Recovery from Adolescent Depression as a Joint, Adolescent-Parent Goal-directed Project

by

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Abstract

This study explored female adolescent perspectives on the joint and goal-directed processes enacted in the adolescent-parent relationship around recovery from adolescent depression. Seven female adolescents with a diagnosis of depression participated in a research conversation and self-confrontation interview. The guiding research question for this study was, “How do female adolescents in a process of recovery from depression describe their recovery as joint goal-directed action in the context of their relationship with parents?” Data were collected using the qualitative action project method (Young, Valach, & Domene, 2005), and participants were asked to describe the important actions they took specific to recovery and how their parents were involved in the recovery journey. Data analysis was conducted following qualitative action project and instrumental case study method (Stake, 2005). The findings generated seven-detailed action-theory informed descriptions of the salient projects, actions and internal processes involved in each participant’s story. Two superordinate and three subordinate recovery-related joint projects involving adolescents and parents, as described by adolescent participants, emerged from a cross case analysis. Findings identified recovery as jointly enacted through the navigation of the adolescent-parent relationship and engagement in formal and familial support processes. The findings also identified joint and intentional action specific to relatedness and autonomy goals, governance transfer, and attending to perceptions of the parent experience as recovery relevant processes in the context of the adolescent-parent relationship. Recovery-related projects shifted over time to reflect changes in adolescents’ internal processes and meaning associated with action. Overall, the findings emphasize the relational embeddedness of recovery from depression in adolescence, adding to our understanding of adolescent priorities in recovery and how adolescents see themselves as working with parents to mobilize toward wellness goals.
Preface

This dissertation is an original intellectual product of the author, L. Wilson. The participant interviews reported in Chapter 3-5 was covered by UBC Ethics Certificate number H12-02733. Ethical approval was also obtained through Vancouver Coastal Health Authority, certificate number V12-02733, as recruitment efforts involved some of the mental health services of this health region. Lastly, ethical approval was sought and obtained through the Newfoundland and Labrador Health Research Ethics Board, certificate number 14.112, as this researcher recruited participants and conducted one research interview while residing in this eastern region of Canada.

Participant interviews were completed by the author in collaboration with five research assistants. D. Munro (Doctoral Student, University of British Columbia), E. Polack (Doctoral Student, University of British Columbia), K. Socholotiuok (Doctoral Student, University of British Columbia), A. Richter (Doctoral Student, Memorial University of Newfoundland), and M. Zhu (Masters Student, University of British Columbia).
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Chapter 1: Introduction

Introduction to the Research Problem

Adolescence, which is broadly identified in the literature as a time in people’s childhood/youth between the ages of 10-20 (e.g., Kaczmarek & Riva, 1996), is a period marked by a multitude of developmental changes (Harter, 1999) and a time of identity exploration and development (Erikson, 1968). This period is also the typical age for the onset of depression (Leitch, 2007), with lifetime and 12-month prevalence rates of Major Depressive Disorder of 11.0% and 7.5%, respectively (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015). More specifically, literature identifies females at greater risk of developing depressive symptoms and asserts that the highest prevalence rates are in young women aged 15-20 years (Fichter, Kohlboeck, Quadflieg, Wyschokon, & Essert, 2009). The onset of depression during this developmental period has implications for the psychosocial development of adolescents due to their unique needs at this life stage and the way in which depressive symptoms complicate relationships, intellectual functioning and academic performance, family life, and career development (Leavey, Goering, Macfarlane, Bradley, & Cochrane, 2000). In addition, this mental illness is associated with high rates of suicidal ideation and completed suicide (American Psychiatric Association, 2013), as well as interpersonal difficulties (e.g., Hammen, 2009). Depression, and the characteristic symptoms (e.g., lack interest and motivation, cognitive slowing), may also act as a barrier to other developmental milestones, such as gainful employment (Health Canada, 2002).

Longitudinal studies have demonstrated reoccurrence and persistence of symptoms into adulthood (e.g., Lewinsohn, Rohde, Klein, & Seeley 1999; Roza, Hofstra, Van Der Ende, & Verhulst, 2003). The notion of “recovery” in the field of mental health is still relatively new,
with its emergence in the consumer literature occurring in the 1980s (Onken, Craig, Ridgway, & Ralph, 2007). As a result, a clear definition of recovery remains elusive. Various models of recovery have been articulated, which range from symptom-based models to those with an emphasis on outcomes (e.g., Frank, Prien, Jarrett, Keller, Kupfer, & Lavori, 1991) to process-oriented models with an emphasis on context (e.g., Jacobson & Greenley, 1991; Noiseux, St-Cyr, Corin, St-Hilaire, Morissette, Leclerc, et al., 2010; Resnick, Fontana, Lehman, & Rosenheck, 2005). The Mental Health Strategy of Canada has described a view of recovery as a process characterized by principles of hope, empowerment, self-determination and responsibility (Mental Health Commission of Canada, 2012). Although the construct of recovery has been conceptualized in a number of ways, recovery from adolescent depression has been predominantly conceptualized and operationalized according to outcomes associated with pharmacological and psychiatric treatment (e.g., Curry et al., 2011). What is known about the relational processes associated with recovery from depression in adolescence is limited.

Similarly, current research on depression largely focuses on the etiology of the illness and best practices in clinical treatment. As this literature is principally rooted in the medical model, a counselling psychology perspective – one that privileges context, relationships, and systems – is largely absent, despite the reality that depression is a presenting problem often addressed in this discipline (Bitsika, Sharpley, & Melhem, 2010). Additionally, there is a paucity of research attending to adolescent perspectives on living with depression and associated recovery processes. Research has found a strong link between family-level factors, such as parent/child conflict, and depressive symptoms in adolescents (Lewandowski & Palmero, 2009). Similarly, levels of parent support, such as availability and affection, have been shown to predict depression in adolescents (Young, Berenson, Cohen, & Garcia, 2005). The important role of parents in adolescent
depression is echoed in literature recommending family therapy (Keitner & Ryan, 2009) and other interpersonal psychological treatment approaches (Young, Gallop, & Mufson, 2009). These treatments, which emphasize the relational system in addressing mood concerns, often result in faster recovery times and a decrease in depressive symptoms (e.g., Young et al.). Thus, parents play a critical role in adolescent recovery. Attending to the parent-child relationship is essential for the well-being of adolescents engaged in a process of recovery from depression.

To summarize, current approaches to the investigation of recovery from depression in adolescence largely reflect positivist paradigms, which have resulted in much valuable literature on the etiology, sequelae, and pharmacological and psychological treatment recommendations association with this mental health issue (e.g., Curry et al., 2011; Essau, Lewinsohn, Seeley, & Sasagawa, 2010; March & Vitiello, 2009). At present there is a lack of research investigating the perspectives of youth and families on the processes of recovery.

In an attempt to understand how recovery from depression in adolescence is enacted in the adolescent-parent relationship, and to add youth and family perspectives to a medically dominated literature, this research explored the joint goal-directed processes associated with recovery in the adolescent-parent relationship, as told from the perspective of female adolescents (17-19 years of age) with depression using a multcase study approach (Stake, 2005) and Qualitative Action Project Method (QAPM; Young, Valach, & Domene, 2005). Exploring the experiences of those engaged in recovery-related action and goals is important to gaining a holistic understanding of this phenomenon, and may ultimately facilitate clarity regarding the implementation of targeted treatment planning and interventions that attend to the realities of this fundamental relational context. The purpose of this chapter is to introduce the literature relevant to this exploration, as situated in a counselling psychology framework, and to present the
purpose and methodology of this dissertation research.

Counselling Psychology and Conceptualizations of Adolescent Mental Health

Counselling psychology has a distinct vantage point on human development, psychological phenomena, and the role of practitioners in the field. Sinacore, Borgen, Daniluk, Kassan, Long, and Nicol (2011) articulated the specific foci of Canadian counselling psychologists, namely (a) multiculturalism, social justice, and advocacy, (b) health, wellness, and prevention, and (c) career psychology. Furthermore, counselling psychology has been defined as,

…a broad specialization within professional psychology concerned with using psychological principles to enhance and promote the positive growth, well-being, and mental health of individuals, families, groups, and the broader community. Counselling psychologists bring a collaborative, developmental, multicultural, and wellness perspective to their research and practice. They work with many types of individuals, including those experiencing distress and difficulties associated with life events and transitions, decision-making, work/career/education, family and social relationships, and mental health and physical health concerns (CPA Counsellor, 2009, p. 2).

Thus, counselling psychology adopts the view that the application of a developmental lens to supporting individuals and families experiencing difficulties with life transitions and mental health, such as depression in adolescence, is necessary to working effectively and ethically with individuals.

Despite a professional identity that emphasizes a developmental perspective and a core focus on life events and transitions (CPA, 2009), the field of counselling psychology is limited in its contributions to the period of adolescence (Riha, 2010; Stoltenberg, 2005). According to Riha
(2010), literature in this field has failed to address the question why there is a lack of emphasis in counselling psychology on this developmental stage. Throughout the lifespan problems in living emerge differently, and attending to this full developmental context is important to our conceptualization and intervention-related efforts. Establishing a more direct focus on children and adolescents in the discipline has been encouraged (e.g., Stoltenberg, 2005).

A review of the literature originating from counselling psychology indicates that scholars recognize the unique perspective this field has to offer in conducting research on, and intervening therapeutically with, youth. Broadly speaking, the existing body of work on adolescent development in this field suggests that counselling psychology embraces a multidimensional view by attending to biological, cognitive, emotional, social, moral, and vocational domains (Wagner, 1996), that rests on the seminal work of early developmental theorists, such as Hall’s (1904) “storm and stress” view of adolescence, and Erikson’s (1968) stage model that identified adolescence as the period of identity formation.

When looking more specifically at adolescent depression, a counselling psychology presence is also limited. Current conceptualizations of depression are largely rooted in the medical model, complicating the investigation of this disorder from a counselling psychology perspective. The Diagnostic and Statistical Manual 5 (DSM 5, American Psychological Association, 2013) is the tool that guides the identification of diagnosable mental illness, where depression is operationalized according the presence of somatic and cognitive symptoms. In contrast, the field of counselling psychology recognizes this mental illness as a common experience in the lives of individuals, and thus, a presenting problem counselling psychologists are likely to face (e.g., Bitsika et al., 2010). Given some of the foundational underpinnings of counselling psychology, such as a collaborative stance, social justice aims, health, wellness, and
prevention, there is a role for the discipline in conducting research on depression in youth in a way that contextualizes, and expands current conceptualizations of this phenomenon. This dissertation research is highly relevant in contributing to a limited body of work by exploring adolescent development and mental health that brings a unique counselling psychology perspective.

**Depression in Adolescence: An Overview**

Depression is a common mental illness experienced in adolescence, with prevalence rates highlighting gender differences emerging at this developmental stage; specifically, in epidemiological studies, female youth demonstrate markedly greater prevalence rates than male youth (e.g., Avenevoli et al., 2015). Etiologically speaking, biology and genetics (Eaves, Silberg, & Erklnani, 2003; Vendlinski, Lemery-Chalfant, Essex, & Goldsmith, 2011), social and psychological factors (e.g., Qualter, Brown, Munn, & Rotenberg, 2010), and life events have all been identified as relevant to the onset of depression (e.g., Cicchetti & Toth, 1998). Depression is typified by somatic and affective features, and a depressive episode, which is required for a diagnosis of the illness is characterized by depressed mood or loss of interest in nearly all activities for a two-week period (American Psychiatric Association, 2013). In contrast to adults, youth may exhibit irritability rather than a depressed mood. Additional defining features of adolescent depression include at least four of the following: changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans or attempts (American Psychiatric Association, 2013).

Beyond a diagnostic picture of depression, those living with the illness offer a contextualized perspective, which emphasizes a holistic view capturing biological, social, and
psychological factors (Furnham, 1991). Furthermore, this view recognizes the interwoven nature of depression in the lives of individuals, suggesting it is impossible to isolate depression to one domain of an individual’s life. Specifically, depression exists within a “relational field” (Noiseux et al., 2010). Research on the perspectives of those living with this mental illness highlights the way in which relationships with family, friends, and the larger community play a role in the onset and course of depression (e.g., Leavey, 2005; Lewandowski & Palmero, 2009). For example, conflict in the family home, bullying in the peer context, and stress in work settings have been identified by participants as factors contributing to depression (e.g., Kangas, 2001). Family cohesion has also been linked to a lower likelihood of adolescent depression (Erdem & Slesnick, 2010), and high levels of social support have been identified as a protective factor against depression (Rao, Hammen, & Poland, 2010). These findings reinforce the relational context of depression, but do not address the processes of these relationships and their influence in the maintenance of, and/or recovery from, depression.

Furthermore, treatments for depression attend to the biological and psychological components of the illness (Reinecke, Curry, & March, 2009). Pharmacological treatments are common and are often prescribed in conjunction with evidence-based psychological interventions, including cognitive-behavioural therapy and interpersonal psychotherapy (e.g., March & Vitiello, 2009; Reinecke et al., 2009). Psychological treatment for depression often involves an interpersonal component emphasizing the relational context of depression.

**Conceptualizations of Recovery**

Consensus regarding the terminology and operationalization of recovery has been elusive since recovery emerged in the psychological literature (see Onken et al., 2007). Indeed, scholars in the field of mental health, and specifically depression, have advocated for a clearer
conceptualization of recovery (Frank et al., 1991). Challenges inherent in construct confusion, as identified in the case of recovery, complicates research and practice in the field of “recovery”.

The Mental Health Commission of Canada (2012) recently released the Mental Health Strategy of Canada, which articulated a vision and strategy for mental health care in Canada, including principles associated with recovery such as hope, self-determination and responsibility. These principles reflect the general consensus in much contemporary literature on recovery, which emphasizes respect, engagement, community connectedness, and contextual awareness (e.g., Amering & Schmolke, 2009; Johnson & Greenley, 2001; Onken et al., 2007). A vision for Canadian mental health is guided by the following perspective on recovery:

...the concept of ‘recovery’ refers to living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses...the approach to recovery has been broadened to include the concept of well-being, so that, with some adaptations to the different stages of life, the principles of recovery can apply to everyone. With infants, children, and youth, for example, the focus is on becoming resilient and attaining the best mental health possible as they develop (Mental Health Commission of Canada, 2012, p. 15-16).

Much of the literature exploring the emotional and mental health of youth references “resilience” as a salient construct (e.g., Ungar, Brown, Liebenberg, Cheung, & Levine, 2008), particularly as it has been conceptualized as a facilitative factor involved in recovery processes (e.g., Amering & Schmolke, 2009). Current theorizing about and research on resilience recognizes the relevance of both intrinsic personal characteristics and contextual/environmental factors (e.g., Aldwin, Cunningham, & Taylor, 2010; Ungar et al.). Research in the resilience and recovery domain has identified themes associated with resilience processes that include intra-
and interpersonal features, such as self-reliance/capacity to care for oneself and relationships with significant others, as well as community and culture-based features, including balancing personal interests with needs of community and local cultural adherence (Ungar et al.). Thus, resilience is understood as a process that involves the capacity of an individual, his or her relational world, and the larger community. A similar view is held of recovery (e.g., Amering & Schmolke; Jacobson & Greenley, 2001; Leavey, 2005; Noiseux et al., 2010).

In looking at depression specifically, state-based models (e.g., Frank et al., 1991) that are consistent with an asymptomatic presentation as delineated by the DSM 5 are largely adopted in studies of recovery in adolescence as demonstrated in the use of measures designed to capture symptom change (e.g., Curry et al., 2011; March & Vitiello, 2009; The TADS Team, 2007). Largely, this body of literature does not attend to the contextual and relational factors identified and emphasized in the broader mental health literature on recovery. Furthermore, the quantitative nature and treatment focus of these investigations precludes an understanding of the processes involved in achieving remission, recovery, and relapse.

**The Current Study**

As a way to address some of the gaps in current research on female adolescent depression, this dissertation research explored recovery from depression in adolescence as a contextually situated and goal-directed process. This study focused on capturing adolescent perspectives on recovery from depression as situated in the adolescent-parent relationship. This research rested in a social constructionist paradigm, which views experience as co-constructed in relationship with others and the systems surrounding these individuals (Spivey, 1997); furthermore, the study reflected a relativist ontology that necessitated attention to context (Buchanan, 2005). Using Stake’s (2005) multicase study approach and Qualitative Action
Project Method (QAPM, Young et al., 2005), the latter of which is rooted epistemologically in Contextual Action Theory (CAT), this research explored the way in which female adolescents with depression and their parent/caregiver engaged in goal-directed action related to recovery processes, as told from the perspective of the adolescent. CAT assumes that individuals, jointly with others, engage in intentional, goal-directed action that has meaning and significance both in the moment, and in the larger context of their lives (Valach & Young, 2009). Thus, QAPM seeks to capture joint action as it exists in a relational context and then explore additional layers associated with this action (i.e., affect/cognition, social meaning) as a way to obtain a rich understanding of human action as it relates to a particular phenomenon. In the case of this research, joint action specific to recovery from depression as enacted in the adolescent-parent relationship was the focus.

A multicase study enables an approach that emphasizes both the individual case, as well as the commonalities among cases, which offers a rich and nuanced understanding of a phenomenon (Stake, 2005). QAPM has been employed in the study of other domains of adolescent development, such as health behaviours (Young, Lynam, Valach, Novak, Brierton, & Christopher, 2000), career exploration (Young et al., 2008), and counselling support (Young et al., 2005), and thus possesses a history of efficacious utility in investigations similar to the proposed dissertation research. This research builds on existing literature in the field of adolescent health behaviour and goal-directed actions by utilizing the theory and methodology of this literature to explore adolescent depression and recovery. Specifically, the research question for this study was: How do female adolescents in a process of recovery from depression describe their recovery as joint goal-directed action in the context of their relationship with parents?
**Purpose and significance.** Depression in adolescence is a significant health concern impacting development at a time when young people are developing skills to transition successfully into young adulthood. There is a significant body of research on the etiology of depression, trajectories, and treatment outcomes (e.g., Curry et al., 2011; Fichter et al., 2009; March & Vitiello, 2009; The TADS Team, 2007), which also acknowledges the role of parents (e.g., Cumsille & Epstein, 1994; Erdem & Slesnick, 2010; Keitner & Ryan, 2009). Research on recovery has largely emphasized a conceptualization associated with an asymptomatic state (e.g., Curry et al.; Frank et al., 1991; March & Vitiello; The TADS Team) despite a growing body of literature that describes recovery as a complicated and ongoing process, involving the navigation of multiple relational and systemic contexts (e.g., Jacobson & Greenley, 2001; Leavey, 2005; Noiseux et al., 2010).

This study makes a unique contribution in many ways. Firstly, by attending to youth voices, we, the research community, connect with youth priorities in this area. Much of the extant research focuses on medical/clinical priorities, such as etiology and sequelae, evidence-based practice, and pharmacological interventions, which are vital to the field, but result in an unbalanced understanding. Secondly, including a relational context in this research allowed for an exploration of the social embeddedness/constructedness of experience. This research breaks new and important ground because it conceptualizes and investigates recovery from depression in adolescence as a joint process that occurs in families, while recognizing that the recovery process occurs simultaneously with pharmacological and psychotherapeutic interventions. This research prioritized the unique voices of those affected, and ultimately created an opportunity to broaden our understanding of adolescent depression and recovery. This research explicated some of the actions, goals, and processes associated with recovery in families. Findings from this
research will aid those involved in assisting adolescents struggling with depression (e.g., psychologists, school counselors, parents) in understanding how youth think about and mobilize toward wellness, barriers to recovery, resources that can best assist in recovery, and the priorities these young people set in addressing this health goal. Furthermore, this exploration of a relational context surrounding depression complements existing clinical literature that often neglects the relational embeddedness of this mental illness.

