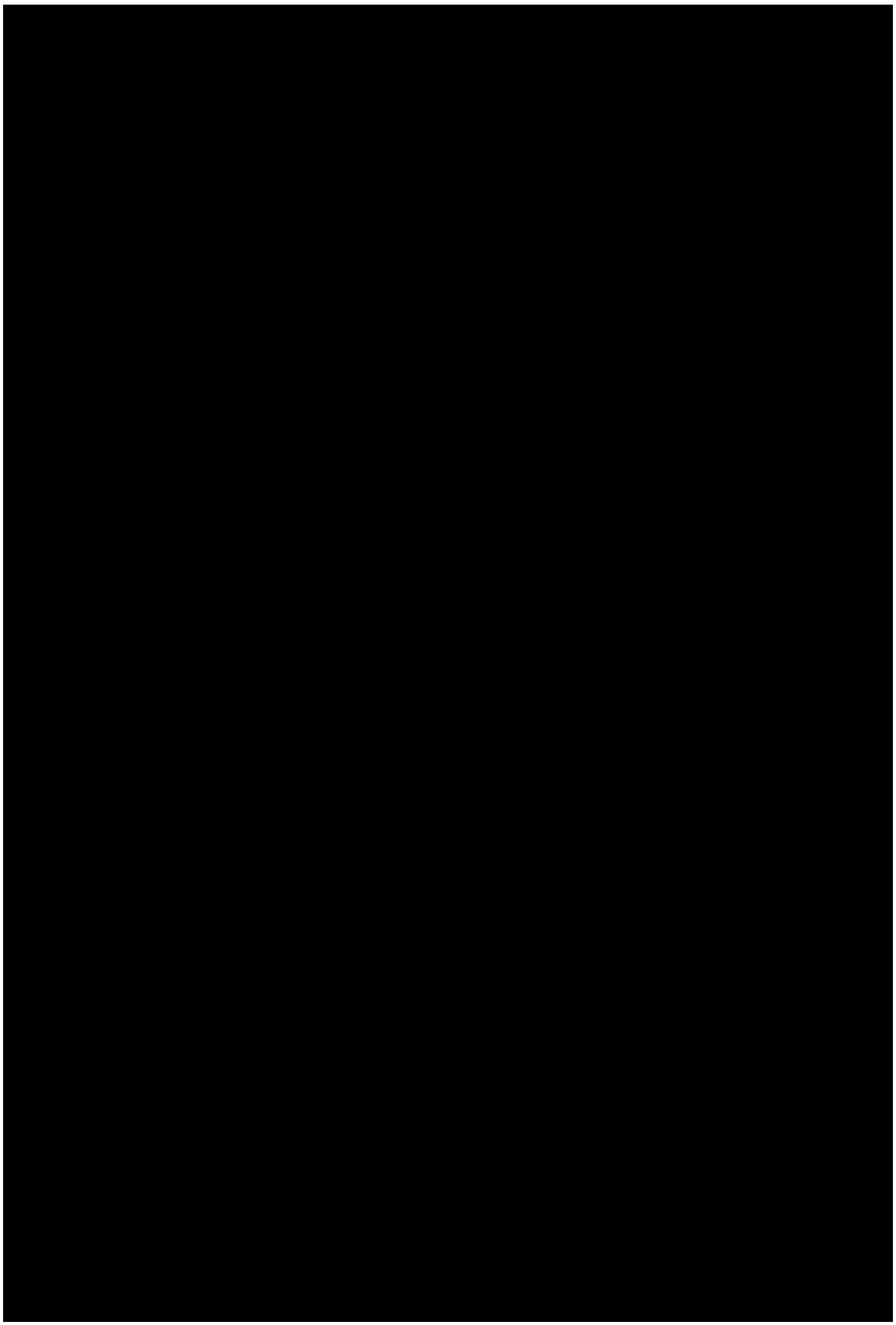
Research Supervisor: [redacted]

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University London. If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [redacted] or via email: [redacted]