**Conclusion**

Depression in adolescence is a significant health concern affecting youth, families, and the larger community. An understanding of recovery processes, as these processes occur jointly in the context of the adolescent-parent relationship, is vital to supporting young people and their families in coping with depression as these individuals work toward recovery goals, ultimately contributing to the improved health of the individual, family, and surrounding community. This dissertation research explored recovery processes situated in the adolescent-parent relationship, thus enhancing and broadening the current scholarly literature and emphasizing goal-directed joint action in recovery from depression in adolescence.
Chapter 2: Literature Review

Adolescence is characterized by simultaneous change and development across multiple domains, such as physiological, biological, cognitive, and relational (Harter, 1999), which coincide with key developmental tasks of identity and autonomy (Erikson, 1968). This life stage is also the typical period of onset for clinical depression, a biologically, cognitively, and socially bound mental illness. With high prevalence rates in adolescence, depression affects approximately 7.6% of the Canadian population between 15-18 years of age (Cheung & Dewa, 2006). Gender-based trends also emerge at this life stage, with females being at greater risk of developing depressive symptoms (Fichter et al., 2009). Recovery, as it relates to adolescent depression, has largely been studied in the context of pharmacology and evidence-based treatments and associated outcomes, usually reflecting symptom improvement (e.g., Curry et al., 2011; March & Vitiello, 2009). However, literature in the field of mental illness more generally has consistently articulated a dynamic and interactional perspective on recovery that emphasizes a process-orientation (e.g., Jacobson & Greenley, 2001; Mental Health Commission of Canada, 2012; Noiseux et al., 2010; Onken et al., 2007). Recovery in adolescent depression has yet to be examined as a relational and goal-directed process that occurs over time in the context of larger relational systems.

Current investigations of adolescent development adopt an ecological perspective, which emphasizes context, and specifically the intersection of the multiple relevant contexts (e.g., family, peers, school, neighbourhoods, and communities) in the lives of young people (Kaczmarek & Riva, 1996; Kia-Keating, Dowdy, Morgan, & Noam, 2011). With an orientation toward conceptualizing mental health and wellness from a developmental and contextual framework, counselling psychology has much to offer this domain of inquiry. One contextual
dimension highly relevant to youth is that of the family, and specifically, relationships with parents. Parents remain crucial in adolescent development (e.g., Engels, Finkenauer, Meeus, & Dekovic, 2001; Steinberg & Sheffield Morris, 2001), and have been found to be instrumental in positive change outcomes for youth with depression (e.g., Lewandowski & Palmero, 2009; Young, J. et al., 2005). Adopting a counselling psychology perspective and rooted in Contextual Action Theory (CAT), the purpose of this research was to explore the joint and goal-directed processes adolescents and parents engage in together around recovery from adolescent depression.

CAT has informed many investigations of joint processes in a variety of relational contexts relevant to youth (e.g., Young et al., 2000; Young et al., 2008), and enables an understanding of recovery as a joint, goal-directed process relevant to the lives of both the young person with depression and her parent. Such an exploration elucidates ways in which adolescents and parents identify, articulate, and understand recovery goals, and how they then act, or fail to act, on these goals. Clarity regarding such processes offers important insights to aid health care professionals in supporting families to both express and carry out goals identified in treatment. In addition to highlighting the key joint processes, associated internal processes, and ascribed meaning, findings from this research also point to therapeutic considerations and interventions that may be efficacious in the recovery process, as well as suggest areas for future research.

The purpose of this chapter is to discuss the literature that informs this dissertation research, and highlight the ways in which this study addresses limitations in this body of literature. The landscape of adolescence and depression in adolescence is vast, and thus, in an effort to tailor the review to the goals of this research, the adolescent-parent relational context is emphasized. Finally, CAT, the epistemological grounding of this research, is articulated in
greater detail to provide clarity around how this theory offers a unique and innovative conceptualization of recovery in female adolescents with depression.

**Adolescent Depression and Recovery**

Adolescent depression is a serious mental health concern with implications for the achievement of developmental milestones (Health Canada, 2002), interpersonal functioning (Hammen, 2009), and suicide risk (American Psychiatric Association, 2013). Investigation into how adolescents engage in recovery efforts related to this illness is fundamental. At present, research in the area of depression and recovery has largely reflected quantitative, positivist approaches, which has resulted in much literature on the etiology and sequelae of this mental health concern, as well as an extensive list of evidence-based treatment practices (e.g., March & Vitiello, 2009; The TADS Team, 2007). As a result, the dominant discourse on adolescent depression and recovery is of a medical nature. However, the perspectives of those living with depression have demonstrated an appreciation of a holistic view that captures biological, social, and psychological factors (Furnham, 1991).

Depression, as it is conceptualized in the DSM 5, is a mental disorder characterized by somatic symptoms, such as changes in appetite and sleep patterns, and behavioural markers, including loss of interest in previously enjoyable activities, and is associated with delineated criteria necessary for a diagnosis (see American Psychiatric Association, 2013). This medically-based resource shapes practitioners’ conceptualization of mental illness. Recovery is similarly understood, often characterized by the absence of clinically significant symptoms for a period of time (i.e., 8 weeks). Investigation in this area has centred on pharmacological and psychological treatment effectiveness (e.g., Curry et al., 2011; March & Vitiello, 2009; The TADS Team, 2007).
One of the largest North American studies investigating the treatment of depression at adolescence is the Treatment for Adolescents with Depression Study (TADS; The Treatment for Adolescents with Depression Study Team, 2003, 2005), which follows adolescents receiving treatment for depression over an 18-week period to determine evidence-based treatment recommendations. The emphasis on pharmacological and psychological interventions is evident in the four treatment groups, namely (1) CBT, (2) medication, (3) CBT + medication, and (4) placebo. As part of a follow up to this investigation, Curry et al. (2011) expanded the monitoring period by 42 months to further explore recovery and recurrence trajectories. Results demonstrated recurrence in approximately half of the adolescent participants who received treatment for and were deemed “recovered” from depression. For those adolescents who experienced a recurrence, the average length of time between recovery and recurrence was just under 2 years, with most youth having only one recurrent episode (Curry et al.). Research has established gender differences in the course of adolescent depression, with females experiencing longer and more frequent depressive episodes (Essau et al., 2010). Additionally, females are more likely to experience recurrence, compared to male peers (Curry et al.; Essau et al.).

**Etiology of depression.** An etiological understanding of depression is important in exploring and understanding the literature on the associated recovery processes. Risk factors for adolescent depression have been identified in the literature, and fall into categories of cognitive processing styles, genetics and biological factors, and interpersonal competence (Cicchetti & Toth, 1998). Cognitive processing, such as negative attributional styles (e.g., Lau, Rijsdijk, Gregory, McGuffin, & Eley, 2007) and self-verification (e.g., Giesler, Josephs, & Swan, 1996; Joiner, 1995; Joiner, Katz, & Lew, 1997), has also been linked to depressive outcomes. It is widely accepted that environmental factors interact with genes (gene X environment interaction).
to affect developmental outcomes (e.g., Eaves, Silberg, Erkanli, 2003; van Aken, Junger, Verhoeven, van Aken, & Dekovic, 2007; Vendlinski, Lemery-Chalfant, Essex, & Goldsmith, 2011). Investigation into this interplay as it relates to psychopathology has yielded helpful frameworks for understanding interaction effects in the differential manifestation of psychiatric disorders. The diathesis-stress model (e.g., Meehl, 1962; Monroe & Simons, 1991) of psychological vulnerability is one such model, which highlights how genetic vulnerability (diathesis) interacts with a stressor to increase individuals’ susceptibility to subclinical psychological issues, and for some, psychopathology.

Differential trajectories associated with depression in youth have also been noted in current research. In a review of psychopathology and gender in childhood and adolescence, Crick and Zhan-Waxler (2003) highlighted two predominant depressive pathways identified in the literature, namely child- and adolescent-onset. The child-onset pathway is associated with more problematic outcomes (e.g., Moffitt & Caspi, 2001). The adolescent-onset pathway is typified by a period of healthy development earlier in life and a post-pubertal emergence of depression symptoms. From a gendered perspective, girls are less likely to follow the child-onset pathway, and instead, are liable to experience depression-related difficulties in adolescence (Crick & Zahn-Waxler).

In a number of ways, the parent-child relationship has also been identified as central in the onset, maintenance, and treatment of depression. Parental mental illness has been identified as a risk factor for depression in childhood. For example, in infancy, depression has been discussed both as it relates to maternal depression, and as a phenomenon that results from some interaction between, or combination of, three possible dimensions, namely “depressogenic” triggers, such as real or perceived loss, risk of vulnerability factors, and reduced or inadequate
social coping supports/capacities (Kovacs, 1997). Maternal depression has been identified as a risk factor for a number of cognitive, behavioural, and psychological difficulties in infancy and childhood (e.g., Murray & Cooper, 2003), and is a factor shown to be predictive of depressive symptoms in youth (e.g., Lau et al., 2007). Murray and Cooper assert, “marked disturbances” that occur in exchanges between mothers with depression and their infants may negatively impact children’s functioning in the long term (p. 33). In contrast, interpersonal contact and attention have been found to be protective against adverse experiences, such as loneliness (e.g., Schmid et al., 2011). In a review of research exploring internalizing disorders and family systems, Hughes and Gullone (2008) summarized findings emphasizing the link between both parental and adolescent internalizing disorders and poorer attachment quality and family functioning, and increased negative parenting behaviours. Thus, parents, both at a genetic and environmental level, play a role in depression in youth populations.

**Gender differences and depression.** Gender differences are consistently cited in research on depression in adolescence; generally speaking, females are more greatly affected by the illness and experience higher rates of reoccurrence (e.g., Essau et al., 2010; Fichter et al., 2009). Such gender-based trends have been strongly established in the field of depression research, however, the factors and dynamics contributing to such trends remain unclear (Steinberg & Sheffield Morris, 2001). In a closer examination of gender and depression, Bitsika et al. (2010) cited a variety of differences in the symptom presentation of depression by gender. Specifically, findings demonstrated that females were more likely to report anxiety-related symptoms with a focus on pain, fatigue, sleeping and digestive difficulties. In contrast, males were more likely to identify cognitive symptoms. Such research has given rise to gendered recommendations for therapeutic intervention (Bitsika et al.).
Possible explanations for higher prevalence rates of depression in females have placed relational issues at the centre. For example, Cyranowski, Frank, Young, and Shear (2000) asserted that attachment is particularly important for female adolescents; specifically, females’ relationships with parents offer a secure base, which serves to “buffer the effects of negative life events” (p. 23). Such assertions have implications for the developmental task of navigating autonomy and relatedness characteristic of adolescence such that adolescent-parent relationships may be challenged and thus, less able to offer the secure base for these adolescents.

It has also been argued that, for females, adolescence is a time when social and biological factors combine in a way that increases the need for affiliation (Cyranowski et al., 2000). According to Edge and West (2011), depression may be viewed as “…a social role, which if more commonly ascribed to and internalised by women, renders them both more willing to self-label and to engage in the kinds of help-seeking behaviours which will increase the likelihood of receiving psychiatric labels” (p. 19). Despite the presence of hypotheses regarding gender differences, there is still much that remains unknown about the processes underlying these differences in the manifestation of adolescent depression (Essau et al., 2010). An understanding of the way in which gender and recovery interact is also largely unexplored.

**The relational emphasis in adolescent depression and recovery.** Depression exists within a relational context. Research on the perspectives of those living with this mental illness highlights the way in which relationships with family, friends, and the larger community play a role in the onset and course of depression (e.g., Keitner & Ryan, 2009; Leavoy, 2005; Lewandowski & Palmero, 2009). For example, conflict in the family home, bullying in the peer context, and stress in work settings have been identified by participants as factors contributing to depression (e.g., Kangas, 2001). Research findings consistently point to a particularly salient role
for parents in depression and treatment. The adolescent-parent relational context as it pertains to recovery action and goals is the focus of the current study.

Much research has been conducted exploring the ways in which familial dynamics and parent factors are predictive of depression in adolescence (e.g., Cyranowski et al., 2000; Lau et al., 2007; Murray, Woolgar, Cooper, & Hipwell, 2001; Schwartz, Dudgeon, Sheeber, Yap, Sommons, & Allen, 2012). A meta-analytic review of parental factors associated with depression identified the following as factors with solid evidence for depression: parental warmth, inter-parent conflict, over-involvement, aversiveness, autonomy granting, and monitoring (Yap Pilkington, Ryan, & Jorm, 2014). More specifically, higher levels of aggressive parenting behavior, such as angry or belligerent affect and cruel or provocative behavior, have been found to be predictive of higher levels of symptoms of depression (Schwartz et al., 2012). Conversely, positive parenting behavior, including happy or caring affect and approving or validating comments, was predictive of lower levels of depressive symptoms. Thus, depression symptoms have documented links specific to parental and parenting factors.

Attachment remains a relevant construct in adolescent wellness, and insecure parental attachments at this stage have also been identified as a risk factor (Cyranowski et al., 2000). Self-reports of adolescents with depression reflect perceptions of impaired parental attachment (Pavlidis & McCauley, 2001). Similarly, Draucker (2005) found that adolescents with depression felt disconnected in relationships; specifically, she noted, “adolescents who are depressed all struggle to feel connected with, anchored by, or guided by important people in their lives” (p. 948). Some research has found that adolescents and significant adults (e.g., parents) engage in a process of creating a “façade of normality”, which is demonstrated by concealing or blocking out distress in order to avoid the stigma associated with mental illness (Draucker, p. 949). Similarly,
O’Grady and Skinner (2012) reported that families often wanted to ignore the problem to
decrease stress and worry, and in hopes that it would resolve on its own. Additional qualitative
research has demonstrated that when parents dismissed suffering, adolescents with depression
reported feeling a sense of “emotional homelessness” characterized by increasing distance and a
sense of isolation in these relationships (Farmer, 2002). However, some of these findings are
limited by solely self-report data by participants with depression. Many authors have commented
on the tendency of adolescents with depression to over report problems with parental
relationships and support (e.g., Pavlidis & McCauley; Roisman, Fortuna, & Holland, 2006),
which is an important consideration in understanding the adolescent-parent relationship in the
context of depression.

Family functioning reflects a family’s ability to manage life as well as employ effective
coping regarding problems and changes (Hughes & Gallone, 2008) and has been identified as a
relevant variable in understanding depression and treatment outcomes (e.g., Garoff, Heinonen,
Pesonen, & Almqvist, 2012). Family cohesion specifically has been linked to a lower likelihood
of adolescent depression (Erdem & Slesnick, 2010), and may serve as a protective factor in the
context of risk for depression (Cumsille & Epstein, 1994). In research on family cohesion in
adolescence and the effects of depression, Cumsille and Epstein found an inverse relationship
between depression and family cohesion. This suggests that family cohesion may serve as a
protective factor in the context of risk for depression. However, a gender-specific investigation
of the data revealed that the inverse relationship between depression and family cohesion was
specific only to male adolescents; female adolescents did not demonstrate such an association. In
addition, loneliness in childhood has been linked to depressive symptoms in adolescence, and
acts as an “interpersonal stressor” (Qualter et al., 2010). Based on findings from a longitudinal
study of children followed from 3 months to 19 years of age, Schmid et al. (2011) concluded, “…children who continue to receive less attention and interpersonal contact during early childhood will experience themselves as less meaningful and more isolated” (p. 1391).

A relational emphasis at the parent-child level is also apparent in treatment approaches. Although pharmacological treatments are common, such approaches are prescribed in conjunction with evidence-based psychological interventions. Thus, treatment of depression recognizes the biological and psychological components of the illness (Reinecke et al., 2009), and many approaches to therapeutic intervention attend to dimensions of relationship (e.g., Carr, 2008; March & Vitiello, 2009; Moran & Diamond, 2008; Reinecke et al.). Parent involvement in the treatment of depression is emphasized in literature as such involvement has been associated with a decrease in depressive symptoms and faster recovery (Keitner & Ryan, 2009).

Examples of treatment addressing issues of relationship include intervention at a cognitive behavioural level, or more explicitly at the interpersonal level as in Interpersonal Psychotherapy (IPT; Mufson & Sills, 2006), or finally, at the familial level as in attachment-based family therapy (e.g., Diamond, 2014). For example, treatment utilizing attachment-based family therapy focuses on reducing the blaming and critical attitudes commonly associated with parents of adolescents with depression (e.g., Moran & Diamond, 2008). Such a treatment approach has been associated with positive outcomes, including parental increased empathy for and understanding of their adolescents’ experience with depression (Moran & Diamond). Family functioning, as assessed by self-report questionnaires and observer-rated questionnaires, has been shown to impact depression treatment outcome in youth (e.g., Garoff et al., 2012). The emphasis on the inclusion of parents in treatment for adolescent depression seems to reflect the strong body of literature emphasizing the importance of relatedness and autonomy in adolescent
development (e.g., Cicchetti & Toth, 1998; Smith, Calam, & Bolton, 2009; Tompson, Boger, & Asarnow, 2012).

Contemporary perspectives on adolescent development highlight the importance of balancing both connectedness and autonomy in the parent-adolescent relationship (e.g., Cicchetti & Toth, 1998; Smith et al., 2009; Tompson et al., 2012). In reviewing research on family level treatment for depression, Tompson et al. emphasize the developmental context in understanding depression;

Adolescents are developing autonomy from parents and expanding their social worlds, while still needing to maintain adaptive parent-adolescent relationships. Successful relationship functioning in adolescence includes maintaining ongoing connectedness and yet increasing independence in family relationships, establishing strong and dependable friendships with similar-age peers, and managing emerging romantic desires and experiences. (p. 360)

Connectedness has been defined as a parent-adolescent relationship characterized by closeness, trust, and reciprocity (Beyers, Goossens, Vansant, & Moors, 2003). Adolescents reporting high levels of connectedness also view their parents as available and describe easy communication (Beyers et al.). Measures of autonomy have included multiple dimensions, such as (a) attitudinal autonomy: being aware of and choosing from one’s list of choices, (b) emotional autonomy: trusting and believing in one’s ability to identify self-goals independent of the wishes of others, (c) functional autonomy: determining a manner in which to implement self-regulation in working toward goals (Beyers et al.).

Parental support has been identified as a protective factor in coping with distress in adolescence (e.g., Goosby, Bellatorre, Walsemann, & Cheadle, 2013). In a study of parental
relationships as described by participants who were suicidal as adolescents, Bostik and Everall (2006) found that adolescents felt misunderstood by their parents, felt relationships with parents lacked trust and closeness which impeded open communication, and desired parental acceptance and connection. Detachment in parental relationships has been linked to increases in suicidal ideation, particularly in cases in which depression is also present (e.g., Pace & Zappulla, 2010). Similarly, perceptions of a negative relationship with parents have been associated with depression and/or risk of suicide (e.g., Consoli et al., 2013).

In a study of adolescent suicidal behavior and attachment, adolescent participants referenced difficulties achieving autonomy in the context of strict and controlling parenting behaviours (Bostik & Everall, 2006). Autonomy has been inversely related to depression and loneliness in adolescence (e.g., Inguglia, Ingoglia, Liga, Coco, & Cricchio, 2014), and successful navigation of the balance between autonomy and relatedness has been associated with positive outcomes in psychosocial functioning (e.g., Allen & Hauser, 1996; Allen, Moore, Kuperminc, & Bell, 1998). However, depression appears to complicate the navigation of this life task, with research reporting increased depressive symptoms in adolescence predicting lower levels of parental support for autonomy (e.g., Van der Giessen, Branje, & Meeus, 2014; Yap et al., 2014). In addition, higher levels of depressive symptoms were reported by adolescents who viewed their parents as less supportive of their opinions and needs. Van der Giessen et al. assert that the child effect pathway, namely the former predictive pathway, tended to be stronger than the latter pathway, termed the parent effect. Issues of autonomy and connectedness and perceived relationship quality are relevant factors in understanding the adolescent-parent relationship and depression.
The limitations of this literature. Current conceptualizations of adolescent depression and recovery are limited. The diagnostic criteria for Major Depressive Disorder (MDD), or a Major Depressive Episode (MDE), are largely the same for youth and adult populations (see American Psychiatric Association, 2013), despite an early recognition that the clinical picture of depression in adolescence differs from adult symptomatology (Toolan, 1962). Determining characteristic features of depression in childhood and adolescence is complicated by developmental factors, such as developing cognitive abilities and hormonal changes (e.g., Bhardwaj & Goodyer, 2009). Weiss and Garber (2003) assert, “According to the developmental viewpoint, the manner in which depression is experienced, as well as expressed, will depend in part on the individual’s level of physiological, social, and cognitive development” (p. 404). Thus, there is recognition that symptoms of depression manifest differently throughout the lifespan, which similarly suggests developmental differences in the expression and experience of recovery; however, little is known about the recovery processes in adolescence.

In addition, although the DSM 5, as well as recent earlier versions of the DSM, outlines specific criteria for diagnosis, these criteria are not uniformly adopted in depression research. Instead, depression is often measured according to a variety of standardized instruments (e.g., Beck Depression Inventory II; Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Kaufman et al., 1997, respectively). Different criteria for identification of a disorder or phenomenon, depression in this case, have implications for understanding, comparing, and integrating research findings, and additionally, for building on the existing knowledge base.

The way in which childhood and adolescence, as developmental periods, are defined varies across studies. For example, in a prospective study examining the longitudinal
implications of depression in adolescence, Pine, Cohen, Gurley, Brook, and Ma (1998) identified participants ages 9-18 as “adolescents”. Mufson, Dorta, Wickramaratne, Nomura, Olfson, and Weissman (2004) examined the effectiveness of interpersonal psychotherapy (IPT) in treating adolescent depression, and included “adolescents” ranging in age from 12-18 years. Research on recovery and recurrence in adolescent depression has included 14-22 year old participants (e.g., Curry et al., 2011). Other studies have grouped childhood and adolescence together in investigating depression (e.g., Fichter et al., 2009), which makes it difficult to interpret results as they apply to a particular developmental period. Such issues of age range variability in participant pools complicates research findings and the application of a developmental lens in understanding predictive factors, treatment outcomes, and relational processes.

Research in the field of recovery from depression in adolescence emphasizes risk factors, predictive pathways and treatment outcomes associated with standardized intervention protocols. There is a limited body of research examining the mechanisms, processes, and relational dynamics involved in recovery efforts. The question of how recovery is enacted, and particularly, how adolescents experience parents as contributing to or impeding wellness and recovery efforts, is one with limited answers. With statistics highlighting the prevalence and recurrence of depression in adolescents, it is important to direct research efforts toward understanding how to support adolescents to work toward recovery.

Finally, the medicalized discourse in this field is pervasive. Bennett, Cogan, and Adams (2003) asserted that such a discourse on depression serves to decontextualize the illness and presents the view that expertise and treatment rest solely with mental health professionals. This dissertation research attends to context and seeks to prioritize the voices of those living with depression, and their loved ones. Such a focus adds richness to the existing body of literature in
this area, which serves to complement the substantial fund of knowledge that has emerged from
the medical field.

**Stepping Back: Looking More Broadly at Recovery**

**Recovery and issues of operationalization.** Undertaking a study of recovery
necessitates a broad understanding of the way in which this phenomenon has been
conceptualized and investigated in the field of mental illness. Despite a relatively young history
in the literature, the construct of recovery has been conceptualized in a number of different ways,
reflecting either asymptomatic state-based models (e.g., Frank et al., 1991) or process models for
which the absence of symptoms is not required (e.g., Jacobson & Greenley, 2001; Leavey, 2005;
Noiseux et al., 2010). Thus, consensus regarding terminology and operationalization of recovery
has been elusive since it emerged in the psychological literature (see Onken et al., 2007) and a
clear conceptualization of the construct has been advocated for in the field of mental health
(Frank et al.). Generally, literature on recovery both acknowledges and seeks to address the
challenges of articulating and conducting research in an area confused by the presence of
multiple constructs used to reflect similar processes (e.g., recovery, resilience, remission) and
that includes conceptualizations that rely on either objective markers or subjective experiences.
These challenges complicate research and practice in the field of “recovery”. An awareness of
these conceptual obstacles is important in achieving clarity in the use of this term in this
dissertation research; thus, a discussion of predominant models, and associated constructs, is
outlined in the following section.

**Conceptualizations of recovery.**

**Recovery as an asymptomatic state.** Asymptomatic state-based models of recovery are
consistent with both the dominant positivist and medical investigation and discourse in the field
of depression, and with the central diagnostic tool, the DSM 5. Frank et al. (1991) articulated a model for practitioners that included conceptualizations, proposed definitions, and tentative operational criteria, which has been referenced in current studies of recovery (e.g., Curry et al., 2011; March & Vitiello, 2009; Rao et al., 2010). This model included terminology outlining how recovery proceeds from one state to another, each of which can be understood by looking at observable phenomena, such as symptom presentation, and associated treatment implications. According to Frank et al., an episode, which means that an individual exhibits symptoms that meet criteria for diagnosis, can be followed by spontaneous or treatment induced partial remission in which the individual’s symptoms improve, but are still minimally present. Full remission follows and reflects a relatively brief period during which the individual does not exhibit any symptoms. If during remission, but before recovery, the individual experiences a re-emergence of full symptoms, this is termed a relapse. Once an individual has been in remission for a determined period of time (not identified in this article), she is in the recovery phase; this may last indefinitely and can reflect recovery from the episode, not necessarily the illness. Finally, recurrence has been defined as the appearance of a new episode of MDD that must occur after recovery. Amering and Schmolke (2009) have referred to such conceptualizations as “clinical recovery”, which focuses predominantly on the decrease of symptoms and improvement in functional domains.

Many current clinical investigations of depression treatment response adopt such asymptomatic state-based models in discussing the links between pharmacological and psychological intervention and recovery trajectories. For example, in a study of short-term treatment for depression and recurrence rates, Curry et al. (2011) specifically referenced a definition of recovery that included the absence of “clinical significant Major Depression
Disorder symptoms” as measured by a semi-structured diagnostic interview. Findings demonstrated recovery and recurrence rates by treatment as predicted by certain factors, such as higher levels of global functioning, and associated with a specific treatment group. Similar approaches to investigating and measuring recovery have been adopted in the field of adolescent depression and reflect an emphasis on symptom absence as indicative of recovery (e.g., March & Vitiello, 2009; Melvin et al., 2006; Rao et al., 2010).

**Recovery as a contextually bound process.** Alternate conceptualizations of recovery are in line with what has been termed “social recovery”, which emphasizes economic and social independence and resonates with notions of renewing, regaining, and reconnecting in life (Amering & Schmolke, 2009). Models that fall into this category of conceptualization identify relational and environmental factors associated with recovery, and view recovery not as a cure or dissolution of symptoms, but rather as a process that is ongoing and depends on active adaptation and coping. Such conceptualizations are consistent with the practice standards and future mental health strategies of Canada (Mental Health Commission of Canada, 2009; Mental Health Commission of Canada, 2012). In a recent document outlining a framework for the development of a mental health strategy for the country, the Mental Health Commission of Canada (2009) embraces this alternate view of recovery, emphasizing reconnecting to life and regaining well-being over symptom reduction:

…recovery is not the same thing as “cure,” as it may or may not include a full and permanent remission of symptoms. But this approach to recovery affirms the ability of people to recover their lives, even if they do not fully “recover from” their illness; it highlights their capacity to retain or regain their mental health and well-being, while managing whatever symptoms of illness may remain. It draws on the idea that people
living with mental health problems and illnesses will experience varying degrees of mental health, just as everyone does…A recovery orientation is founded on the principles of hope, empowerment, choice and responsibility (p. 8).

Other conceptual models outlined in the recovery literature also emphasize principles of hope, empowerment, and connection (e.g., Jacobson & Greenley, 2001), and additionally underscore the role of context and systems in a process-oriented view of recovery (e.g., Leavey, 2005; Noiseux et al., 2010; Onken et al., 2007; Ungar et al., 2008). Jacobson and Greenley described a conceptual model that includes both internal and external conditions necessary to support recovery efforts. Internal conditions reflect the previously articulated principles, such as hope and empowerment, and external conditions are comprised of (1) human rights, including being treated with dignity and respect, (2) a positive culture of healing, which is reflected in a surrounding community that is supportive and hopeful, and (3) recovery-oriented services in which the systems in place to support individuals are accessible, respectful, and offer hope.

In a review of the recovery literature, Onken et al. (2007) similarly outline an ecological view of this process in which both community- and person-centred elements are identified as necessary. In this way, recovery is understood as a phenomenon that depends on relational, community, and systems engagement and capacity, rather than as a process that resides solely within an individual. Specifically, Onken et al. explain,

Recovery is multidimensional, fluid, nonsequential, complex, and permeates the life context of the individual, with some elements linked primarily to the individual and others that are more deeply infused with the role of the community to provide resources and opportunities to individuals as they embark on a recovered journey. All elements of
recovery involve interactions and transactions between the individual and community and within society (p. 10).

Mental health issues often co-occur with addictions, and recovery in this domain has been similarly conceptualized. In the concurrent disorders (CD) literature, recovery has been conceptualized as a process, rather than an outcome, in which social factors are instrumental in the journey toward wellness (e.g., O’Grady & Skinner, 2012).

Experiences of recovery as relationally bound. A limited body of work has explored how recovery is experienced by individuals living with mental illness, and in some cases, by their family members. Findings from this research highlight the social connectedness of the process of recovery. Leavey (2005) noted that adolescent participants reported a pervasive sense of loss associated with receiving a diagnosis. One key dimension of this loss was related to a change in family status. Youth discussed how their family members treated them differently once they were diagnosed. These youth were, subsequently, not included in the family in the same way, and parents engaged with them in a cautious manner. In a study of the interaction patterns of youth with depression in relationship(s) with significant adults, Draucker (2005) found that, for adolescents with depression, healing was contingent on these young people “[revealing] the depth of their emotions and [expressing] who they were to an adult, and an adult [responding] by being wholly receptive and persistent in their support” (p. 958). Such findings further emphasize relationships in the experience of depression and coping. Additionally, themes stressing the interpersonal nature of the recovery process have been cited and include: having the right therapist, family support, volunteering, and community-based youth support (Leavey).

Research has demonstrated that different people involved with the recovery process hold different views about how recovery unfolds and how successful recovery is experienced. A
qualitative study exploring the points of convergence and divergence in the experiences of client, family members, and health care professionals, highlighted the complex network of relationships and supports that exist in recovery processes and noted how different people involved in this process, such as clients and family members, hold different views on how recovery is evidenced (Noiseux et al., 2010). For example, clients have identified recovery as an internal struggle, whereas family members have cited external resources and support as key elements in recovery (Noiseux et al.). These findings further highlight the importance and complexity of relational contexts in understanding mental illness and recovery.

Connection and interdependence are also important for family members engaging in a recovery process with a loved one (O’Grady & Skinner, 2012). In fact, O’Grady and Skinner (2012) highlighted three phases of the recovery process based on interviews with family members who were affected by CD; each of the phases articulated reflect a part of a larger journey. Specifically, the authors referenced the (1) “journey into illness”, which was characterized by issues of ambiguity, confusion, and systems navigation, (2) “journeying through illness”, which was characterized by compassion fatigue, fear of stigma, and an inner conflict, and (3) “journeying on”, which was characterized by hope, knowledge seeking and sharing, need for connection among similar others, and self-care and empowerment. As family members moved into the third phase, O’Grady and Skinner (2012) explained that recovery was understood as a “family journey” that shifted from “fixing” to “being with” and “journeying alongside” (p. 1057). Thus, research has highlighted the way in which the entire family is involved in the recovery experience. Specifically, O’Grady and Skinner stated, “the family’s view of the whole experience shifts. Consistent with the realities of the ill person’s recovery experience, this
transformation is not a magical cure from sadness, anxiety, and worry; rather, it is marked by a cautious but hopeful sense of renewal and the ability to move on” (p. 1053).

Recovery as a contextually situated process, in which families play a significant and essential role, is becoming a more pervasive perspective in the recovery literature, and yet it is unclear how this translates into treatment and research that investigates treatment outcomes. In fact, it has been noted that evidence-based treatment practices and the recovery movement are incompatible at present, as the former privileges empirical evidence and the latter emphasizes the internal, subjective experience of individuals (Resnick et al., 2005). Although there is a body of literature that acknowledges the role of relationship in recovery from mental illness, there is a relative absence of an explicit relational exploration in literature on recovery from depression in adolescence. There is no published literature that investigates how youth and parents engage together in the journey toward wellness from depression in adolescence.

Conceptualizations of recovery in youth mental health. Recovery processes regarding mental illness in youth have been distinguished from such processes associated with adult mental illness (e.g., Friesen, 2007). This distinction serves to highlight very different developmental and contextual realities inherent in these stages of life, while also clarifying priorities associated with recovery across the lifespan. However, such distinctions are problematic in two ways. Firstly, the term “recovery” is not commonly used in youth mental health (Friesen), favouring terms such as “resilience” (e.g., Kumar, Steer, & Gulab, 2010; Nrugham, Holen, & Sund, 2010; Smith, A. et al., 2009) which results in additional confusion regarding terminology appropriate to describing, studying, and supporting the process of getting well subsequent to a depression diagnosis. In addition, resiliency as a construct is similarly associated with much confusion regarding operationalization (e.g., Erdem & Slesnick, 2010; Fraser, Richman, & Galinksy, 1999; Masten,
2001), which further complicates research in this area. Secondly, measures of recovery, as articulated in the DSM 5, largely reflect adult-informed criteria (American Psychological Association, 2013), which do not align with the recognition of life stage differences associated with depression.

Quantitative research investigating recovery from depression in adolescence largely adheres to the notion of symptom absence as indicative of recovery (e.g., Curry et al., 2011; The TADS Team, 2007). However, in some ways, such a view does not resonate with the perspective of the youth treatment service system. For example, in an exploration into recovery in children’s mental health, Friesen (2007) highlighted how the service system designed to support young people with mental illness approaches recovery efforts. In this context, youth recovery processes emphasize the promotion of healthy development, with a focus on the family context, educational possibilities, and the developmental of adaptive peer relationships (e.g., Friesen).

Some qualitative studies have explored the relational dimensions of adolescent recovery (e.g., Draucker, 2005; Leavey, 2005). Leavey conducted a qualitative study of youth experiences with mental illness and articulated a summary of what recovery meant to youth participants. Findings from this research further highlighted the social connectedness of the process of recovery from mental illness, as told by youth living with such illness. Particularly, themes stressing the interpersonal nature of the recovery process included: having the right therapist, family support, volunteering, and community-based youth support. In addition, youth described themselves as active and intentional in this recovery process.

From adolescents’ discussions of the experience and meaning of being diagnosed and living with a mental health problem, Leavey (2005) identified four nonlinear and dynamic stages related to recovery processes, namely, emergence, loss, adaptation, and recovery. Emergence
captured the beginning experiences of receiving a mental illness diagnosis, which was often characterized by misdiagnosis, rejection of the label, and stigma and change in social relationships. The stage of loss encapsulated experiences of loss of identity, independence, academic functioning, and friendships. During the adaptation stage participants talked about coming to a place of acceptance and working to cope, such as taking medication or seeing a therapist; proper intervention and support were identified as key elements in helping these youth move into this stage. Finally, a transformation of identity was seen as the fundamental element of the recovery stage. Leavey explained,

Recovery involves emerging from the onset of a mental illness and re-establishing a social identity. This includes a process of forming a new self-definition and finding ways to decrease the impact of a problematized illness identity. Participants stated this was accomplished by regaining some social reintegration and by identifying strategies needed to maintain a state of recovery. (p. 122)

The model that emerged from this data set is dynamic, iterative, and unique to the individual. It offers an important framework for understanding mental illness and moving toward wellness from the perspectives of adolescents.

**Resilience processes.** As resilience is a construct often favoured in the field of youth mental health, it is efficacious to briefly explore this literature base to obtain a broader understanding of processes relevant to recovery. Generally speaking, resilience necessitates the presence of risk and has been linked to both intrinsic personal characteristics, such as self-efficacy and optimistic worldview (e.g., Aldwin, et al., 2010) and, more currently, to contextual variables, such as ecological resources, systemic supports (e.g., Ungar, 2008). Research in the field of resilience generally, and as it relates to the context of mental illness, continues to identify
personal characteristics and situational factors associated with resilient outcomes (e.g., Theron & Melindi, 2010), while neglecting to explore the interactional dynamics. Thus, a compartmentalized and static perspective on resilience is common in the literature. A view that recognizes the interactive nature of personal and contextual factors has been advocated for (e.g., Aldwin et al., 2010), but is currently lacking. Furthermore, an understanding of the processes of resilience has been identified as necessary in gaining a comprehensive picture of this phenomenon (Theron & Melindi).

Similar to recovery, resilience as studied in the field of adolescent depression has been determined largely by a reduction in, or an absence of, symptoms for a set period of time (e.g., Rao et al., 2010; Silk et al., 2007). Indeed, this view of resilience overlaps with asymptomatic and state-based models of recovery (e.g., Frank et al., 1991). Silk et al. adopted a dynamic and process-oriented perspective in their investigation of resilience in children and adolescents with depression. In this case, resilience was seen as positive functioning despite facing adverse circumstances. Other studies in the context of youth depression have used standardized measures of resilience (e.g., Connor-Davidson Resilience Scale; Resiliency Scales for Children and Adolescents; Connor & Davidson, 2003; Prince-Embury, 2007, respectively), which include subscales focusing on individual characteristics associated with resilience (see Kumar et al., 2010; Nrugham et al., 2010). Examples of domains captured in these measures include: self-mastery, emotional reactivity (Kumar et al.), positive acceptance of change, high standards and tenacity, and control (Nrugham et al.). Only one domain of each measure reflected attention to relational or contextual factors (e.g. relatedness; spirituality). These conceptualizations/definitions of resilience in youth depression are limited in that they neglect the relational and contextual dimensions, and the transactional nature of the process.
The trend toward advocating for a contextual and relational perspective on resilience reflects the reality that individuals exist within multiple contexts (e.g., home, school, work) and engage in a myriad of relationships throughout the lifespan, such as friend, son, daughter, employee. Thus, individuals are rooted within social worlds and cannot be extricated from these worlds when studying a phenomenon such as resilience. Adolescents (14 – 19 years of age) in particular are embedded within an increasingly diverse life context. Relationships with parents shift into the background as young people engage in normative independence and autonomy seeking. At this time, peer relationships become central (Hartup, 2001). These relationships offer opportunities for socialization as well as for the regulation of emotions and self-understanding.

In a review of the literature on adolescent friendships, Hartup noted, “Friendships contributed to social adjustment, to feeling good about oneself, to being socially connected, and to being successful in subsequent relationships” (p. 135). Research on resilient outcomes in youth has identified the importance of social support (e.g., Leavey, 2005; Theron & Malindi, 2010); familial and peer contexts are fundamental in an exploration of resilience in youth.

Similar to resilience research in general, social support has also been consistently noted as a factor that promotes resilience in youth with depression (e.g., Rao et al., 2010). These themes are echoed in results of other studies of resilience in the context of adolescent mental illness. For example, Silk et al. (2007) found that “social contextual factors”, such as maternal nurturance and parent-child relationship quality, predicted positive adjustment or resilience. Interestingly, despite increasing research reporting the importance of relationships and social support in overcoming depression, measures of resilience continue to privilege individual factors. In a study of resilience in Canadian adolescents, Ungar et al. (2008) highlighted the salience of adolescents’ social ecology in navigating mental health. Specifically, resilience was
associated with the relational resources available to and accessed by the young person, such as relationships with significant others, connection and contribution to the broader community, and material resources. Connection and a sense of personal identity were emphasized (Ungar et al.) and similar dimensions of resilience have been identified by other authors in the field (e.g., Leavey, 2005).