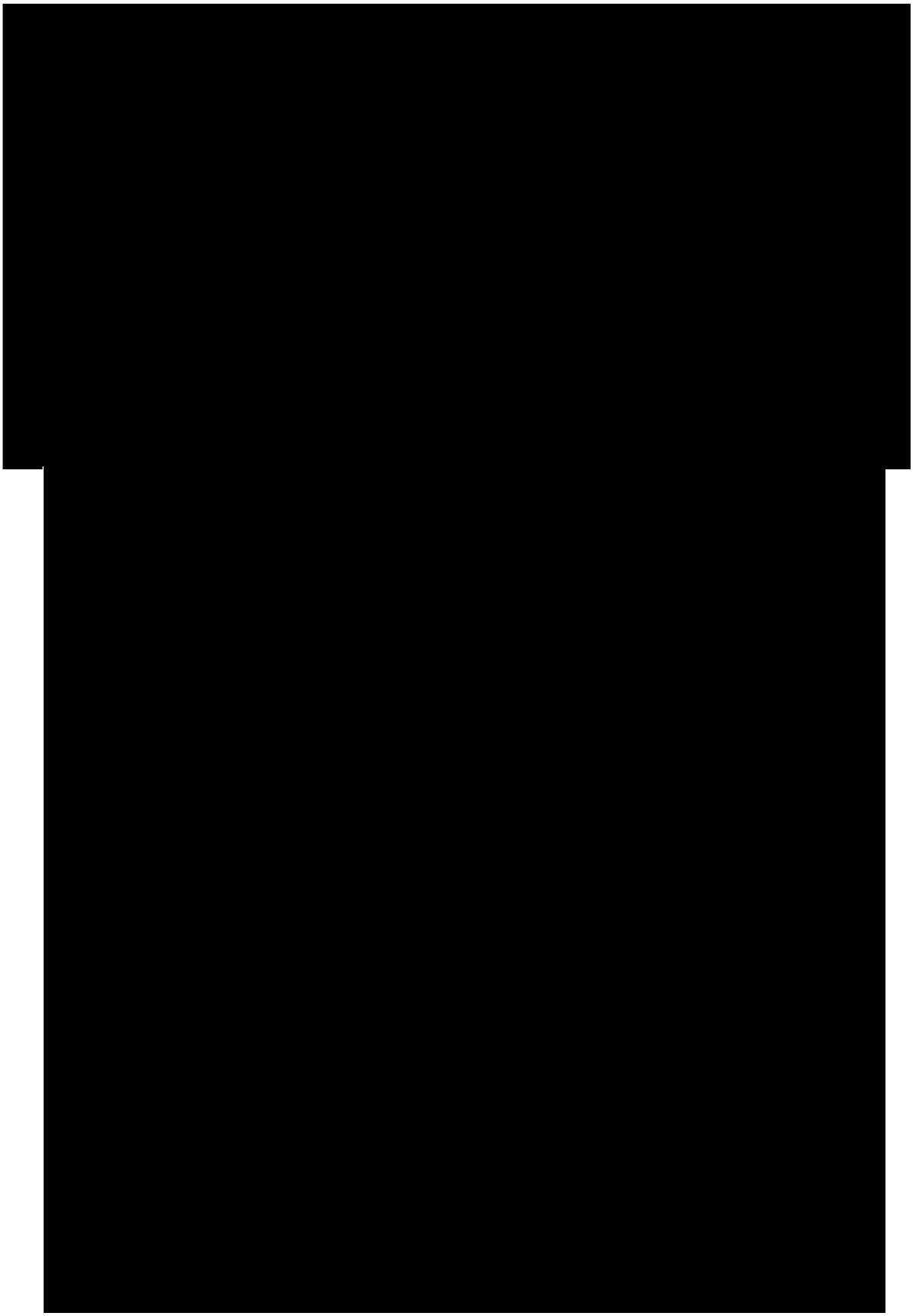
6.10. *Appendix 10: Interview Transcript Example - (Claire)*







6.11. *Appendix 11: Clustering Visual Examples*



6.12. *Appendix 11a: Draft 2 – Master themes early clustering*

1. Process of Recovery

Recovery as an arduous process

Slowness of the recovery process

Rockiness within the recovery

Length of the recovery

Stages of recovery

Support in recovery

Complexities in recovery

2. Coming back to life / Regaining consciousness

Living

Returning

Breathing

Awakening

Recognising feeling

3. Irreparable Vs Repairable (sense of permanent

Broken/snapped

Marked

Expectations

Lasting

Sense of abandonment (due to being broken/faulty)

Changed/different self (Never going back to original self)-loss?