Conceptualizations of and research on resilience in the context of adolescent depression are further complicated by the re-occurrence of depression and associated symptomatology, gender differences in the etiology of depression, and ongoing issues associated with measures of resilience. These realities highlight the significance and relevance of a contextual and temporally situated approach to understanding the features/properties of resilience. Overall, research on resilience and recovery in the field of depression has long emphasized an individually focused view resting on symptoms as markers; however, theoretical literature and research has begun to expand to include contextual, relational, and developmental dimensions, as well as recognize recovery as process versus a state.

Contextual Action Theory and Depression

In an effort to address the limitations in the extant literature on recovery as it relates to adolescent depression, this research explores the joint recovery processes in the adolescent-parent relational context from the perspective of adolescents with a diagnosis of depression. The theoretical grounding for this research is Contextual Action Theory (CAT; Young et al., 2005), which privileges action in the study of human development and has been used efficaciously in the study of adolescent development as relationally situated (e.g., Young et al., 2000; Young et al., 2008). CAT is based on the earlier work of von Cranach, Ochsenbein, and Valach (1986). In articulating a theory of self-active systems, these theorists argue that humans engage in
purposeful striving toward a goal that is both steered by behaviour, and influenced by internal and external stimuli and forces, such as thoughts/feelings and feedback from the environment. Furthermore, purposeful action is believed to occur in a reciprocal relationship with context (e.g., relational, situational, systemic), which provides information to the individual that may signal the need to adapt and/or modify action.

CAT builds on this theory and provides a framework for understanding action from multiple perspectives, as situated in relationship(s), and organized hierarchically (e.g., higher and lower order levels of action). It is a theoretical framework that views action as intentional, goal-directed, and embedded within a broader social context (Young, Valach, & Collin, 2002). Human action is understood as a multi-layered and temporally organized process that involves both individual and joint action as it relates to goals. Joint action may reflect shared goals, but it can also reflect individual, and sometimes competing goals. As such, relational and contextual realities are fundamental to and are captured by the CAT perspective. Specifically, Valach and Young (2009) state, “It is crucially important to consider all goal-directed processes as joint processes, thus clearly marking a position that distinguishes contextual theory from theories that identify agency and actions with individualism” (p. 94).

Three different perspectives on action are articulated in CAT, namely social meaning, internal processes, and manifest behaviour. By examining action from three perspectives it becomes possible to capture a more holistic understanding of action (Young et al., 2005). Social meaning reflects the value, significance, or understanding an individual, and the associated community, attributes to the action. An individual’s thoughts and feelings about an action comprise internal processes. Finally, the perspective of manifest behaviour denotes the observable verbal and non-verbal behaviour(s) associated with the action. These perspectives are
relevant to both the individual engaged in the action and to those either interacting with the person or observing the behaviour. According to Young and Valach (2008), “In observing another’s behavior or in acting in relation to that behavior, people attribute goals and thus make sense of the stream of behavior” (p. 214).

According to CAT, action is also conceptualized from an organizational systems framework, which reflects a hierarchy of human action. At the lowest level of the organizational system are elements, which is the smallest unit of action comprised of physical and verbal behaviour. Functional steps are the second level of action in this system and can be defined as “…a series of contiguous behaviors” (Young & Valach, 2008, p. 218); elements are connected to, and form, functional steps. Finally, goals are the highest organizational level of action and reflect the intentionality of the individual. At each level of the organizational systems framework, context is fundamental to understanding the way in which the levels operate and the meaning associated with such operation.

Temporal organization and meaning-making over time are highly relevant processes from a CAT perspective (e.g., Young et al., 2002). Such features are captured in, what are referred to as, action systems. The three action systems associated with CAT are: joint action, project, and career. Action is temporally differentiated; action that lasts for a few minutes is different from a mid-term project that includes action lasting days, weeks, and/or months, which also differs from long-term action that reflects a career in the lives of individuals (Valach & Young, 2009). Joint action reflects the short-term action noted above and is a process involving two or more individuals in which all are working together toward a common goal. According to Young and Valach (2008), this system is “…based on the assumption that many actions occur between and among people…Although individuals have their own intentions, a dyad or group also develops
joint goals and joint action” (p. 215). This system highlights the co-construction and social context of action. It is here that communication among individuals is necessary in order to mobilize toward a goal. A project is another system of action and captures the process of joint action over time, ultimately reflecting a larger goal; it is considered “mid-term” (Valach & Young, 2009).

Finally, the notion of career captures long-term meaning in one’s life and encompasses a multitude of projects that coalesce around a career (Young & Valach, 2009). In this way, career is used more broadly than traditional connotations of vocation. This notion of career allows for individuals to create connections among actions and projects over time that ultimately reflect significant meaning in one’s life. Examples of career could include: an illness career comprised of several related projects, such as a pain management project or a healthy living project, a parent career comprised of several projects, such as a mother identity project or a family connectedness project, and a professional career comprised of projects, such as a training and expertise project, a practical experience project, or a professional identity project.

Literature demonstrates the centrality of relationships, particularly relationships with parents, in the successful navigation of recovery from adolescent depression (e.g., Leavey, 2005; Lewandowski & Palermo, 2009; J. Young et al., 2005). Theories of depression have indicated that relationships are likely even more salient for females engaged in recovery processes (e.g., Cyranowski et al., 2000; Essau et al., 2010). The question of how adolescents and parents engage together in this process remains unanswered. CAT has informed research investigating how parents and youth jointly construct and act on goals related to topics such as health and vocation (e.g., Young et al., 2000; Young et al., 2006; Young et al., 2008). It has enabled a depth of understanding regarding the processes involved in parent-child relationships as it relates to
working toward developmentally appropriate tasks and overall adolescent wellness. In the case of this research, CAT offers a theoretical means of conceptualizing recovery as goal-directed and intentional occurring between adolescents and their parents, which ultimately facilitates an understanding of how joint actions related to recovery are enacted and what it means in the larger sense of the lives of adolescents with depression.

This research assumes that adolescents with depression, together with their family members, engage in joint actions related to recovery goals. An example is articulated to highlight the way in which CAT can be applied conceptually in understanding recovery from depression. Together an adolescent and parent have a recovery goal related to returning to regular school attendance [joint goal]. The adolescent gets showered and dressed for school in the morning [observable behaviour] and agrees to attend if her parent drives her to school [functional step]. From the adolescent’s perspective, getting a ride to school from her parent may signal care and compassion for the difficulties she is facing [social meaning] and cause her to feel loved and supported [internal process] during the recovery journey. The parent agrees to drive her daughter to school [joint action] because she is worried [internal process] that her daughter might not graduate if she misses too much school [social meaning]. These joint actions reflect a larger project that has meaning in the lives of both the adolescent and parent; they may be working on a project related to returning to life as they knew it before the depression diagnosis. Ultimately, this project is connected to a larger career, which may reflect a wellness career for the youth and an aspect of a parenting career for the parent.

CAT offers a perspective on human action that acknowledges and incorporates intentionality, goal-directedness, relational and cultural contexts, and the temporal features of action and meaning. It provides a theoretical structure for a holistic view of human experience,
and specifically action. In its application to research, “…an action theory conceptualization allows researchers to move beyond unidirectional or bidirectional relational influence models to models of joint action and shared meaning” (Young et al., 2005, p. 218). In examining the course and maintenance of the illness, adolescent depression and recovery processes can be conceptualized as action. This does not negate the biological underpinnings of the disorder, particularly in the illness onset and potential reoccurrence. In its application to the recovery processes of adolescents with depression specifically, CAT reflects a view that recognizes the intentional and goal-directed action relevant to depression, offering a new perspective on this illness and recovery, suggesting next steps for research endeavours, and highlighting diverse avenues for intervention and treatment.

Conclusion

Adolescent depression is a significant mental health concern that has implications for the successful navigation of developmentally appropriate tasks, and the transition to young adulthood.

It is critical for professionals to gain a clear understanding, from the youths’ perspective, of how best to assist them in their recovery and reintegration processes. Qualitative data provided by youth with mental health problems can reveal information helpful for policy-makers, planners and providers of the mental health service system in developing and delivering a more youth-focused service system tailored to age-appropriate developmental needs. (Leavey, 2005, p. 109)

There is a solid body of literature identifying the risk factors, etiology, and treatment outcomes associated with depression, which emphasizes a medical perspective focused largely on symptom presence and absence. Such a solid base is important to the field of adolescent depression and a
qualitative exploration into the lived experiences of adolescents as they engage jointly and intentionally with parents around recovery goals can contribute to a fuller understanding of recovery processes. An understanding of recovery processes as jointly constructed from the perspectives of those who live with the disorder will aid both counselling psychology professionals in therapeutic intervention and guide future investigation of this serious mental illness. CAT offers a unique theoretical backdrop for research examining the relational dynamics and processes of youth and their parents as they jointly work toward recovery goals.
Chapter 3: Methodology

An exploration of recovery from adolescent depression as conceptualized as a goal-directed process that occurs jointly in the adolescent-parent relational context is absent in the literature. Additional attention directed at the relational processes has been encouraged (e.g., Leavey, 2005, Ungar et al., 2008), as such a focus elucidates the interactional dynamics involved in the navigation of recovery, which ultimately has implications for interventions designed to facilitate recovery efforts and for future research priorities. In an effort to address this limitation in the extant literature, this dissertation research, resting theoretically on Contextual Action Theory (CAT), conceptualized recovery from depression as, to a certain extent, a joint, goal-directed process that occurs in the adolescent-parent context. Further, using the multicase study approach (Stake, 2005) and Qualitative Action Project Method (QAPM, Young et al., 2005), this study sought to explore the way in which adolescents described how, together with their parents, they engaged in action to reach, or fail to reach, recovery goals. Thus, the specific research question of this study was: How do female adolescents in a process of recovery from depression describe their recovery as joint goal-directed action in the context of their relationship with parents? The purpose of this chapter is to articulate the rationale for the method used in this research project and describe the methodology that was utilized in this exploration. Issues of trustworthiness and validity, as well as the role of the researcher, are also outlined.

Rationale for the Methodology

A multicase study approach (Stake, 2005) and Qualitative Action Project Method (QAPM, Young et al., 2005) were utilized in the execution of this dissertation research. The former approach informed ‘what’ to study, namely the case, in an effort to understand the phenomenon, which is jointly enacted recovery from adolescent depression. QAPM guided
‘how’ to execute the study of the case and associated phenomenon. A rationale for each component of the methodology is outlined below.

**The instrumental multicase study approach.** An instrumental multicase study approach (Stake, 2005) was chosen for this study for a number of reasons. First, this approach emphasizes the case, or the individual, while also seeking to understand a larger phenomenon. For the purposes of this research, the phenomenon of interest represents the jointly enacted process of recovery from depression in adolescence. According to Stake, multiple case study seeks to understand the phenomenon via an examination of single cases, or “manifestations” (p. 6). He explained that it is through the examination of differences and similarities in cases that we are in a better position to understand the phenomenon of study.

The dual emphasis on the specific and the more general facilitates access to an in-depth and nuanced understanding of recovery, thus adding new dimensions to the extensive clinical and quantitative research on depression and recovery, which emphasizes risk and facilitative factors, trajectories, and treatment outcomes. Instrumental multicase study research acknowledges and attends to context. Stake (2005) explains,

> Each case to be studied is a complex entity located in its own situation. It has its special contexts or backgrounds. Historical context is almost always of interest, but so are cultural and physical contexts. Others that are often of interest are the social, economic, political, ethical, and aesthetic contexts. The program or phenomenon operates in many different situations. One purpose of a multicase study is to illuminate some of these many contexts, especially problematic ones. (p. 12)

By utilizing a multicase approach, which facilitates depth of exploration at both the individual case and multiple case level, this researcher was well positioned to maximize the data.
This dissertation research explored the case pertaining to the process of recovery in female adolescents as embedded in the relationship with parents/caregivers. The research question and case descriptions are further meant to enable a deeper and more nuanced understanding of recovery as a joint process in the adolescent-parent relationship. These aims were achieved through (a) choosing an approach that emphasizes the case and its inherent value, and (b) a close and systematic exploration and description of the particularities associated with how recovery was described, energized, executed and understood by participants within their relationship with parents.

**The qualitative action project method.** The Qualitative Action Project Method (QAPM, Young et al., 2005) was chosen as the research method to collect and analyze data across cases for a number of reasons. QAPM contains a systematic and comprehensive protocol, which outlines steps for framing research questions, collecting and analyzing data, and finally, for explaining and contextualizing results. The first step in engaging in research utilizing QAPM involves the articulation of a research question that conceptualizes the topic of focus “as a goal-directed action system” (Young et al., p. 218). Recovery is comprised of action; however it is not often framed in this way and thus not investigated accordingly. QAPM is an approach to conducting research that is informed by Contextual Action Theory (CAT), which has been used as a conceptual framework guiding research in various fields related to the study of human action (e.g., counselling psychology, social work, health psychology). Specifically, QAPM is a methodology that reflects CAT in the use of language, such as joint action, project, and element, the conceptualization of action, and the emphasis on contextual and temporal systems (Young et al.). Research utilizing QAPM in the investigation of parent-child joint processes has shown that,
together, parents and adolescents engage in joint action relevant to their goals, which ultimately has significance in the lives of both individuals (e.g., Young et al., 2006; Young et al., 2008).

Recovery has been described as a process that depends, in large part, on the relationships and social systems in the life of an individual with mental illness (e.g., Leavey, 2005; Noiseux et al., 2010). Furthermore, literature in the field supports the assertion that it is through an active process of engaging in joint action with individuals such as family members, health care providers, and friends that individuals work toward recovery goals, and related projects (e.g., Amering & Schmolke, 2009). QAPM, with grounding in social constructionism (Young et al., 2005), aligns clearly with the relational emphasis in recent trends in recovery literature (e.g., Jacobson & Greenley, 2001; Noiseux et al.; Unger et al., 2008). In addition to privileging action, QAPM prioritizes the relationship as well as context, which enabled an investigation of recovery as embedded in context. Such an approach matched contemporary perspectives on recovery (see Onken et al., 2007) and served to enhance this literature base. In addition, QAPM and the associated theoretical framework supported the view of recovery as a process and provided a systematic approach to accessing this process, which aligns with current theorizing and views on recovery in mental illness.

In conceptualizing this research from a goal-oriented joint action perspective, the specific research question was: How do female adolescents in a process of recovery from depression describe their recovery as joint goal-directed action in the context of their relationship with parents? With an efficacious history in the study of the joint processes in a relational context, namely that of the adolescent-parent relationship, QAPM is the ideal methodology for this dissertation research.
Ontology and epistemology. Scholars in the field of action theory, and the associated QAPM, assert that, at the methodological level, action theory does not fall within traditional research paradigms, such as positivism, postpositivism, constructivism, or critical theory (Young et al., 2005). Although not clearly aligned with one research paradigm, Young et al. note that, in some ways, CAT resembles social constructionism. Social constructionism falls within the poststructuralist paradigm of science, in which beliefs of knowledge and human experience centre on relativist and anti-essentialist ontologies (Buchanan, 2005). More specifically, drawing on the work of Spivey (1997), a social constructionist perspective rests on the belief that it is the nature of human beings to create meaning as we interact with and make sense of our environment; we then desire to communicate these constructions with others. Fundamentally, this perspective is congruent with an action theoretical approach.

From an ontological standpoint, QAPM is relativist in nature, acknowledging and articulating the co-construction of reality that is unique to each individual (Domene & Young, 2008). Young et al. (2005) state that CAT possesses a more “explicit ontology” than constructionism; specifically,

…this ontology begins with our everyday experiences of ourselves, others, and our world and extends to our ongoing interpretation of these experiences as meaningful. If we want to understand ontological questions of meaning, we have to enter the hermeneutic dialectic of human, goal-directed action. This ontology and this epistemology allow for agency; intentionality; and the social, cultural, and historical basis of the construction of knowledge.

(p. 218)

In QAPM, data is triangulated through the incorporation of multiple perspectives on action, such as manifest behaviour, internal processes, social meaning, multiple forms of data (i.e., textual,
video), and a two-tiered approach to data collection in which participants first participate in the research and then reflect on the action of their participation in the self-confrontation interview.

**Research Team and Researcher Reflexivity**

The research team involved in this dissertation research included: the primary researcher (Leah Wilson), the research supervisor (Dr. Richard Young), and five graduate student research assistants. Throughout the two years prior to the execution of this research, this researcher was involved in extensive training in QAPM. This training involved coordinating a multi-year QAPM research project exploring the joint action of peers in the transition to adulthood (e.g., Young et al., in press). As research coordinator, this researcher was involved in recruitment, data collection and analysis, and the written preparation of results, each of which followed QAPM protocol (see Young et al., 2005). In addition, the primary researcher completed a semester long directed study course in action theory and action project method designed to deepen the theoretical understanding of QAPM, as well as begin to conceptualize depression and recovery in adolescence from the perspective of action theory.

The research supervisor of this research was involved in the design of QAPM and has carried out several studies employing this method in the study of human action, with a particular focus on adolescents and the young adult transition (e.g., Young et al., 2000; Young et al., 2008; Young et al., 2010). The research supervisor was actively involved in the decision making around the execution of data collection, analysis, and the preparation of the findings. Four University of British Columbia and one Memorial University of Newfoundland graduate student research assistants (RAs), four female and one male studying in the counselling psychology and clinical psychology program respectively, volunteered their time to assist in this research project. Each of the RAs was previously trained in QAPM and four RAs had been or were involved in a
separate large-scale study also utilizing this methodology. The primary researcher worked with three of the RAs on a previous QAPM research project.

**Researcher relationship to the research topic.** Acknowledging the researcher as a relevant factor in qualitative research is common in addressing issues of quality and ethics in conducting research (e.g., Haverkamp, 2005; Haverkamp & Young, 2007). Researcher reflexivity is an important component of conducting research and refers to attending to acknowledging the researcher’s relationship to the topic of study, researcher-participant interactions as it relates to the research process, and personal awareness of power differentials inherent in research contexts.

**Professional relationship.** Since undertaking my graduate studies in the field of counselling psychology at the Masters level, I have focused on child and adolescent mental health. This focus included involvement in both research and clinical/therapeutic contexts. I have had the opportunity to work face-to-face with youth with depression and their families as they engage in efforts specific to recovery. As a practitioner working to build rapport and a therapeutic alliance, it was my stance to meet the adolescent client where she was, valuing her unique perspective on depression and recovery, and how she described her experience. Thus, the experiences of engaging in therapeutic work with youth and the voices of these youth have been an important emphasis in my clinical work. It is my view that these voices have much to contribute to an enhanced clinical understanding of recovery processes, and can act as an informative guide in conducting future research.

**Researcher’s process/researcher-as-instrument.** As a researcher and practitioner, I value authentic human connection/interaction that emphasizes the distinct perspective of the individual with whom I am connecting. It is my view that QAPM enables authentic connection between
researcher and participants. Such connection was facilitated in this research project first via repeated contact with the participants prior to the data collection, such as in the telephone screening conversation and the research warm-up conversation. Authentic connection was further facilitated through the invitation to participants to discuss those aspects of recovery that were personally significant, and through the encouragement to speak openly and honestly about their experience of the relationship, the joint-action, and the meaning this had in the context of their lives. In addition, both this researcher and the research assistant made space for comments specific to the participants’ experience of participating in the research and/or of being a member of the participant-researcher relationship.

One way in which quality and trustworthiness were addressed in this research study was through the recognition of this researcher’s role as both a researcher and instrument for this study (Morrow, 2005). Throughout the research study I monitored my process and experience of conducting the research on an ongoing basis by engaging in regular journaling practices, receiving ongoing supervision from my research supervisor and research committee, and involving others outside of the research, such as RAs, to aid in analysis and integration of findings. This practice addresses one criterion for conducting solid qualitative research, namely that which Tracy (2010) terms “sincerity.” Sincerity refers to self-reflexive and transparent processes that are integral to the execution of research. A few journal excerpts have been included to highlight aspects of this reflexive process as the project unfolded.

May 3, 2013: As the research becomes real (i.e., I have interested participants), it is interesting how many unanticipated issues have arisen: turning down a person based on a dual relationship and ensuring I do it sensitively because my relationship will continue with her in other capacities; being flexible with my inclusion criteria while maintaining a
rationale for doing so, constantly revising my ethics application in order to support my recruitment efforts.

January 7, 2014: It always feels like there’s more, so much more to know or that the participant can share on her experience. It can be hard to always know when to stop.

July 16, 2014: 19 year old participant today. Difficult to get her to elaborate and at times appeared unclear about what was being asked. However, she responded well to probes and reflections. It seemed she had less “specifics” to offer/share than other participants, speaking in generalities.

Researcher reflexivity was an important component of addressing issues of quality and ethics in this qualitative research project.

Participants

In QAPM, the dyad is the “participant” and it is thus the dyad’s joint action that is the focus. For the purposes of this research, the dyad of interest was comprised of the parent and adolescent. As such, the study emphasized this focus in the guiding/overarching research question, the interview protocol, and the focus of the data analysis and reporting. The design of this research was different from typical executions of QAPM, which includes having a dyad engage in a discussion about shared goals, and then later commenting on their own internal processes and perspective on meaning. In this study only one member of the dyad of interest was included, namely the adolescent, who was then invited to comment on the relationship, the roles, and the activities associated with the dyad. In this way the study explored the social embeddedness of the recovery process. Such an approach to studying the social embeddedness of a phenomenon using QAPM has been executed in prior research in the field (Valach, Michel, Young, & Dey, 2006).
Participant recruitment. With regards to recruitment more specifically, participants were engaged through local child and youth mental health teams, the mental health services department of the local children’s hospital, and a mental health resource centre using posters (Appendix A) and invitation letters to clinicians (Appendix B). In addition, advertisements for the research project were posted online in places such as Craigslist and Kijiji and using social media, such as Facebook. Recruitment materials briefly summarized the research project, outlined involvement, and provided contact details for more information. Adolescents were invited to contact the researcher to learn more about the study and to indicate their interest. Once an adolescent contacted the researcher, which occurred solely through email, a standard response highlighting the details of the study (e.g., length of time involved in participation, video/audio recording, general procedures) was shared and a copy of the invitation letter (Appendix C), adolescent assent form (Appendix E), and parent permission form (Appendix F) was attached to the response. If individuals were still interested in participating after receiving this information, we arranged a mutually convenient time to complete a telephone screening interview (Appendix D). At this time the consent form was reviewed, the demographic and screening questions were completed, and individuals were invited to ask any additional questions. It was made clear that their participation was completely voluntary and that they could withdraw from the study at any time without any penalty.

Eligibility criteria. Eligibility criteria for participation were shared with interested individuals both in invitation to participate letters and then reviewed during the telephone screening interview. Criteria for the participants included the following:

1. Self-identification as female,
2. Between the ages of 16-19 years,
3. Primary diagnosis of Major Depressive Episode (MDE) or Major Depressive Disorder (MDD) by a mental health/medical professional (e.g., psychiatrist, family physician),
4. Receiving counselling services (e.g., local mental health team, youth clinic, psychiatrist) at the time of the interview and for at least 4 months prior to the interview,
5. Have not attempted suicide in the past 6 months, and
6. Be living with a parent/caregiver.

Female participants were chosen for this study for a number of reasons, (a) females in adolescence have higher rates of depression compared to males, (b) this researcher is building on her previous and on-going focus in research (i.e., adolescent female health and well-being), and (c) this researcher is female and thus expected the participants would feel more comfortable speaking to someone identified as the same gender. Although the highest prevalence rates for adolescent depression are associated with female youth aged 15-20 years (e.g., Fichter et al., 2009), the age range of the sample for the current study was slightly narrowed for two reasons: (1) late adolescence (16+ years) is characterized by advanced cognitive capacity, including the ability to think abstractly and in complex ways about the self (Harter, 1999), and (2) the local youth mental health system provides services only until the age of 19. As recruitment for the current study was closely connected to the local mental health service system, the upper age limit was important.

As the phenomenon of interest in this study was adolescent depression, participation required a formal diagnosis from a medical/mental health professional. The primary diagnosis had to be MDD or MDE; however, given the reality of co-morbidity in youth with depression (e.g., Lilienfeld, 2003), secondary diagnoses did not result in automatic exclusion from participation. Many participants identified secondary diagnoses, and in these cases suitability
was determined on a case-by-case basis in consultation with the research supervisor. In the context of this research project “recovery” was conceptualized as a process that formally began following both the receipt of a diagnosis and the initiation of ongoing counselling services/support; as such, adolescents participating in this research must have also been receiving counselling services for at least four months. Literature shows a response rate of 65% after four months of CBT treatment (The TADS Team, 2007) and this literature was utilized to inform the criteria for being in a process of recovery.

It was important for participants to continue to have access to counselling services during participation in this research, as discussing experiences around recovery from depression may have been difficult for some participants; thus, access to regular counselling was designed to support participants if they experienced difficulties. Exclusionary criteria included: failure to meet inclusion criteria and active suicide attempts, the latter of which was captured via adolescent self-reports of a suicide attempt in the past 6 months.

Ultimately, the determination of eligibility according to inclusion and exclusion criteria was a part of the initial screening process all participants underwent prior to becoming a participant in this research. Interested individuals were made aware at the initial point of contact of the eligibility criteria, and information regarding these criteria was sent out to interested individuals via email. In addition, interested individuals were informed at outset of the screening interview that before a determination of their eligibility could be made, this researcher would need to consult with her supervisor. Directly following the screening interview the researcher contacted the research supervisor, discussed the interested individual in the context of the eligibility criteria and made a collaborative decision regarding suitability. Subsequent to this consultation the researcher followed up with each interested individual to discuss next steps. For
those individuals who did not meet the eligibility criteria, a script designed to clearly and supportively deliver the information was followed. A total of six additional individuals were also screened for participation in this study, but did not move forward with an interview. Four screened individuals were deemed ineligible to participate because they were not seeing a counsellor at the time of the screening interview; one of these four also identified a recent suicide attempt. Two additional interested individuals were screened and booked for an interview, and later cancelled. Lastly, eight other individuals contacted this researcher indicating interest but did not follow through with the telephone screening interview.

Seven adolescents with depression met the inclusion criteria outlined above and agreed to participate in the study. Although most of the research that has been conducted utilizing QAPM includes 15-20 dyads, these projects have been carried out by a team of researchers over a longer period of time, such as 9 months (see Young et al., 2000; Young et al., 2008). The multiple case study approach identifies four to ten cases as the ideal sample size (Stake, 2005). Stake argues that fewer than four cases does not provide enough data from which commonalities can emerge, and greater than ten cases produces too much data to manage. Such parameters are designed to “allow a good embrace of the Quintain [phenomenon of interest]” (Stake, p. 18). Overall, the sample size for the current project was informed by the descriptive nature (rather than causal or explanatory) of QAPM (Zaidman-Zait & Young, 2008), issues of feasibility for a doctoral dissertation to be carried out predominantly by one researcher and an assistant, and the case study sample size parameters outlined by a multiple case study approach (Stake).

**Participant demographics.** Seven female adolescents were recruited and participated in this study. All but one of the participants resided in an urban city on the west coast of Canada and one participant resided in an urban city on the east coast of Canada. The mean age of the
participants was 17.86 years (SD = 0.90) and the mean age at diagnosis was 15.07 years (SD = 2.01) (see Table 1). Three participants lived at home with both of their biological parents. One of the seven participants lived part time with her biological mother and part time with her biological father. One of the seven participants lived at home with her biological mother. Another participant had just moved out of the home she shared with her foster mother. In the case of this participant, the relationship of focus was the one she had with her foster mother, who she considered her primary caregiver. All but one of the participants had siblings living in the family home. Length of treatment varied by participant with a mean length of 28.07 months (SD = 25.85). Each participant was given an honorarium of $15 as a token of appreciation for her time. Bus or parking fare coverage was also available, however none of the participants requested this coverage/reimbursement.

Table 1.

**Participant Demographics**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Age at Diagnosis</th>
<th>Length of Treatment (months)</th>
<th>Additional Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ananda(^1)</td>
<td>18</td>
<td>15.5</td>
<td>30</td>
<td>Bipolar, ADHD, OCD, Anxiety, OCD</td>
</tr>
<tr>
<td>Brooke</td>
<td>17</td>
<td>15</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Celia</td>
<td>19</td>
<td>18</td>
<td>12</td>
<td>Anxiety, OCD</td>
</tr>
<tr>
<td>Daljeet</td>
<td>17</td>
<td>12</td>
<td>54</td>
<td>Anxiety, OCD</td>
</tr>
<tr>
<td>Eleanour</td>
<td>17</td>
<td>16</td>
<td>6.5</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Fiona</td>
<td>19</td>
<td>13</td>
<td>72</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Gillian</td>
<td>18</td>
<td>16</td>
<td>18</td>
<td>Eating Disorder, Anxiety</td>
</tr>
</tbody>
</table>

| Mean        | 17.86 | 15.07 | 28.07 |
| SD          | .90    | 2.01   | 25.85 |

\(^1\) All participant names have been replaced with pseudonyms.
Procedures for Data Collection

QAPM outlines a specific and comprehensive, yet flexible, protocol for data collection procedures (see Young et al., 2005). Data collection began in the telephone screening interview during which potential participants were asked to provide demographic details. This step also served to determine if the interested individual met the eligibility criteria. If criteria were met, this data was included in the study. If criteria were not met, this data was confidentially destroyed. Participation in this study subsequently involved a research conversation and self-confrontation interview with each participant. Detailed procedures are outlined in the sections below.

Role of participants. Participants in this study were involved in shaping the specific focus of the study in that they determined the relevant aspects of “recovery from depression” by choosing to highlight these aspects in their conversations the researcher. Similarly, adolescents identified goals and actions relevant to the recovery process and, in this way, shaped the research. Furthermore, participants engaged in a process of member checking (e.g., Tracy, 2010) through completing the self-confrontation interview directly following their research conversation, thus validating the findings. This is described in greater detail later in this chapter.

Research conversation. Following the telephone screening interview, the adolescent was invited to attend the interview at a mutually convenient time. This interview was comprised of three components: the introduction/warm-up, the conversation, and the self-confrontation interview. Consent forms were reviewed and signed at the outset of the interview, and this researcher verbally reviewed the limits of confidentiality (i.e., mandated reporting in the case of harm to self or other, child abuse/neglect). Due to the age of majority in British Columbia, parental consent was not required for participants who were 19 years of age. Prior to beginning
the joint conversation between the primary researcher and adolescent, the primary researcher and research assistant (one of the five identified in the previous section) led the participant in an introduction and warm-up conversation that involved (a) orienting the participant to the process, (b) reminding the participant of the topic of interest for this research, (c) and inviting any questions/comments before beginning the conversation. The introduction and warm-up were not recorded.

Following the introduction/warm-up, the research assistant left the room and the researcher began the conversation with broad questions following a pre-established protocol (see Appendix G), which was designed to facilitate the narrative sharing in an open-ended and participant-directed way. For example, the researcher asked, “Tell me what it has been like to live and cope with depression.” In some cases, this open-ended question lead participants to comment on joint action with their parents. For other participants, the researcher probed more specifically asking, “Can you tell me the story of how your parents have been involved in your recovery process?” The latter question prompted narrative sharing specific to the relational context of focus in this study. Participants were always asked if there was anything else they thought was important to share before terminating the interview. This conversation was video- and audio-recorded. The researcher made note of the point at which the participant began discussing her experience of her parent(s) in the recovery process to enable the identification of an appropriate start point for the self-confrontation interview.

Research conversations varied in length, which was largely determined by the participant’s degree of detail and elaboration in response to interview probes (see Table 2 for duration data). The mean length of research conversations was 44 minutes and 10 seconds (SD =
5.36), 36 minutes and 43 seconds (SD = 7:34) for the self-confrontation interview, and 80 minutes and 53 seconds (SD = 6:56) for the total duration of the research participation.

Table 2.

Duration of Research Procedures by Participant

<table>
<thead>
<tr>
<th>Participant</th>
<th>Conversation (Mins : Secs)</th>
<th>Self-Confrontation Interview (Mins : Secs)</th>
<th>Total (Hr : Mins : Secs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ananda</td>
<td>37:26</td>
<td>36:43*</td>
<td>1:14:09</td>
</tr>
<tr>
<td>Brooke</td>
<td>41:57</td>
<td>38:06</td>
<td>1:20:03</td>
</tr>
<tr>
<td>Celia</td>
<td>47:35</td>
<td>23:26</td>
<td>1:11:01</td>
</tr>
<tr>
<td>Daljeet</td>
<td>45:56</td>
<td>41:45</td>
<td>1:27:41</td>
</tr>
<tr>
<td>Eleanour</td>
<td>54:14</td>
<td>31:07</td>
<td>1:25:21</td>
</tr>
<tr>
<td>Fiona</td>
<td>40:05</td>
<td>38:24</td>
<td>1:18:29</td>
</tr>
<tr>
<td>Gillian</td>
<td>41:58</td>
<td>47:30</td>
<td>1:29:28</td>
</tr>
</tbody>
</table>

Total 5:09:11  4:17:01  9:26:12
Mean 44:10  36:43  1:20:53
SD 5:36  7:34  6:56

* missing data - data based on average.

Self-confrontation interview. Directly following the research conversation, participants met with a research assistant to view the 15-minute videotape playback of a section of their conversation with the researcher. The section of video viewed was determined on a case-by-case basis depending on the point at which the participant discussed recovery as enacted in the adolescent-parent relationship. This point in the interview was different for each participant, with some participants beginning their story by sharing the role of their parent(s) and others requiring a specific prompt to speak to this aspect of recovery. The research assistant began the playback at the researcher-determined point of the conversation (i.e., the point noted by the researcher during the conversation) and then paused the video at one-minute intervals. During the paused moments the participant was asked to comment on her thoughts and feelings during that minute in the research conversation (see Appendix G for additional details). For example, participants
were asked, “What were you thinking as you were describing that outing with your mom to Leah?” This process of self-confrontation offered additional layers of information that reflected the individual’s internal processes and social meaning (Valach et al., 2002). In addition, it offered the participants opportunities to clarify their communications and intentions.

Upon the completion of the self-confrontation interview, the researcher returned to the room and facilitated a debriefing with the research assistant and participant together. This debriefing consisted of: (1) checking in with the participant about how she was feeling after sharing her story, (2) asking the participant if she had any questions and inviting her to contact the researcher should any questions arise after the interview, (3) providing the participant with a list of local support contacts should she need someone to talk to after the interview and highlighting her connection to her current counsellor/psychologist, and (4) providing the participant with the $15 honorarium. Any participants interested in receiving a copy of the research results were also invited to fill in a form indicating their interest.

**Member checking and the self-confrontation interview.** QAPM protocol has a built in system of member checking through the self-confrontation interview (Young et al., 2005). The self-confrontation interview is designed to invite the participant to clarify, elaborate on, and/or explain the intention behind what was shared in the research interview following a minute-by-minute playback. In this way participants were provided with the opportunity to say, for example, “When I said X, I was trying to describe how I felt about my parent’s support.” They were further able to speak to the meaning they associated with action in the context of the adolescent-parent relationship, and clarify components of their story that may have been unclear. This aided in the data analysis phase of the study as the researcher had access to the participant’s
clarified view, which included data on intention(s), internal processes, and social meaning. Such built in procedures enabled a process similar to in vivo member checking.

**Participant-researcher dyad.** Another dyad beyond the adolescent-parent dyad emerged in the data collection of this study, namely the participant-researcher dyad. Despite not being the primary dyad of interest, the recognition of this dyad is important as it has implications for the overall research project. In the action-project method, the action that comprises the data of interest is the conversation between the relevant participants, for example, parents and adolescents (Young et al., 2005). The analysis follows this action explicitly linking it to a longer-term “project” of the “dyad”. In the case of this study, the action (conversation) occurred between the researcher and the participant in which the participant described relevant actions engaged in with her parents. The participant-researcher dyad became particularly important during the self-confrontation interview when the participant was asked to recall her thoughts and feelings while relaying a part of their narrative to the researcher. As a result, the researcher became a part of the data. When the research assistant asked the participant, “What were you feeling when you told Leah about being frustrated with your mom?”, the participant commented on her feelings in interaction with the researcher as they described their relationship with their parent(s).

**Procedures for Data Analysis**

Data analysis followed the QAPM protocol (Young et al., 2005). Analysis began subsequent to each participant interview and did not depend on the completion of all participant interviews. Data analysis began with the verbatim transcription of both the conversation and self-confrontation interview. This researcher transcribed each conversation and interview and transcriptions were later checked with audio data to ensure accuracy.
**Within case analysis.** Data were analyzed according to the levels of action, which included elements, functional steps, and goals. Broadly speaking,

The analysis process demands a clear understanding of the research question and the purpose of the research. It involves both description of the actions that occurred and drawing inferences from these actions to other actions as well as to underlying projects and careers. (Young et al., 2005, p. 219)

First, transcripts and videotape of the conversation and transcripts of the self-confrontation interviews were reviewed in their entirety. Elements are units of behaviour and were coded line-by-line in the transcript (Young et al.). This step involved the use of a coding list (see Appendix H) developed and applied previously in a variety of research projects utilizing QAPM in the study of young adult development and transitions (Young et al., 2010). Coding the text according to elements facilitated the identification of functional steps. Coding for elements associated with both the adolescent and the parent were completed; coding for the parent was based on the adolescent’s perspective on her parent and associated action and internal processes. Subsequent to the broad review of each participant’s data, this researcher returned to the section of each conversation on which the self-confrontation was based, closely examining commentary in the self-confrontation interview that helped to explain the identified 15-minute conversation segment.

Together the elements and functional steps, in conjunction with the self-confrontation interview data, aided the researcher in identifying action and goals, internal processes, and social meaning. Such an approach to analysis was similar to a hermeneutic process that involves a “back-and-forth movement” between the data and the conceptual framework (Young et al., 2005, p. 220). Joint goals and actions were identified throughout the transcript. The language of the
goals and projects was determined by the researcher and informed by the participant’s description of how and why she and her parent(s) worked toward recovery. These data were then transferred to a chart for each participant and the elements were organized by goal/project as determined through the researcher’s analysis of both the research conversation and self-confrontation interview. Quotes that exemplified the goal and/or project were also included within this chart.

After the entire conversation was analyzed, the researcher constructed a narrative, which included an introductory section on context/background, such as demographic, familial, and diagnosis/treatment details, and then identified and described each project identified in the adolescent’s story. Narratives were organized by projects, which summarized the action, the roles of the dyad members, and the goals of each dyad member, as told from the perspective of the adolescent. Data emphasizing salient relational dynamics and internal processes were also included as sub- and separate categories within the narrative. The integrated narrative captured each of the three perspectives on action, namely the manifest behaviour, internal processes, and social meaning, as outlined in the theoretical underpinnings of the method. Quotes were included in the narrative to both emphasize the adolescent’s language in describing action as joint and goal-directed, as well as demonstrate the adolescent’s conceptualization/discussion of the project. The temporal emphasis of QAPM is reflected in the narratives as these summaries encapsulate meaning over time, as articulated and understood by participants, and serve to provide coherence to human experience (Young & Valach, 1996).

Once the draft narrative was prepared, the researcher sent each narrative to the research supervisor for his review and commentary. His feedback was then integrated into a revised narrative that comprises the findings of Chapter Five. In addition, three research assistants
involved in this research project also reviewed three narratives and associated data to ensure the within case findings reflected the data. Any commentary and revisions suggested by the research assistants were integrated into the narratives, and now exist in the findings section of this dissertation.