4. Coming to terms (Not returning to a previous self/ or a previous 'normal')"some expect you to go back to normal"

Adapting

Acceptance

Understanding

Letting go

Transforming

5. The meaning of recovery

Physical health analogy

Imagery

Beliefs (returning or not returning to former state, symptoms vs. symptom free)

Continuous

Complete vs. Incomplete

Hope

Uncertainty (Some questioned the term 'recovery' tended to use 'getting better'. Sense of discomfort/disbelief with the word recovery...preferring to use 'in recovery' rather than recovered.

6. Feeling

Light

Sense of relief

Sense of dread

Guilt

Exhilaration

Contained

Vulnerable

7. Healing process /Rebuilding

Containment

Compassion for self

Therapy Experience

Medication

Collaboration

Rebuilding /restoring self

Abstract/otherness

8. Responsibility (Almost like they decide to no longer be a 'patient' and instead take control of self)

Perseverance

Willingness

Self-management

Empowerment

7. The other side/Coming out

9. The self /identity (self- worth etc.).

10. Depression/Fallen

Suddenness/realisation

6.13. *Appendix 12: Example of Elisha's super-ordinate and emergent themes*

Cluster Headings	**Emerging Themes**	**Line & page number**	**Key Quote**
Empowerment	Acceptance Independence Taking responsibility	29,622-623 56, 1223- 1224. 28,602- 604.	Rather than it was stuff I was doing to get to where people thought I should be I'm a lot more aware of spotting my triggers quite a lot I diary manage myself ***laughs***. I'm really proactive about getting help having support, or taking positive steps.
Containment	Comfort/soothing Reassurance Protection/guidance Support	54,1177- 1180 37,1025- 1026 54, 1167 29,629-630	Oh am I going to be able to get back to that guiding light am I going to be able to have that again cos really I quite enjoyed it that was a nice feeling. She's just like stay on it I doesn't matter ***laughs*** if it makes you better that's all that matters. and that's kind of your guiding light Well at the moment my friends are always great but family um. are too personally involved in the situation to be able to look at it objectively
Symbols/colours	Purity / Prestige/special Virtue/glow Trust/warmth/protectio n	58,1267- 1268 54,1176	Yeah it's that silver, **silver white** angel on this one I like the **silver and white.**

			you got that **light angel** and you are **living** yeah and that's kind of your **guiding light**
Complexities of Recovery	Facets of recovery Inadequacy? Points in recovery Belonging	3,43-44. 52,1130-1132 11,235-236. 28,599-600	Umm got to a point of recovery **not properly** recovery but in recovery managed. If you don't understand the things that you do that are linked to your mental health issue you can't ever **quite be recovered**. So if you think I got myself to a point where I've managed or coped by myself to deal with depression. I'd fit, hopefully start to fit in somewhere else it's kind of like double edge.
Reconnection	Returning Re-engaging	2, 71. 57,1247	and got myself back....sorted again. It **feels really nice** It's **nice** to be able to kind of enjoy things again.
Re-establishing	Re-learning Restarting Fulfilment/certainty ***Reprogramming gives a mechanical/robotic feel??*** Finding self	30,653-655. 53,1158-1159 55,1198-1199 704-706	"Some techniques I'd obviously learnt in the past and just not used /***aughs*** and some of it was learning new ones you're not fighting but you are kind of like trying to re-programme yourself in a way literally **re-programming** myself and I can actually have fun in the end of that I think that's kind of why and how I know I can do it.

			It was about learning who i am and how i can...what i can do to be the person i want
Perception of Recovery	Abnormality Without symptoms ***Is there a sense of being rejected****?* Misconception Background Influence Expectation/Pressure Physical Health comparison	8, 154-155. 9, 179-180 10, 210-211 9, 177-178 7,135-178.	Use to be you're not recovered until your symptom free and your normal kind of thing Generally society still seems to think that it has to be symptom free rather than managing symptoms I think it's perceived **really badly** because I mean especially with mental health people automatically think of drug addicts I've got a slightly skewed view on it. My my family is all medical. I've had a bad day and someone will be like oh well you've probably got problems still If you had the flu you can have weeks and get better but you can have a breakdown or episode of depression and it can **take years** to **get back** from that.
The Self	Hidden Self-***shame?*** False Self Compassionate Self Self first Different self-	12, 134-235 11,224-226. 30, 649-653 10, 192-193	When I was **hiding** getting treatment from my parents to replicate someone else without mental health issues to have no signs or symptoms with it umm...and that's a **hard struggle**

		33,709	Instead of having all the immediate **pressure** on myself to do well tomorrow it was like actually lets slowly work through this let's see what I can do to make myself better It's about being able to live your life in the way that works for you not in the way that works for society. I wasn't going back to where i was actually
Deliverance	Released/liberation Escaped Freedom Carefree	58, 1271-1274 59, 1278-1279 58,1273=1274 54-1172-1176	It's that **lightness** instead of having me feeling overwhelmed and pushed down like the dark angel does it's just like having **a nice light** one and it enables you to feel free. It's just like being able to know that you know what you are actually safe and you can enjoy and live again" It's just like having **a nice light** one and it enables you to feel free not realise what's going on around you (repeated quote) When things get bad it feels so much worse so you get that hope that you go out and you actually have a goodtime and you won't think about the fact that you have mental health problems or you want think

			about your social anxiety, you won't think about anything like that and that **feels amazing**
Regaining Consciousness	Starting to feel Realisation Senses (little things)	57,1247 54, 1171-1172 39,855-857	It **feels really nice It's nice** to be able to kind of **enjoy** things again. When you are in recovery you started actually going you know what I can actually enjoy things again you know I can **enjoy** things. I had some chocolate and I could **taste** and was getting to that stage where I was close to recovery.
Falling back	Bad episodes in recovery Relapse Loss of control	15,305-308. 46,994-996. 29,615-616	I'm never gonna get passed this that kind of like feeling, like you fallen back all the way because it's so far away from where you're idealising. I think I came off the citalopram but then I relapsed within less than 2 years I' relapsed and went back on the citalopram. What can you do to help me because I need to get myself sorted otherwise I'm going to go absolutely insane here.
Recovery Process	Flips Slowly but surely	53,1157 30,648-649	I think you kind of like **have flips** or like all of them like it feels **challenging**

	Unsteady Transitioning	30,655-656 57,1251- 1254	This last time I found it quite gradual but because it was gradual it felt more sustainable I found it quite gradual I think gradual with steep steps though sometimes. When you are depressed you are literally just surviving you are surviving and being recovered or in recovery towards the end of recovery you're living.

Additional Comments/Reflections

- Laughter /Sarcasm throughout the interview in points which appear difficult/emotional/painful- Humour as a defence mechanism?
- Significant pauses and fillers appeared to portray feeling not much in tone of voice which remained quite steady throughout. She reported earlier being able to hide feelings very well etc , was she masking in the interview, did she return to this way of coping when feeling vulnerable in the interview?
- Initially I felt she was quite anxious and later she appeared to get more comfortable e.g. swearing without realising than apologising.
- Observed reflecting in the interview often reported "I think & I don't know"- I got a sense that recovery is not often reflected over ... (people tend to go with the motion and practicalities) is that easier? Have they noticed this? Are people wanting to just forget?
- Opinions regarding type of therapy treatments, she expressed finding talking therapies a waste of time generally- remembering feeling a bit taken aback by the comments. What were my feelings about there?? Was I slightly offended or shocked??
- There was something relatable with her??
- Other single themes not included.
- She frequently used the word 'positive' which I felt limited the sense of raw feeling almost like there was an assumption that I would automatically know the emotion she was trying to convey under that one word. Is there this language in therapy where things are labelled

as positive/negative “positive steps, feeling positive”. I feel the word can be limiting but I should have unpacked this more maybe. What is positive, what does positive feel/look like?

- Will have to change some of the headings.