**Cross case analysis.** Typical of both QAPM (Young et al., 2005) and instrumental multicase study design (Stake, 2005), cross case analysis was undertaken once data collection for all dyads was complete. One exception involved the final participant, Gillian, who indicated interest in participating after cross case analysis had begun. Once her within case data was analyzed it became incorporated into the cross case analysis procedures. Beneath the overarching research question of this study, there were two guiding questions relevant to cross case analysis using QAPM with a multicase study design: (1) What do these cases share in common (at the level of actions, goals, projects)? and (2) What are the unique features within the case data set (at the level of actions, goals, projects)? This level of analysis involved looking across all dyads and highlighting themes and patterns that were consistent throughout the data set. Domene and Young (2008) explain, “The cross-case analysis permits the researchers to identify and discuss the general characteristics of the findings: what goals, actions, and other themes emerge across the entire sample” (p. 62). It involved an iterative process of identifying common and disparate themes across dyads, returning to the data of each participant to ensure identified themes were supported by the data, and revising themes and patterns. More specifically, three cases were explored at once with a focus on obtaining a better understanding of the phenomenon of study, which continued until each case had been reviewed with other cases at least twice. This approach was informed by QAPM protocol (e.g., Young et al.) and Stake’s guidelines for instrumental multicase analysis.
Criteria for noting specific themes centred on the frequency with which they occurred in the sample (Domene & Young, 2008). Regular supervision and guidance from the research supervisor was an integral element of cross case analysis, which reflected the emphasis on team consensus processes typical throughout all stages of research using QAPM. Overall, this level of analysis added depth and richness to understanding the joint recovery processes in the lives of female adolescents with depression and their parent/caregiver. By emphasizing both the commonalities and unique processes in the entire data set, findings maintain the integrity and complexity of the case, as advocated by Stake (2005).

In addition, as a part of researcher reflexivity and guiding principles for trustworthiness and rigour in qualitative research (e.g., Haverkamp, 2005; Haverkamp & Young, 2007; Tracy, 2010), the researcher made notes regarding possible themes throughout the data collection and analysis procedures. Such researcher journaling occurred directly following the interview and/or during within case analysis procedures. In all of these ways, themes and assertions emerge from the data (i.e., participant-researcher conversations and subsequent self-confrontation interviews), as well as from real-time researcher reflection.

**Assertions.** A multicase study approach also includes assertions, which represent the distillation of the findings as they relate to the primary research question (Stake, 2005). In the case of this research, assertions have been included both at the within and cross case level with the intention to aid in understanding joint processes between female adolescents and their parents regarding recovery goals. Related to cross case analysis, Stake provides additional detail about assertions, stating, “The assertion should have a single or common focus, a contribution toward understanding the Quintain [phenomenon of interest], and evidence from more than one Case to support it” (p. 56).
**Consensus practices.** Additional forms of member checking reflecting the consensus building approach typical of analysis in larger QAPM studies (e.g., Domene & Young, 2008; Young et al., 2005) were also utilized in this study. Specifically, the participant narrative prepared by the researcher was forwarded to the research supervisor to review and verify. Similarly, three research assistants reviewed the data analysis, including the coded transcripts of the research conversation and the self-confrontation interview and the researcher-prepared narrative, for one of the participants with whom they were involved. Research assistants were asked to comment on the degree to which they found the data analysis to be consistent with the data, which also included their first hand experience of completing the self-confrontation interview with the participant. Research assistants found the analysis to be generally consistent with the data, and offered minimal revisions, which were incorporated into the analysis.

**Quality and Trustworthiness**

**Theoretical and paradigmatic grounding.** In an article examining concepts of trustworthiness both as they apply indiscriminately/transcendently to all research paradigms, and as they relate uniquely to specific paradigms, Morrow (2005) outlines recommendations for addressing standards in research. The first of these recommendations is that research be grounded theoretically and paradigmatically, as this facilitates clarity in addressing trustworthiness. One of the key strengths of QAPM is that it is firmly rooted in CAT, which provides a clear framework for articulating research questions, outlining research procedures, and analyzing and conceptualizing results (Young et al., 2005). CAT has been applied to the study of human behaviour in many contexts, such as parent-child relationships and conversations of health and career and client-counsellor conversations about change processes, and thus has
demonstrated theoretical utility in research endeavours. The explicit ontology of CAT further addresses Morrow’s recommendation regarding trustworthiness. Young et al. explain,

…this ontology begins with our everyday experiences of ourselves, others, and our world and extends to our ongoing interpretation of these experiences as meaningful. If we want to understand ontological questions of meaning, we have to enter the hermeneutic dialectic of human, goal-directed action. (p. 218)

CAT and QAPM attend to and prioritize/emphasize context and the relational in conceptualizing human experience. This is consistent with Morrow’s argument that “contextual grounding is essential for understanding the meanings that participants make of their experiences” (p. 253).

The firm theoretical grounding of QAPM in CAT, and the contextual emphasis of the theory and method, are important components of trustworthiness in the current research study.

**Rigour and authenticity.** Lincoln and Guba (2000) assert that the rigour of the research must be evaluated in determining the validity and trustworthiness of qualitative research. The rigour of QAPM has been discussed elsewhere (see Young et al., 2005), with the overarching assertion that this methodology demonstrates rigour in the comprehensive and systematic procedures of data collection and analysis, and self-confrontation interviews. Additionally, Young et al. addressed Lincoln and Guba’s requirement that valid and trustworthy research also be reasonable or authentic:

This method can generate findings that resonate with human experience and stand firmly alongside other interpretations of human experience…The fact that the method is grounded on the empirically supported principles of action theory contributes significantly to this argument (Young et al., p. 221).
Furthermore, through attending to multiple perspectives on action, QAPM captures a holistic representation of human experience, as described and understood by those engaged in, and ascribing meaning to, the action (Young et al.). By gathering multiple perspectives on action and engaging in member checking practices through the self-confrontation interview, the current research project addressed rigour and authenticity.

**Resonance.** Resonance as it refers to transferability is explained as the “study’s potential to be valuable across a variety of contexts or situations...[it is] achieved when readers feel as though the story of the research overlaps with their own situation and they intuitively transfer the research to their own action” (Tracy, 2010, p. 845). It is anticipated that the stories, and specifically the joint action and associated meaning, will be valuable to a variety of individuals and communities, each of whom may connect with the results in different, but resonant ways. For example, youth with depression and their families may see similarities in their experiences and learn from the participants’ process and actions. Health care providers, such as psychologists, psychiatrists, and counsellors, may recognize similar elements in the experiences of the participants as they do in the experiences of the youth and families with whom they work. This may affect the way in which they engage with this group.

**Credibility.** Tracy (2010) likens credibility to trustworthiness, verisimilitude, and plausibility in research, which is addressed through multivocality, crystallization, and member checking. Broadly speaking, it involves the inclusion of multiple perspectives in order to ultimately enhance a thick description of an experience or phenomenon. QAPM necessitates the inclusion of multiple perspectives on the same experience (Young et al., 2005). Joint action is the unit of primary interest according to this methodology, and through self-confrontation interviews
the researcher is able to obtain a more holistic picture of the meaning action according to each participant within the context of their relationship, and the larger picture of their lives.

Crystallization, or triangulation, has also been discussed as relevant to addressing credibility in research (e.g., Patton, 2002; Richardson, 2000; Tracy, 2010). Richardson described the crystal in the following way,

[The crystal] combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multi-dimensionalities, and angles of approach. Crystals grow, change, alter, but are not amorphous. Crystals are prisms that reflect externalities and refract within themselves, creating different colors, patterns, and arrays, casting off in different directions. What we see depends upon our angle of repose. (p. 934)

According to Tracy, the metaphor of a crystal reflects the variety and depth achieved through the inclusion of multiple data sources and researchers. In this research project, data was collected from multiple sources, such as demographics and telephone screening, conversations, and self-confrontation interviews, which facilitated crystallization. Additionally, by including direct participant quotes in the narratives and in the representation of the research findings, this researcher also attended to issues of credibility in this research.

**Ethical Considerations in the Execution of this Research**

This research project involved vulnerable individuals, namely adolescent participants, around an issue associated with specific risk factors, including suicidal ideation and suicide. Particular care was given to ensuring this research was executed in a manner that was sensitive to these factors. Three considerations related to ethics in this research were primary: (1) how to minimize the inclusion of participants for whom participation would increase their safety risk, (2) how to ensure participants were supported should they experience participation in the project
as a stressor, (3) how to minimize the impact of participation on participants following the study. The first consideration was addressed via exclusion criteria, which included a reported suicide attempt in the past six months as one such criterion. In cases of recent suicide attempts, exploration of the experience of depression and recovery processes in the context of this research was considered an additional stressor and thus, individuals reporting these symptoms were not suitable candidates for participation in this research.

This researcher acknowledged that discussing experiences of depression and coping may bring about difficult feelings and/or act as a stressor for adolescent participants. As a means to ensure participants had access to support subsequent to the interview, inclusion criteria stipulated that participants be connected to and involved in counselling or psychological services. Additionally, participants under the age of 19 needed the signed permission of their parents to participate and parents were provided with a permission form outlining the study and risks and benefits associated with participation. Lastly, during the debriefing with participants directly following the interview, this researcher checked in with each adolescent about her emotional state and provided her with local resources with specific reference to her “best” support contact (e.g., counsellor, parent), which was identified in conversation with the participant.

In addition to ensuring access to professional support and reinforcing additional community supports, this researcher further consulted with her research supervisor about member checking protocol as outlined in the initial dissertation proposal. Initial member checking plans involved typical QAPM procedures wherein analyzed data is circulated to participants for confirmation that the findings resonate with the participant’s experience (see Young et al., 2005). However, this plan was later revised. Together with the research supervisor, this researcher engaged in a cost-benefit analysis regarding sharing prepared narratives with
participants. Ultimately, we anticipated that the risk of forwarding a summary of the emotionally laden research conversation and self-confrontation interview (i.e., narrative as stressor) without the presence of a support person outweighed the benefit of participant confirmation. This decision was further strengthened due to the process of member checking already built into the self-confrontation interview wherein participants were asked to clarify the meaning of aspects of the interaction, speaking directly/explicitly to their thoughts and feelings.

This study received ethical approval from this researcher’s educational institution’s ethics review board, Behavioural Research Ethics Board of the University of British Columbia’s Office of Research Ethics. Additional ethical approval was sought and obtained through Vancouver Coastal Health Authority as recruitment efforts involved some of the mental health services of this health region. Lastly, ethical approval was sought and obtained through the Newfoundland and Labrador Health Research Ethics Board as this researcher recruited participants and conducted one research interview while residing in this eastern region of Canada.

**Delimitations**

This research project was limited in advance of its execution due to a number of factors, and the current project reflects some revisions since the time of the initial proposal based on challenges with recruitment. First, this study was limited by the inclusion criteria, such that individuals without a formal diagnosis of depression, who lived outside the family home, and who were not receiving counselling were not included in this study. The exclusion criteria further precluded the participation of any participants who were recently or actively suicidal. Such limitations were decided in advance of the execution of this study.

In terms of revisions to the dissertation research as initially proposed, alterations to the recruitment plans and participants of interest were made. The initial research study was to
include parents and adolescents to comprise the “dyad” typical of QAPM and to obtain both perspectives on joint action in the context of recovery from adolescent depression. Recruitment plans as laid out in the dissertation proposal were followed, such as notices posted on social media sites and community outreach meetings held with this researcher and mental health clinicians in community. Over the course of approximately six months of these active recruitment efforts, there was minimal adolescent interest, and only one interested adolescent was willing to be interviewed with her parent. Such low levels of interest were not conducive to continuing with the existing research plan. Given the timeline and scope of this dissertation research, this researcher consulted with the research committee to revise the research plans such that the research could be executed.

Given the feedback from interested adolescents and from mental health clinicians in the community, namely about the apprehension expressed by adolescents about parent involvement, the inclusion of adolescent participants only was explored. Ultimately, the research question was revised to emphasize the recovery process in the context of the adolescent-parent relationship from the perspective of the adolescent. In this way data relevant to this key context in recovery from depression was still primary in the research, and it was still possible to capture and emphasize the voices of those individuals most closely connected to depression and recovery – the adolescents who live this reality.

Finally, further delimitations were determined surrounding member-checking procedures. Specifically, following analysis in QAPM, the prepared narrative is typically shared with participants as a means of member-checking. Such member-check procedures involving the research participants were decided against in the case of this research for reasons outlined in the Ethical Considerations section of this dissertation.
Chapter 4: Cross Case Findings

Both within and cross case analyses were conducted as a part of this study, resulting in a large body of findings. To facilitate ease of access the findings have been presented in two parts, beginning with cross case findings, which are ultimately emphasized in the discussion and implication section of this dissertation. It is important to recognize that the analysis was sequential with the within case analysis preceding the cross case analysis. The findings presented in this chapter are based on the findings in the within case analysis presented in detail in Chapter 5. Some details specific to participants have been changed to protect their anonymity.

Summary of Analysis Procedures

As is typical in an instrumental multicase study (Stake, 2005), cross case analysis occurred subsequently to within case analysis. The former analysis consisted of a process of looking at the commonalities that existed across the cases, while also exploring the unique processes inherent in each case. This process is also consistent with the analysis protocol outlined in QAPM (Young et al., 2005). Stake emphasizes an approach to analysis in multicase study that maintains the richness and complexity of the case, while working to obtain greater understanding of the phenomenon of study.

Cross case analysis findings are delineated by theme/category related to the actions, goals, and projects of the jointly enacted processes involved in recovery, as reported by adolescent participants. This part of the chapter ends with the presentation of Assertions, which “have a single or common focus, a contribution to toward understanding the Quintain [phenomenon of interest], and evidence from more than one case to support it” (Stake, 2005, p. 56).
Summary of Key Findings

Cross case analysis revealed two superordinate and three subordinate projects undertaken by participants and their parents as part of the overarching recovery project. An overview of these projects, as well as associated processes, is presented in Table 3. Actions specific to navigating the adolescent-parent relationship, accessing support(s), and relatedness and autonomy featured centrally across participant narratives. The joint actions described by these adolescents were rarely described in absolutes. Instead, there were caveats to their experiences, requests for support, and perceptions of the successful enactment of projects, thus emphasizing the complexity of relational dynamics related to recovery in the adolescent-parent relationship.

Table 3.

Cross Case Findings

<table>
<thead>
<tr>
<th>Superordinate Projects</th>
<th>Subordinate Projects/ Processes</th>
<th>Processes</th>
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<tbody>
<tr>
<td>I.</td>
<td></td>
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<tr>
<td>Navigating the adolescent-parent relationship in the context of depression</td>
<td>Connectedness project</td>
<td>• Desire for connection/time with parents&lt;br&gt;• Balancing connection with autonomy, as embedded in safety risks, fear, and trust</td>
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<td></td>
<td>Attending to perceptions of the parent experience</td>
<td>• Overlays of affect&lt;br&gt;• Parental expressions of emotion as impactful&lt;br&gt;• Managing the impact of depression on parents&lt;br&gt;• Understanding the experience of parents</td>
</tr>
<tr>
<td>II.</td>
<td>Joint engagement in accessing formal support</td>
<td>• Parents facilitate access to and participate in treatment</td>
</tr>
<tr>
<td>Support project</td>
<td>Parental/informal support (emotional and tangible)</td>
<td>• Persistent and readily available support from parents&lt;br&gt;• Rejecting-acceptance relational processes in giving/receiving support</td>
</tr>
<tr>
<td>Superordinate Projects</td>
<td>Subordinate Projects/Projects &amp; Processes</td>
<td>Processes</td>
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<tr>
<td>III.</td>
<td>Autonomy project</td>
<td>• View of self as independent and private</td>
</tr>
<tr>
<td>IV.</td>
<td>Governance transfer project</td>
<td>• Governance transfer in the context of safety concerns and depression</td>
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| V.                     | Recovery-related joint, goal-directed action in the participant-researcher dyad | • Internal processes associated with adequacy of narrative sharing  
|                        |                                          | • Recognizing progress |

**Commonalities**

Themes were assessed as “common” if they were relevant to most of the participants included in the study, which was quantified as 4 out of 7 participants. The themes described below respond to the research question: how do female adolescents in a process of recovery from depression describe their recovery as joint goal-directed action in the context of their relationship with parents? Overall, commonalities emphasized: the centrality of the adolescent-parent relationship with regards to tasks of autonomy and relatedness, as well as formal and familial support, the rejecting-acceptance dynamic inherent in communicating about personal experiences and feelings, the role of affect in recovery actions, and the impact of depression and recovery on family roles and relationships. For clarity in sharing the results, themes delineated below have been formed and articulated as separate categories. However, the themes do not exist discretely in the real world stories of these participants, but rather overlap and/or interact as components of a larger relational structure occurring naturally beyond the constraints of the research study.

**Navigating the adolescent-parent relationship in the context of depression.** All participants described a process of determining how to be in relationship with their parents throughout the recovery process. The negotiation efforts were differentially impacted depending
on where the participant was with regards to her mental illness struggles (i.e., safety concerns). This process appeared to reflect a relationship navigation project specific to the recovery journey. That is not to say that a navigation project is not a component of typical adolescent-parent relationships, but rather, that the project described here is distinct due to the mental illness context.

The joint actions involved in this project unfolded over time and included redefining roles, spending time together, communicating about needs and boundaries, and attending to the parent experience in the recovery context. Navigating the relationship appeared to be a superordinate project within which other projects related to recovery occurred, such as engaging in formal treatment and giving and receiving support. Some participants (2) described a shift in the relational landscape subsequent to participant actions that first revealed depression struggles, including a suicide attempt and a request to see the family physician. The resulting shift was enacted through changes in parenting behaviours such that parents became increasingly permissive. Participants viewed permissive action as energized by parental fear, as well as ignorance or uncertainty; it was participants’ view that parents did not know how to support them. However, in these cases the relationship shifted again over time. It seems as though once parents had adjusted to their daughters’ diagnosis, previous parenting behaviours were resumed and old parental roles were enacted. Participants described these shifts as difficult because it added another level of adjustment within the family structure at a time when there were many other adjustments occurring, such as coping with depression.

In some cases, the issue of trust was raised as relevant in this relational navigation project. Trust and emotional safety were described as relevant factors for some participants in making the decision to open up to their parents and share their experiences. For example, trust
issues contributed to the initial secrecy some participants adopted regarding their struggles and
the associated delay in informing parents. According to participants, it was the act of “not
telling” parents about struggles or the degree of difficulty that was seen to challenge existing
trust in the adolescent-parent relationship. For others, trust issues emerged following a
participant’s suicidal gesture, leaving parents fearful for their child’s safety going forward. Trust
was described as an element of the adolescent-parent relationship that was threatened or broken
by the actions of the adolescent.

Some participants commented on the process involved in rebuilding trust in the
relationship. The passage of time and the absence of actions that threatened safety seemed to be
two components associated with the development of increasing trust. Participants noticed,
commented on, and ascribed meaning to parents’ actions, ultimately seeing gestures, such as
transferring medication management to the adolescent, as indicative of trust. Jointly enacted
actions specific to trust were experienced positively by participants; it felt “good” to know that
their parents trusted them.

Participants identified concerns regarding their parents’ response to information shared
should participants decide to be open about their feelings. Making assessments based on previous
interactions with and responses from parents was a common internal process undertaken by
adolescents involved in evaluating trust. If participants felt their feelings/experiences had been
minimized, dismissed, or that their boundaries had not been respected, they were less likely to
disclose struggles to parents. For some of these adolescents, lying or being silent were actions
that reflected a lack of trust or a belief that disclosures would decrease their opportunities for
autonomy. Parent responses to their daughters’ sharing of cognitions and affect related to
mood/depression shaped the degree to which some of these adolescents opened up to their
parents. This seemed to be jointly enacted over time with the participants choosing to share information, parents responding, and participants subsequently evaluating the parent responses as a means to guide future actions/choices regarding sharing.

Trust was a fluid process, with it being nearly absent at some points, such as following a suicidal gesture, and being present to a greater degree at other points in the recovery journey, such as following a period of improved mood and committed treatment. The presence of trust appeared to both depend on and facilitate actions related to navigating the adolescent-parent relationship. Spending time together, enacting gestures of care and concern, and listening without judgment were relationship actions that seemed to build trust. Trust served to foster greater communication between some of the adolescents and their parents. When these adolescents felt they could trust their parents, they were more likely to open up to them, as well as be open to spending time together.

**Connectedness project.** The appreciation of and desire for connection with parents was present in all participants’ stories of joint recovery-related action with parents. Enjoying and longing for shared time motivated participant action, which included suggesting plans and being receptive to parent suggested plans, as well as to more subtle connecting actions, such as choosing to join parents in the living room. However, participants also described a difficult and delicate balance between connection and autonomy needs. Issues of safety, parental fear, and compromised trust complicated the joint enactment of this balance.

**Desire for connection/time with parents.** One joint action relevant to recovery and common to most participants (5) was spending time with parents and/or the larger family. However, this category encapsulated two streams of participant experience: (i) some adolescents spent time with parents and enjoyed the connection and (ii) other adolescents had small glimpses
of this shared time, but wanted more or felt it was lacking. With regards to the first stream, the opportunity to share time and activities was experienced as positive by most of the participants. This time for connection appeared to enhance the adolescent-parent relationship. Spending time together was perceived as meaningful for participants because it focused on the relationship rather than on the mental illness. By prioritizing the relationship in this way, participants also felt it contributed to recovery. Some participants described a process of explicitly asking parents for shared time, and others described simply choosing to be in their parents’ presence, both of which required parental willingness.

For two of the participants, shared time with parents was seen as minimal, but desired. One participant explained that prioritizing spending time together sharing in experiences signaled that her parents wanted to be connected to her. In cases such as this it appeared that participants viewed their parents as the driving force in creating opportunities for family connection. Some participants expressed openness to this joint action, but did not identify a sense of agency in creating opportunities. In other instances, conflictual communication and a tense relationship seemed to act as the barrier to connection and enjoying shared time. In addition, feeling unaccepted and misunderstood at times by parents, particularly mothers, kept adolescents from being receptive to opportunities for connection.

*Balancing connection with autonomy, as embedded in safety risks, fear, and trust.* Most participants (5) described a tension between the desire for connection with parents and also having opportunities for autonomy. Spending time together as a family enjoying daily activities, such as watching television or running errands, and/or doing extra activities generated pleasant affective responses. These shared times offered opportunities for meaningful connection with caregivers.
Such connection and longing for connection was balanced with the need for independence. Many adolescents (5) also referenced the desire for privacy and space in the family system, which was complicated by threats to safety, such as suicidal gestures, and general worries about mental health. In some cases, parental internal processes, such as fear of possible future suicidal gestures, appeared to act as a barrier to obtaining space and privacy. However, when actions specific to building trust were enacted, some participants were able to regain some autonomy in their health care. For one participant, actions that reflected such a process included time spent demonstrating safe behaviour and responsible use of medication, while genuinely connecting with parents.

Some participants spoke about setting limits with parents regarding mood check-ins as a means to garner privacy, as well as communicate agency as a young person (i.e., I can take care of myself). Most participants acknowledged that communication was an important functional step related to connection with parents and for getting well. However, the question became, ‘How can I communicate about my experience/needs and still maintain my privacy and autonomy regarding decision making?’ Some participants minimized or omitted information when discussing their current mental health status with parents in an effort to be autonomous and self-determining regarding health care decisions.

Other participants referenced the value and utility of using the counselling appointments as a venue to engage in conversations related to boundaries and autonomy in care. As highlighted in Daljeet’s and Gillian’s narratives (see within case analysis) counselling sessions with parents were often seen as a safe place to inform parents they needed to give their daughters space. Practicing communicating about needs and boundaries with parents in the context of counselling sessions were described as a facilitative step in initiating similar conversations outside of the
session. For some participants, being given space for autonomy by parents made them more likely to reach out and/or disclose. In this way it felt like connection was on their own terms, thus in their control.

**Attending to perceptions of the parent experience.** Many participants (5) described internal processes and associated actions specific to their parents’ experience of having a daughter with depression. Witnessing parental emotion, empathizing with parents, and intentionally engaging in action to minimize the impact of depression on parents were joint relational processes involved in attending to parents in the experience of depression and recovery.

**Overlays of affect.** All participants described an affective component attached to the story of their parents’ involvement in the recovery process. Stories of parental involvement and joint action often included internal processes characterized by guilty feelings on the part of the participant. The sentiment was, ‘I feel badly/guilty for negatively impacting my parent by: having depression; struggling with my mood; making suicidal gestures; and getting angry at them.’ For most participants guilty feelings were pervasive throughout the research conversation and self-confrontation interview. Internal processes of guilt existed both in the present moment during the research conversation as the participant reflected on their parents’ involvement, and in the actual moments participants described as a part of joint action with parents. In instances in which the latter emerged, some participants explained how this served to energize behaviours specific to minimizing their distress or refraining from reaching out in the moment with parents, in an effort not to be a “burden”. For some, minimizing or withdrawing served to exacerbate their struggles.
Gratitude was also readily identified as an energizing force in these adolescents’ stories of their parents’ role in recovery. In fact, each participant, irrespective of the degree to which they felt supported by their parents, referenced feelings of gratitude. Such affect was attached to parents’ actions undertaken in order to help their daughters move toward wellness. More specifically, gratitude was expressed for tangible assistance offered, such as finding a counsellor for her daughter, driving to and from appointments, taking his daughter on an outing, and buying favourite items (e.g., tea, soups). Reference was also made to feelings of gratitude for intangible support, which took the shape of consistently being available to talk when needed and refraining from anger in favour of understanding. Such affective components were present even for some participants who acknowledged a tense and conflictual relationship with parents.

*Parental expressions of emotion as impactful.* Witnessing the expression of parental emotion was discussed as a relevant component of the recovery journey for five of the adolescents. In three of the cases such emotional expression was described as facilitative of empathy. Observing their mother or father cry in response to a depression related incident provided these participants with the opportunity to view depression from their parents’ perspective. For a couple of participants, such an experience acted as a means to recognize their parents’ intention behind their actions regarding treatment and recovery. As a result, these adolescents described a shift in perspective or a turning point in their journey. In these cases, parental emotions facilitated empathy and signaled a need for a change.

For most participants, witnessing parental emotion was a difficult experience associated with an affective response of pain and sadness. Expressions of emotion did not always serve to facilitate empathy. This was also true for those participants who felt consistently supported by parents during recovery from depression. Instead, witnessing emotion left participants feeling
guilty for negatively impacting their parents. A couple of participants appeared to personalize their parents’ emotional expression and assume responsibility for their feelings. This was particularly true for one participant who described such experiences as compounding additional problematic elements in the adolescent-parent relationship, such as resistance to treatment, lack of understanding, and minimizing of concerns. This appeared to create an environment that communicated that the participant’s struggles were a problem for her mother.

*Managing the impact of depression on parents.* A number of participants (5) commented on their awareness of how depression was or could impact negatively on their parent(s). As a result, participants worked to mitigate the impact by remaining silent about their feelings and struggles, not outwardly challenging parents’ views of general improvements, and encouraging parents to focus on their own life. One participant used humour as a means to lighten heavy moods and the impact on her parents. Overall, participants expressed guilt and regret about the ways in which their struggles with depression impacted their parents.

In addition, some participants cited worries about being a “burden”, which motivated withdrawal or concealing behaviours. Such internal experiences and associated actions persisted despite parental reassurances that they were not a burden. The beliefs described here speak to the degree of responsibility these adolescents felt for having depression and for mitigating the impact on their parents. At times, their desire to manage the impact acted as a barrier to communication and accessing help when needed, thus has implications for recovery efforts/goals.

*Understanding the experience of a parent with a daughter with depression.* Many participants (4) empathized with their parents and for what they imagined it must be like for them to have a daughter with depression. For most, articulating a sense of understanding seemed
to emerge as a function of telling their story in the research interview. Reflecting on their experiences in this way seemed to create space for participants to comment on the way they have come to appreciate/understand their parents’ perspective/experience. For example, one participant noted, “…it was their first try with a kid with mental health problems so, you know, they tried their best” (A-SC\textsuperscript{2} 133). Another participant identified her cognitions related to telling the researcher about her parents’ involvement in her story; she stated, “…it was kind of interesting for me because then it was like not just thinking about my self and feelings, I was thinking about how it was for them [parents]. So, it was really interesting actually, to think about that” (D-SC 62). These comments emerged out of the reflective process inherent in the self-confrontation interview, but were processes that also occurred during the conversation. In an example of the latter, a diagnosis of parental mental illness subsequent to this participant’s diagnosis fostered reflection and an awareness of her mother’s experience.

**Support project.** A second primary project comprised of recovery-specific joint action was the support project, which was relevant for all seven participants. However, variations were identified in the way support was enacted by category of support, namely formal and informal/familial, and type of support, including instrumental and emotional. Overall, parents were identified as central to the support projects, and participants cited gratitude as prominent internal processes. The latter was true even when participants’ outward/external behaviour signaled rejection of the parental role.

**Joint engagement in accessing formal support.** Except for one participant, all adolescents described a joint process with their parents related to accessing formal treatment for

\footnote{A-SC refers to a quote from Ananda’s self-confrontation interview.}
depression. In this project, the adolescents’ actions served as the initial step, as it was their communication (verbally or behaviourally expressed) that first signaled the need for joint action. These initial actions ranged from informing their parent that they were feeling unwell to making a suicidal gesture that resulted in hospitalization. For some, these actions were met with parental actions demonstrating understanding, such as receptivity to and engagement with formal intervention systems. In these cases, adolescents and parents began to work together to mobilize toward formal treatment. For one participant the process of conveying the need for formal intervention to her parents involved repeated explicit requests for service. Indeed, she cited her persistence in this way as the means to which she was eventually able to obtain such treatment.

The roles of parents in the shared goal of accessing formal intervention included: listening to their daughter’s expression of need, understanding the need for treatment, locating appropriate counselling supports, driving their daughters to and from counselling and psychiatric appointments, participating in sessions and communicating his/her perspective on mental health status, and transporting his/her daughter to the hospital in times of crisis. These specific actions varied by case and were clearly articulated in participants’ stories of how they worked together with parents toward overall recovery goals. Of note, all participants whose story reflected this theme identified transportation to appointments as a joint action. In terms of the meaning associated with such action, this also varied by case. Some participants explained that providing transportation was a means for parents to ensure attendance. Other participants noted that transportation was linked to their parents’ participation in counselling/psychiatric sessions.

Five participants’ parents attended and were active in the adolescents’ treatment sessions. Participants described the affect and meaning associated with having parents involved in counselling sessions. Initial experiences were characterized by annoyance at the intrusion into
their personal experiences, awkwardness associated with exploring topics with parents that were not previously discussed, and silence due to discomfort. However, over time, many participants commented on how they came to appreciate their parents’ presence in the session as it provided opportunities to address support and relationship needs. Joint treatment sessions enabled adolescents and parents to “get on the same page”. A shared perception of mental health status seemed to facilitate additional recovery actions by pointing to areas of concern, thus suggesting possibilities for familial action, such as practicing how to respect their daughters’ assertion of boundaries.

In addition, the counselling room was seen as a supportive environment for these adolescents to identify concerns and make specific requests for the relationship. In this way the support of the counsellor appeared to offset feelings of fear participants identified in disclosing to and making requests of parents. In many cases, these opportunities for expression and acknowledgement in the context of formal treatment appeared to translate positively in the adolescent-parent relationship outside of the counselling session. For example, gaining clarity on adolescent needs and ideal parent responses seemed to allow participants to engage more easily with parents, ultimately building trust and safety in the relationship. In this way it becomes clear to see how primary recovery projects influence the actions, internal processes, and meanings of the other projects/processes.

**Parental/informal support (tangible/instrumental and emotional).** Most of the participants (6) described the persistent and available nature of the support they received from their parents during the recovery journey. Discussions of support highlighted two types of parental support: tangible and emotional. All six of these participants spoke about emotional support, which included listening, asking for a feeling state, sharing a different perspective, and
simply being together during difficult times. Three of the six participants made reference to the ways in which they received gestures of tangible support from parents, including transportation to and from appointments, arranging participation in various activities, buying them special items, and taking them on outings.

Many adolescents indicated they always felt they could depend on their parents to meet their needs, even if they were sometimes unable to articulate them. On occasion, some of these adolescents described how they were able to ask for support/care. These were explicit “asks”, which appeared to emerge from a place of knowing that the request would be met with a support gesture. In instances for which the supportive gesture did not result in improved mood, as was the identified goal for some participants, parents’ efforts were often still acknowledged and appreciated. Making an attempt to respond supportively was associated with adolescent feelings of gratitude. When participants were unable or unwilling to make explicit requests, some explained that their parents “read” their moods. In this way adolescents described that parents were able to notice when their daughters were in need of support, and subsequently engage in a supportive gesture. Some parental actions described by participants included: sitting with the young person when she was struggling, continuing to inquire about mood and coping, and reaching out to the young person even after she expressed anger.

A monitoring process was enacted by some parents (4), which allowed participants to “know” support from parents was available, even if they did not access it. For the participants, monitoring seemed to convey a sense of parental availability, while also giving adolescents the space they needed. This was described as a process that contributed to feelings of safety and helped adolescents navigate their lives with depression. For some young women, parental monitoring actions involved asking questions as part of a mini mental health assessment (e.g.,
“How is your mood today?”). Other examples of such action involved parents simply being open to invitations to spend time together, such as watching television, sitting together, and reading. When the latter actions were jointly enacted, participants did not feel there was an expectation from parents for a discussion. Instead, they viewed shared time as a silent acceptance of their present state. These monitoring processes seemed to reflect participants’ view of the ideal balance between support and respecting boundaries.

For those participants (2) who did not describe their parents’ support as persistent and readily available, the desire for this support was communicated as a part of their narratives instead. These participants referenced the wish for a different kind of support from their parents. For example, one participant described looking for acceptance from her parents, and she expressed the wish for support that persisted despite her rejecting and angry behaviours. It seems that the underlying goal was to have parents demonstrate understanding of what it means to have depression, and how that might complicate interpersonal dynamics associated with support gestures in the adolescent-parent relationship. One participant described her belief that parental empathy would motivate compassionate action. Similarly, another participant expressed the view that such empathy would also facilitate parental openness and receptivity to discussions of experiences with depression, as well as of needs. In describing internal processes and actions participants wished for from parents, they demonstrated a way in which they did not feel supported by parents.

*Rejecting-acceptance (or push-pull dynamic) relational processes in giving and receiving support.* Participants (4) described a complex interactional pattern related to the giving and receiving of support in the adolescent-parent relationship. There were clear roles related to support in the stories of these adolescents. Specifically, parents often appeared to assume the role
of giving/offering support, while the adolescents carried out the role of receiving the support. However, receiving support was not always enacted in a clear and direct manner with participants openly receiving parents’ gestures. Instead, there seemed to be a relational process of “rejecting-acceptance”, which was characterized by the adolescents outwardly rejecting parents’ gestures of care/support, while inwardly appreciating and acknowledging the effort. Thus, although observable behaviour suggested a stance of rejection, internal processes reflected the opposite, namely gratitude and pleasure. To exemplify this interactional style, a quote from Brooke has been included:

R: …And what’s it like to have [your mother] try even though you know you’re kinda taking out your anger on her?

B: It, it’s a really good feeling because it’s like, she must care a lot.

R: Um hm. It shows how much she cares.

B: Ya (CON 66/67).

In this instance, expressions of anger suggested rejection of the parent’s attempt at support; however Brooke viewed her mother’s efforts as demonstrating care, which was appreciated and described positively in her story.

In other cases this relational process emerged when parents “pushed” participants to attend counselling, which sometimes resulted in outward expressions of anger or withdrawal behaviours. However, inwardly participants acknowledged feelings of appreciation and love, and ascribed meaning that centred on perceiving gestures as conveying caring, commitment, and dependability. For other participants the push-pull dynamic was enacted when they felt they were not in control of support gestures, which felt intrusive at times. In these cases, support was dismissed or rejected by the adolescent, only to be requested at a later date when she felt “ready”
and in control of support processes. The underlying affect that energized these actions included frustration and gratitude. Overall, these adolescents described examples in which they pushed away or rejected supportive gestures outwardly and in the moment, but attached meaning to parents’ actions that suggested receptivity. This is a complex interactional pattern that appears to require parental commitment and patience.

**Autonomy project.** Almost all participants (5) described themselves as a “private person” or largely self-sufficient, which often resulted in keeping their struggles hidden for some time. According to some adolescents, being self-sufficient was perceived by their parents as an indicator that they were coping well. In some of these cases (2), there was another sibling in the family who exhibited challenging behaviour in an obvious manner and thus, received the focused attention of parents. It was only when it became evident to parents that the participant was struggling with depression, that the sibling roles in the family were revised. This required a change in participants’ observable behaviour, from inward/silent coping to external difficulty, which resulted in parents shifting focus from one child to another. Interestingly, such a sibling role revision followed significant gestures of distress, such as self-harm or a suicide attempt. Outward demonstrations of struggles with depression meant that these adolescents were no longer able to keep their experience private and enact self-sufficient coping.

In other instances, participants (3) described feelings of worry associated with beliefs about being a burden to their parents, and thus often tried to be independent in their care. However, these stories are distinguished from the former cases in that it appears that parental care appeared to often be available when needed, and was not otherwise unavailable due to the needs of other siblings. These adolescents refrained from making a direct request in favour of
coping on their own. Thus, beliefs about how their experience would negatively impact parents energized independent care actions.

For many participants, being private and independent emerged more clearly when it came to opening up to parents and counsellors about the struggles. This process of disclosure was challenging for participants and associated initial affect included annoyance and awkwardness. Of the six participants who referenced parental involvement in formal treatment, all cited dissatisfaction with the requirement that they be open in counselling sessions. This dissatisfaction reflected feeling such a process was unfamiliar and/or was contradictory to their self-perceptions. It seemed that exposure to ongoing joint sessions with parents and the passage of time were the contributing factors that made this experience more comfortable for participants.

There was only one participant who did not describe a desire for autonomy in self-care and instead expressed the desire for more involvement and support in coping with depression. She believed her parents were not open to discussions regarding depression, which impeded her ability to open up despite inwardly feeling the pull to do so. Internal processes associated with her perceptions of parental receptivity included feelings of isolation and shame. As a result, she felt forced to be independent in advocating for her needs. This is in contrast to those participants who described a tendency to keep things private and address concerns self-sufficiently, but who were met with support when struggles were made known.

**Governance transfer project.** Several participants (4) made reference to a process of transferring responsibility for certain areas of their lives from their parent(s) to the adolescent. For some, this process more closely reflected normative transition to adulthood tasks. In this way, it seems the focus was not on depression and associated tasks, but rather on activities of
daily living. Examples of domains of such governance transfer included learning to drive and learning how to complete tasks of independent adult living, such as laundry and meal preparation. Other domains were associated with depression-related care, such as being able to manage their own medication and participating independently in treatment sessions. Thus, for others, governance transfer likely reflects parental belief in the capacity of the adolescent to assume more of the care associated with having depression.

**Recovery-related joint, goal-directed action in the participant-researcher dyad.**

Given the design of this research study, the participant-researcher relationship became a relevant component associated with participants’ narrative sharing. Essentially, this relationship exists as another context, which is also comprised of joint action, internal processes, and goals. In this case joint action centres on communication with the goal to understand the participants’ lived experience as described. For some participants (5), the relational context was salient and included an awareness of clear internal processes. Also, for some, the invitation to reflect on their experiences in the adolescent-parent relationship facilitated cognitive processes and articulated experiences regarding recognizing how far they have come.