6.14. *Appendix 13: Example of themes across cases*

Themes across participants (Draft 2)
Key: X not present**, L** - low presence, **P** - Present, **S** - Strong Presence, **Gb**-Go back and review transcript.

Themes	**P1.**	**P2.**	**P3.**	**P4.**	**P5.**	**P6**	**P7**
Process of recovery							
-Arduous	**L**	**S**	**S**	**S**	**S**	**S**	**L**
-Slowness/gradual	**S**	**S**	**S**	**S**	**S**	**P**	**L**
-Rockiness/fluctuation/messy	**S**	**S**	**S**	**P**	**S**	**S**	**L**
-duration	**P**	**L**	**P**	**P**	**P**	**P**	**P**
-support	**S**	**P**	**S**	**S**	**P**	**S**	**P**
-Complexities	**P**	**P**	**P**	**P**	**P**	**P**	**p**
-stages /points(vague)-steps,moments,points	**L/P**	**L/P**	**L**	**P**	**L/P**	**L/P**	**L/P**
-Never ending/continuous/unfinished	**S**	**S**	**S**	**S**	**S**	**S**	**L**
NB -*Can you be put back together?*							
-Battle/fight with recovery, self, depression	**S**	**S**	**S**	**S**	**S**	**S**	**P**
Regaining consciousness/Coming back to life	**S**	**S**	**P**	**P**	**S**	**L**	**S**
-Living	**S**	**S**	**P**	**S**	**L**	**S**	**S**
-Returning /re-engaging/lifting?	**P**	**S**	**L**	**L**	**L**	**S**	**X**
-Relearning	**P**	**P**	**P**	**P**	**P**	**x**	**x**
-breathing/Resuscitation	**P**	**S**	**S**	**S**	**L**	**S**	**S**
-responsiveness/regaining feeling/	**S**	**S**	**S**	**P**	**L**	**S**	**L**
-Awakening (realisations/awareness)	**P**	**?**	**S**	**L**	**P**	**L**	**L(hope)**
-Sense of Survival							
-Self awareness- All gained.							

Irreparable Vs repairable	**S**	**S**	Mecha nical	**S**	*'Fra gile*	**P**	**'***vulnerable'*
Broken/Snapped/damaged/fragmented	**P**	**P**	**S**	**P**	**P**	**P**	**X**
-Marked/Scarred/Left with something changed upon self/residual *Sense of two sides of self*	**P**	**P**	**P**	**S**	**P**	**S**	**P**
-***Changed Self/ Permanent/irreversible*** Sense of abandonment/rejection due to change.	**L**	**L**	**P**	**X**	**X**	**S**	**X**
-Adjusting to change?/reframing meds	**P**	**P**	**P**	**P**	**L**	**P**	**P**
The meaning of Recovery	**S**	**S**	**S**	**S**	**S**	**S**	**S**
-Imagery /Metaphor	**P**	**S**	**S**	**S**	**S**	**X**	**X**
-lightness	**S**	**S**	**P**	**X**	**S**	**X**	**X**
-Physical analogy	**S**	**P**	**X**	**S**	**S**	**S**	**P**
-Never-ending/unfinished	**S**	**S**	**S**	**S**	**S**	**S**	**P**
-Beliefs/understanding/ needed for life to survive/not in vain	**S**	**S**	**S**	**S**	**S**	***S***	**P**
'Is the word 'recovered' really relatable to all? -uncertainty. 'in recovery' or 'getting better' – right wording? It's marked by little occurrences that are not instantly noticeable...caught after- hence difficulty establishing turning point.							
Feeling of recovery	**P**	**S**	**S**	**S**	**S**	**L**	**P**
-liberating /empowering	**P**	**P**	**S**	**S**	**P**	**P**	**P**
-Bliss	**P**	**P**	**L**	**S**	**P**	**P**	**L**
-sense of dread/dips/vulnerability	**L**	**L(Gb)**	**L (Gb)**	**L(Gb)**	**P**	**L**	**P**
Relief	**P**	**L**	**P**	**S**	**X**	**P**	**X**
Guilt??	**P**	**P**	**P**	**P**	**GB**	**GB**	**GB**
Pain/hurting	**P**	**S**	**S**	**P**	**P**	**L**	**S**

Sense of achievement	**S**	**S**	**S**	**S**	**S**	**P**	**P**
Rebuilding/restoration (Could this be in the coming back to life section)	**S**	**S**	**S**	**S**	**S**	**P**	**P**
-Therapeutic and medical intervention	**P**	**S**	**P**	**P**	**P**	**S**	**P**
-Self containment /healing/embracing	**P**	**S**	**P**	**P**	**S**	**P**	**P**
-Compassionate Self /Self-worth	**P**	**S**	**S**	**X**	**S**	**P**	**P**
-Determination/ perseverance /will	**P**	**S**	**S**	**S**	**S**	**S**	**P**
-Responsibility (quite a strong theme generally) control/emotionally/physically	**S**	**S**	**S**	**S**	**S**	**S**	**S**
-Wanting (Strong for all)	**S**	**S**	**S**	**S**	**S**	**S**	**S**
-Empowerment	**S**	**S**	**S**	**S**	**S**	**S**	**S**

N.B -Recheck over the quoted pts sheets according to the colour codes to match.
-Generally recovery feels emotive, moves, not stagnant, meaningful.

6.15. *Appendix 14: Master themes organised/final stages*

How the recovery process feels

- Ongoing/unfinished process (Never-ending)
- Fluctuating/rocky process
- Arduous /slowness
- Vulnerable/delicate/fragile

What recovery involves

- Rebuilding Self –discovering self learning
- Perseverance/determination
- Personal control/responsibility (Empowerment)
- Dumping Vs holding

Making sense of recovery/getting better

- Resuscitation/coming back to life/awakening /living/returning
- Lightness (weight & brightness)
- Liberation
- Sense of steadiness/containment/security.
- discovery

What recovery leaves with you/what you're left with

- Transformation/makeover/change (No back to normal/loss)
- Permanent mark/damage/irreparable self (acceptance)
- Sense of bliss/happiness
- Self Awareness/worth/compassion
  (Cannot have one without the other (pain & growth) together; Before and after self)

Additional notes to self: There is something about delayed 'moments' and a 'suddenness' of feeling better but not noticing at the beginning.

-scars as reminders of survival/trophies.

-Uncertainties (where do I fit in if I am recovering but not recovered?)

6.16. *Appendix 15: Journal article publication guidelines*

Aims: ***International Journal of Qualitative Studies on Health and Well-being*** **(QHW**) is an Open Access peer reviewed scientific journal that acknowledges the international and interdisciplinary nature of health-related issues.

QHW aims to provide a forum for the exchange of data, knowledge, theoretical framework and methods on health and well-being, aiming to further the development and understanding of qualitative research by using rigorous qualitative methodology of significance for issues related to human health and well-being.

The journal's focus is on empirical research, and we accept papers with both a national and/or international focus. We also welcome papers with a methodological focus and papers focusing on philosophical issues related to qualitative research in the health area.

Scope: *QHW* welcomes original research articles, review articles and short communications on qualitative research in relation to health and well-being as long as the articles meet high academic and ethical standards. We encourage qualitative researchers from a wide range of professional groups - and from anywhere in the world – to submit their work to *QHW*. All papers will be subjected to rigorous and fair peer review.

QHW publishes research articles within a variety of qualitative research approaches, qualitatively-driven mixed-method designs, methodological development, meta-analyses, and articles focusing on theoretical and philosophical issues related to qualitative research and health and well-being. For a research paper to be accepted for publication in *QHW* it must be written in a clear and concise manner, discuss findings in relation to existing literature, and use appropriate methodology for qualitative research.

Preparing your paper:

We refer authors to the community standards explicit in the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct.

Word limits

Please include a word count for your paper. There are no word limits for articles in this journal.

Style guidelines

Please refer to these style guidelines when preparing your paper, rather than any published articles or a sample copy. Please use British -ize spelling style consistently throughout your manuscript. Please use single quotation marks, except where 'a quotation is "within" a quotation'. Please note that long quotations should be indented without quotation marks. Oxford -ize spelling apart from yse

Formatting and templates

Papers may be submitted in any standard format, including Word and LaTeX. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting templates.A LaTeX template is available for this journal. Word are available for this journal. Please save the template to your hard drive, ready for use. If you are not able to use the templates via the links (or if you have any other template queries) please contact authortemplate@tandf.co.uk

References Please use this reference style guide when preparing your paper. An EndNote output style is also available to assist you.

Checklist: what to include

Author details. Please include all authors' full names, affiliations, postal addresses, telephone numbers and email addresses on the title page. Where available, please also include ORCID identifiers and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.

1. A non-structured abstract of no more than 200 word. Read tips on writing your abstract
2. **Graphical abstract** (Optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .gif. Please do not embed it in the manuscript file but save it as a separate file, labelled GraphicalAbstract1.

3. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
4. 5-10 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
5. **Funding details**. Please supply all details required by your funding and grant-awarding bodies as follows:

   For single agency grants: This work was supported by the [Funding Agency] under Grant [number xxxx].

   For multiple agency grants: This work was supported by the [funding Agency 1]; under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx].
6. **Disclosure statement**. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.
7. **Biographical note.** Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief (e.g. no more than 100 words).
8. **Geolocation information.** Submitting a geolocation information section, as a separate paragraph before your acknowledgements, means we can index your paper's study area accurately in JournalMap's geographic literature database and make your article more discoverable to others.
9. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.
10. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be saved as TIFF, PostScript or EPS files. More information on how to prepare artwork.
11. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
12. **Equations**. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
13. **Units.** Please use SI units (non-italicized).

6.17. *Appendix 16: Table detailing Participants demographics*

Table x. Participants are numbered to preserve anonymity and confidentiality.

Demographics characteristics of Participants	
Gender	Female 1, Male 1
Ethnicity	White English, 4 Eastern European, 1 White French, 1 Mixed Arab & English, 1
Age	20-29 - 2 30 -39- 4 40-49 – 1
Employed	6 Unknown, 1
Education	Degree level, 6 Studying, 1
Marital Status	Married, 3 Partner, 1 Co-habiting, 1 Single, 1 Unknown, 1
Clinical Depression	Moderate, 3 Severe, 4

Treatment history	Medication ,4 Therapy, 6

6.18. *Appendix 17: Information sheet*

CITY UNIVERSITY LONDON

Title of study: An exploration into the experiences and meanings attributed to recovery following a diagnosis of depression.

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim is to explore the experiences of recovery in those who have been given a diagnosis of depression. It will further explore the meanings one attribute to their experience of recovery following depression. Recovery from a diagnosis of depression is experienced and defined differently for every individual. Research indicates that the process of recovery can be greatly understood through exploring individuals' unique experiences. Therefore, exploring these experiences and meanings can assist in the promotion, facilitation and understanding of recovery following depression. This research is an assessment piece required of students partaking in the Dpsych counselling psychology programme at City University.

Why have I been invited?

To partake in this study, you would have been given a diagnosis of depression however regarding yourself as currently recovered or in recovery. An initial telephone screening will be required prior to recruitment. This will help the researcher determine if you meet the requirements of the research and further entail that you are adequately robust to participate in the research without markedly becoming distressed. Therefore, if you are currently suffering with depression and feel unwell, you will not be able to partake in this research. The age requirement for participation is 18 years and above as the study is to focus on adults.

There will be no gender, race or socio-economic criteria within this study as these factors are not being explored.

Do I have to take part?

You do not have to take part in this study it is your choice and therefore is voluntary. If you decide to take part, a signed consent form is required. This will not mean you cannot change your mind any time before, during or after the research as you are free to withdraw from the study without an explanation needed. You have the right to withdraw yourself and your information from the study at any stage and you will not be questioned or penalised for doing so. You are further able to refrain from answering questions that may feel too personal or difficult for you to address. It will have no effect on your future treatment in anyway. In addition, taking part in this research has no effect on grades if volunteers are to be students.

What will happen if I take part?

The research will be conducted in London in a public space but where there is privacy from others, such as a room located within City University or a local library, which you will be informed of once recruited. On arrival, you will be greeted by the researcher and offered to take a seat. The researcher will then brief you about the study and procedure and a copy of the information sheet will be given. You will further be given a consent sheet in which you are required to sign if you agree to participate. Once this is completed the study will commence. The study consists of an individual semi-structured interview which will last approximately 60 – 90 minutes. The interview will be audio recorded (Dictaphone) to maintain its original form of meaning. Questions devised will be concerned with the individual lived experience of depression and recovery. When the interview is over and data collected, the researcher will invite any questions regarding the study. Once the researcher has answered all questions, you will then be debriefed to ensure that no undue harm has come of this study and further thanked for your participation. You will leave with debriefing and information sheets containing the researcher's contact details as well as other support services. There will be no other requirement for you to meet with the researcher following the study.

Expenses and Payments (if applicable)

You will receive £15 cash in hand in appreciation of your time.

What do I have to do?

- You will be expected to have an initial telephone screening with the researcher in order to see if you are best suited for the study prior to the interview. Once this has been established, a signed informed consent form is required before participation.

-You will be asked to allow approximately 90minutes for the interview.

-The interview will consist of semi-structured questions for you to respond where able to. At any point in the study you can withdraw the data you have provided.

-After the study, a debriefing will be given by the researcher to inform you of the nature of the study and any other issues needed to ensure your well-being. An opportunity will be given for you to ask questions.

What are the possible disadvantages and risks of taking part?

As the subject area is around the diagnosis of depression and recovering, talking about your experiences could evoke difficult memories or uncomfortable feelings. This may cause distress or discomfort with having to part take in the study and would therefore need to be monitored e.g. withdrawing or taking a break where need be. The researcher will ensure that all appropriate measures are upheld in protecting you from being at greater risk of undue harm or distress.

What are the possible benefits of taking part?

-This will assist in the promotion of recovery within the area of depression.

-It can encourage and motivate others who have been given a diagnosis of depression remain hopeful and find alternative ways to facilitate recovery.

-It can further help those experiencing depression understand that recovery is unique and gain insight into other experiences, reducing pressure.

-It will contribute to the knowledge of health care professionals who can explore and develop more adaptive and effective ways to enable recovery.

- It will contribute to the limited psychological research regarding lived experiences of recovery and depression.

What will happen when the research study stops?

You will be informed that data gathered is for research purposes only and will be kept confidential to protect anonymity throughout the study and when the study is complete. Identifiable information would be protected by pseudonyms and recordings and transcripts

will be kept in a secure location to be destroyed once requirements are fulfilled. This is the same for both completion of study and if the study were to be stopped.

Will my taking part in the study be kept confidential?

I will ensure that all data collected will be anonymised and digital data will be kept on a password protected computer. Any identifiers will be removed and destroyed as soon as requirements are met. All audio recordings and transcriptions will be carefully safeguarded and protected with password protected measures.

Confidentiality can be breached in circumstances where the researcher believes there is a serious risk of harm to yourself or others.

Most scientific journals require original data which include videos, audios and transcripts to be kept for five years if research is to be published. However, if research it is not to be published then the data will be kept for 1 year (British Psychological Society, 2005).

What will happen to the results of the research study?

The research findings will be presented in the thesis and will further be read by my supervisor and external examiners.

There may be a possibility for publication of the research; this would be within journal articles, newspapers, professional associations and bodies.

If the research were to be published anonymity will be guaranteed by the researcher and your information will not be revealed or identifiable. This will be the same for those who request a copy of the research in any form; anonymity will be maintained. Requesting a copy of the research will involve contacting the researcher directly and arrangements would be made between yourself and the researcher to receive a copy of the research.

What will happen if I don't want to carry on with the study?

You are free to withdraw yourself and your data from the study at any stage of the research without experiencing any penalties or having to give reason. Participation is by choice and therefore purely voluntary.

What if there is a problem?

If any problems arise please utilise the contact details below.

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research

Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *'An exploration into the experiences and meanings attributed to recovery following a diagnosis of depression'.*

You could also write to the Secretary at:

[redacted]

Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee.

Further information and contact details

Researcher: Bridget Badu-Poku

Email: [redacted]

Project Supervisor: [redacted]

Address: School of Arts and Social Sciences,
Psychology Department
City University, London
Northampton Square,
EC1V 0HB

Email: [redacted]

Thank you for taking the time to read this information sheet.