**Internal processes regarding adequacy of narrative sharing.** Some of the adolescents (5) commented on the experience of sitting with the researcher during the conversation, identifying worries about how well they expressed themselves or how they were being perceived by the researcher. Commentaries related to the experience of sharing their stories often emerged in the self-confrontation interview as participants watched clips and were invited to comment on their associated cognition and affect. Some participants (2) expressed difficulty in finding the correct words to reflect their experience. Internal experiences of worry regarding being unclear or inarticulate appeared to act as a filter through which some participants shared their story.
Finding the right way to express one’s experience was a cognitive process that occurred for participants. One participant expressed her internal process by asking for reassurance at the end of the research conversation, specifically asking, “Did I do okay?”

For another participant the research context and the participant-researcher relationship was prominent throughout her self-confrontation interview, more so than for any other participant in the study. She included an affective component to her description of the challenges inherent in describing her experience, namely feeling “flustered”. This participant later asked the research assistant if he could pick up on her affect. In this way it was clear that she continued to be concerned about the perception of the researcher. She went on to also express initial feelings of awkwardness in sharing her story, as well as feelings of fear regarding this researcher’s reaction to parts of her story. She acknowledged fears of being judged by the researcher, which appeared to influence how she shared her experience. Emotional content related to the experience of sharing her story with a researcher was also relevant for another participant. Specifically, she expressed feelings of embarrassment about both her mother’s actions and also how she presented her mother negatively in the interview. The self-consciousness and contentiousness these adolescents brought to their communication efforts in the research interview was notable. Further, it suggests dynamics that may be at play in other relational contexts of these adolescents’ lives relevant to recovery from depression, such as treatment relationships.

**Recognizing progress.** Many of the participants (4) made reference to acknowledging how far they have come and how different their lives are now. For some participants, recognizing progress also included shifts in their relationship with parents. For most, this process of recognition emerged during the self-confrontation interview as participants watched a portion
of their story back with the research assistant.Reflecting on their story in this way seemed to offer these adolescents opportunities to notice how different their current reality was from the earlier days in their recovery journey. Realizing these shifts seemed to be associated with pleasant affect, such as feeling happy. To exemplify this process, a quote from Daljeet is included; she stated,

So, um, I think in that moment I was feeling actually really happy because I was thinking about how my parents understand me now and that made me feel much happier because like, you don’t really think about those kind of things right? Unless someone asks you a question about it, which made me actually feel really happy and good about it (SC 75).

These reflections are another way in which the participant-researcher relational context shaped the way these young women shared their stories. Broadly speaking, the researcher and participant were engaged in joint action specific to communicating about participants’ recovery process, with the goal to understand their experiences. It is at the level of social meaning that additional layers of data are available. Specifically, these participants commented on what it has meant to them to both share and reflect on their journeys. It seemed as though commenting on progress and changes was an important part of the way some of these adolescents shared their story of joint processes related to recovery.

**Unique Processes**

Although commonalities exist among these adolescents’ stories, there is also much uniqueness in their experiences and narratives. Attending to these unique processes is one way in which to address the complexity of the phenomenon of study and preserve the richness of a case study method. Indeed, Stake (2005) advocates for an approach that maintains the integrity of the case in understanding the larger phenomenon of interest.
One unique process emerged in Eleanour’s narrative and centred on the idea of mental illness stigma within the family. Specifically, the meaning Eleanour believed her parents, particularly her mother, ascribed to having a daughter with depression negatively impacted Eleanour. It was Eleanour’s view that her mother’s fear and denial of the diagnosis acted as a barrier to accessing formal treatment. The perception of her mother’s internal processes also emphasized Eleanour’s feelings of guilt about having depression and continued to impact the degree to which Eleanour felt she could be honest with her parents. This is distinguished from each of the other stories shared by participants, which were characterized by parental actions symbolizing acceptance of the diagnosis and the willingness and motivation to access formal intervention. Examples of such action included: locating counselling resources, attending sessions, performing mood check-ins, and suggesting supportive activities. In contrast, Eleanour described parental actions that appeared to dismiss or minimize her experience, as well as dismiss the presence of mental illness. Such descriptions suggest the possibility of stigma at the familial level. Any reference to such a process was absent from all other participants’ stories.

A second unique process emerged in Celia’s story and involved the solitary and independent manner in which she approached intervention related to depression throughout her story. Indeed, she was the only participant who did not include descriptions of joint action with her caregiver related to formal treatment. Instead, Celia’s description of what it has been like to live with depression and how she has worked toward recovery emphasized the steps she has taken on her own. One aspect of how she explained such an approach referenced internal processes regarding her fear of “burdening” others with her struggles. This was also a part of other participants’ stories, but different in the degree to which she maintained her solitary approach to coping. Another aspect likely stems from her life history, which has involved
abandonment by parental figures and necessitated self-sufficiency for survival. As a result, Celia appears to have internalized the message that she must depend on herself, and further seems to believe that the only way to maintain relationships is to refrain from needing too much from others.

Some independent actions Celia took to address depression included: journaling, finding inspirational quotes, reading self-help books, and practicing cognitive-behavioural strategies she learned through independent research. Indeed, her narrative of living with depression and working toward recovery emphasized the steps she took on her own and did not include joint action until this researcher asked her explicitly about the role of her caregiver. However, over time it seems as though Celia has built an attachment relationship with her caregiver and that this relationship has provided the space/safety within which Celia was able to continue her own recovery actions. In this way her solitary approach to working toward recovery goals has evolved to include limited joint endeavours.

Another unique process emerged in two stories and centred on parental mental illness. Exposure to parental mental illness had implications for these participants’ relationships with parents, specifically related to expectations and empathy. Brooke’s parents both experienced depression in their lives, which Brooke found reassuring and further explained how such lived experience provided clout to their coping suggestions. However, she also expressed a process of meaning making, which reflected the expectation that having lived with depression would facilitate enhanced parental empathy for Brooke’s experience. She felt let down by her parents in this regard. In the case of Fiona, her experience of parental mental illness centred on feelings of

3 Note: Attachment style was not assessed or measured in this study.
guilt (i.e., “I caused my mother’s depression.”) and empathy. With regards to the latter, through attempting to be a support to her mother, Fiona described gaining insight into her mother’s experience of supporting her daughter. For other participants who did not have a family member with a mental illness, there seemed to be decreased expectations regarding the degree to which they understood and/or knew exactly how to help their daughter cope.

**Assertions**

This section of the analysis represents the distillation of the findings as they relate to the primary research question: How do female adolescents in a process of recovery from depression describe this process as joint goal-directed action in the context of their relationship with their parent(s)? According to Stake (2005), “The assertion should have a single or common focus, a contribution toward understanding the Quintain [phenomenon of interest], and evidence from more than one Case to support it” (p. 56). With regards to this research study, the phenomenon of interest is the joint processes of female adolescents and their parent(s) related to recovery from depression. It is intended that these Assertions aid in understanding this phenomenon.

**Assertion 1.** Depression in adolescence impacts families and challenges existing familial roles and relationships, as evidenced by the centrality of the adolescent-parent relationship projects characteristic of almost all narratives of jointly enacted recovery. Living with depression and the associated features described by some participants, such as suicidal gestures and mood fluctuations, changed the nature of either their relationship with their parent and/or their place in the family system. This resulted in an ongoing process of navigating and negotiating the adolescent-parent relationship in order to enable these adolescents to work with their parents around recovery goals. These adolescent-parent relationship projects served as a backdrop in which much of the additional recovery-related projects and processes were enacted. Thus, in
addition to adjusting to coping with depression, these adolescents and their parents were simultaneously adjusting to a change in their relationship and their position in the family system. Furthermore, these adjustments influenced the ways in which adolescents and their parents worked together toward recovery goals. Internal processes for participants included affective responses such as annoyance, anger, gratitude, and guilt, as well as a cognitive awareness of how adolescent depression impacted their parents.

**Assertion 2.** In stories of recovery from depression, these adolescents identified a number of joint actions, goals and projects enacted in the adolescent-parent relationship. Thus, for all participants there was a portion of the recovery journey that was a joint endeavour, which existed even though the participants’ and parents may have been in conflict at times regarding suitable/desirable action relevant to a shared goal. These adolescents and their parents worked together on a number of projects that were related to recovery. Often these projects shifted and changed over time, however both parties appeared to remain engaged in the joint action/goal until the project was no longer relevant, such as with safety projects. Key projects included: navigating the adolescent-parent relationship, of which actions related to communication were salient; giving and receiving, while balancing connection and autonomy; accessing formal intervention; managing the impact of depression on parents; and governance transfer.

**Assertion 3.** These adolescents perceived persistence in gestures of support, balanced with space and without rejection, judgment, or abandonment as facilitative of recovery. Participants seemed to be seeking a secure base with parents, such that they could act independently in their self-care at times, without fearing rejection and abandonment. Feeling vulnerable to rejection and/or judgment appeared to act as a barrier to being open and truthful with parents, which ultimately impacted joint recovery efforts. In contrast, feeling safe and
secure in the adolescent-parent relationship seemed to foster connection, facilitate communication, and build trust. Safety and security in this relationship was also generated by parents’ efforts to create space, which supported these adolescents to feel autonomous. In cases where such processes were not enacted, participants expressed the belief that should persistent, dependable, and spacious support be available, it would facilitate recovery efforts.

Assertion 4. Jointly enacted projects related to both relationship and informal support goals were prominent across these adolescents’ narratives of recovery. However, these adolescents desired more joint action surrounding these goals. Specifically, they identified longing for more support related to managing depression, more time spent together, and generally more opportunities for connection. Time spent together was enacted jointly and depended on the receptivity of both adolescents and their parents. It was further identified as a vehicle for recovery and had implications for the execution of other recovery related goals and actions, such as communication and giving and receiving support. This desire for more connection existed even if external actions, such as outward rejection or expressions of anger, suggested otherwise. In fact, efforts toward connection and support were predominantly perceived positively both in the moment and later upon reflection, which also remained true in instances in which the adolescent may have pushed these gestures away. In these ways, adolescents appeared motivated to enact additional joint action in relationship with parents related to recovery from depression; however, they appeared to lack a sense of agency and clarity regarding the elements and functional steps necessary to join parents in working toward this goal.

Assertion 5. Communication, including emotional expression, appeared to be facilitative of the joint goal-directed recovery process. However, in order for communication to be
facilitative in this way, there were necessary conditions. Such conditions as identified by these adolescents included:

- A safe space available for expression; specifically, a space that was: free of parental anger and respectful of communication boundaries, and
- Expression(s) met with openness and support; specifically, without dismissing or minimizing behaviours on the part of the parent, and with offers of care.

In addition, for some participants witnessing parental expressions of emotion aided recovery efforts as it created opportunities for empathy and motivated change efforts.

**Assertion 6.** These adolescents desired to enact joint action with their parents specific to addressing the goal of being understood. In some ways communication processes and action specific to the relationship project can be viewed as action contributing to this goal. However, it seemed that it was the adolescents’ belief that this goal was not reached, and that further joint action was necessary and desired. The sentiment was: ‘Understand that I am struggling, understand that I might act out in anger or need space, understand that I need your support, and please try and learn how to best support me (by asking me what works best, and by getting educated on what it means to have depression).’ Such a desire appeared to be motivated by internal processes involving feelings of guilt, beliefs about self-blame, and a fear of rejection or judgment from parents. However, these internal processes also seemed to act as a barrier to adolescents initiating action directed at the goal of understanding. Instead, adolescents appeared to place parents in the role of leader in this joint action. It also seems that participants believed that feeling understood would support connection goals and enhance the adolescent-parent relationship.
Assertion 7. The participant-researcher relationship is a relevant context in understanding how participants share their experiences, as well as their internal processes related to joint recovery action. It seems that participants experienced additional layers of affect and cognition regarding to the research relationship, which served to energize action specific to narrative sharing. Thus, this relational context consisted of action specific to the goal of understanding participants’ stories, which was shaped by the behavior, internal processes, and social meaning ascribed to the interaction by both the participant and researcher. It is possible that some elements of the processes involved in this relationship parallel processes in relationships with other individuals relevant to recovery.

Conclusion

Findings from the cross case analysis highlight the centrality of the adolescent-parent relationship in recovery efforts both as a project in and of itself, and as a relational frame within which additional recovery-related actions and projects were enacted. Processes related to giving and receiving support in both formal and familial contexts was also prominent across adolescent stories of joint recovery efforts. Complex interpersonal dynamics were described by participants, namely in the way of a rejecting-acceptance pattern of interaction, which served to complicate action related to support and to the adolescent-parent relationship. The developmental stage of adolescence was also salient as participants described the challenges inherent in navigating the balance between connection and autonomy in the context of mental illness and risk. Trust, emotional safety, and communication were important components of the recovery-related projects. Overall, participants described a jointly enacted recovery with parents, emphasizing the process as it unfolded over time and highlighting the evolution of associated internal processes.
Chapter 5: Within Case Findings

This dissertation sought to explore the following research question: how do female adolescents in a process of recovery from depression describe this process as joint goal-directed action in the context of their relationship with their parent(s)? The focus of this study was on female adolescents’ stories of how recovery from depression was enacted in the adolescent-parent relationship, that is, through their actions, goals, and projects. More specifically, this research explored the joint actions and goals of parents and adolescents related to recovery as told from the perspective of the adolescents with a diagnosis of depression. Exploring adolescent depression in this way emphasizes the relational processes in the “how” of recovery, which builds on existing research that identifies this relational context as key (e.g., Leavey, 2005; Rao et al., 2010).

This chapter begins by presenting a brief review of the analysis procedures and a summary of findings. This review is followed by a presentation of the findings from within case analysis, which are organized by case and then further by projects with associated actions and processes. Detailed within case analysis is presented in this way in an effort to attend to the particulars of each participant’s actions and projects, thus highlighting the complexity and depth of the case. At the end of each case analysis, one assertion is articulated which represents the distillation of the findings at the within case level.

Summary of Analysis Procedures

Consistent with both Stake’s (2005) instrumental case study approach to analysis and the analysis procedures of QAPM (e.g., Young et al., 2005), within case analysis was conducted as the first step of analysis. Within case analysis provides the necessary opportunity for a focus on the particulars of a case, as this facilitates depth of understanding relevant to the phenomenon of
study (Stake). The picture of the case is organized within an action theory framework, thus emphasizing actions, and associated steering processes, such as cognitions and affect, as unfolding temporally toward shared goals.

Findings from within case analysis are organized by (1) context using an initial orienting paragraph specific to the participant’s demographic, familial, and diagnosis/treatment details, which serves as the backdrop to orient the case, and (2) a summary of the case specific findings, which includes a table and associated description, and (3) categories of findings that are organized from an action theory perspective, and thus reflect salient relational processes/dynamics, projects, and themes. Findings by case are organized by project and further delineated by a series of subheadings, each addressing the research question. The use of headings should not imply that findings exist in a discrete and compartmentalized manner, but rather should be viewed as a means of organizing the findings.

**Summary of Key Findings**

This study explored adolescent-parent relational dimensions of recovery from depression in female adolescents. In sharing the story of the role of their parents in the recovery process, participants were able to identify relational patterns/dynamics, joint-actions specific to goals, and projects related to recovery and enacted over time. Indeed, stories of joint action were relayed retrospectively and longitudinally, with participants articulating the ways in which actions and associated affect/cognitions evolved over the recovery process. In addition, participants spoke about current relational dynamics, actions, and goals emphasizing the ongoing relevance of joint action related to recovery in the adolescent-parent relationship, despite generally noticing an overall improvement in depressive symptoms.
Case 1. Ananda

**Context.** Ananda is an 18-year-old female who was diagnosed with a depressive disorder when she was 15 years old. She reported struggling with depressive episodes for three years prior to the diagnosis, although she kept her struggles hidden from her parents during this time. Her parents later became aware of her mood concerns following a suicide attempt that was interrupted by Ananda’s mother. Her mother arranged for her to see the family doctor and she began her recovery journey. Ananda lives at home with her mother, father, older brother, and cat. At the time of this interview, she was completing her last year of high school, and despite getting behind in her coursework due to her mental health challenges, she was set to graduate on time; this was a source of pride for Ananda. When asked during the telephone screening interview to describe how she saw her life, she stated, “successful and happy”. At the time of this interview she just closed her file with the mental health team from whom she was receiving counselling intervention. She continues to receive/access support from her school counsellor and youth and family worker. In describing her experience of the journey of recovery, Ananda stated,

> Um, I always had this heavy feeling in my chest and now my chest feels really light and it feels, I just have this, I just feel light all the time and like, I’m breathing out good energy rather than bad energy now (CON 115).

**Summary of key case findings.** Ananda articulated a number of joint actions and associated projects she and her parents engaged in together during the recovery process. Ananda’s story of joint action with parents elucidated four key projects, some of which were further expanded to include subordinate projects and processes (see Table 4). Overall, Ananda emphasized the centrality of her parents in this process and acknowledged the ongoing nature of recovery, as well as their ongoing role in this process.
Table 4.

*Key Projects and Processes: Ananda*

<table>
<thead>
<tr>
<th>Superordinate Projects</th>
<th>Subordinate Projects and Processes</th>
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<tr>
<td>I. Relational field</td>
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</table>
| II. Navigating the adolescent-parent relationship | • Safety project  
                      | • A process of understanding and perspective taking |
| III. Support project   | • Exploring possible coping strategies (functional step)  
                      | • Expression and response support pattern (functional step)  
                      | • Shifting child/sibling roles and parental attention |
| IV. Recovery achievement and celebration project | |

**Relational field.** Ananda described her parents as central in her recovery journey. “I wouldn’t have made it without my parents. They played probably the biggest role. They did everything in their power to make sure I was happy” (SC 132). Her perspective on her parents’ role in recovery was woven throughout her story, supported by examples of actions undertaken to foster Ananda’s wellness. She articulated a number of actions she and her parents jointly engaged in that were relevant to coping with and recovering from depression; for example, helping her identify and use coping strategies, taking time off work to be available. Indeed, it appears that the entire family system, including her older brother, mobilized to support Ananda.

Ananda described the care-taking roles her family members assumed related to mental illness. It appears that her father assumed responsibility for monitoring her mood daily, as well as ensuring she got to her appointments and took her medication. Her brother often took her out into nature as this was a place of peace and comfort for Ananda. Every member of Ananda’s family assumed a task related to supporting Ananda’s wellness, thus joint action was enacted at
the broader familial level. Ananda’s role in the recovery project involved being open to gestures of support and assistance from family members. Earlier in her journey she appeared largely receptive to such gestures, as evidenced by adhering to parent suggestions regarding coping. As Ananda identified feeling better, she no longer felt the need for daily support from her family members. For example, at the time of this interview, it appears that she was in a process of negotiating a change in needs, and thus associated roles, with her father. She explained some of her efforts toward renegotiating roles in this relationship:

He gets pretty annoyed (laughs), he’s like, “I’m trying to help.” And I’m like, “But you’re not helping, you’re being harmful right now because you’re reminding me of this is what I’ve been through and I could go back to that place, but I’m not there right now and I’ll tell you when I get there” (CON 90).

In this example, it seems as though Ananda and her father continued to share the goal regarding helping Ananda feel well, but that the meaning they ascribed to actions directed at this goal were in opposition. Thus, this renegotiation process appears to involve clarifying needs through communication in an effort to have the relational field be supportive. Ananda’s relational field, or the relational backdrop of her story of joint recovery efforts, featured centrally throughout her story.

**Navigating the adolescent-parent relationship project.** Ananda and her parents also appeared to be involved in an adolescent-parent relationship project, which involved shifts in the enactment of their relationship specific to living with depression. Overall, Ananda believes that having depression positively impacted her relationship with her parents, and specifically her mother. She explained,
It made it a lot better. Before I resented her a lot because she worked a lot of hours and I never got to see her, so when she found out I was going through a rough time she took on a different job that let her be home more, so we got to be a lot closer. My depression with my parents has made our relationship stronger than ever (CON 18).

According to Ananda there were two significant shifts in the relationship with her parents. The first shift occurred after they learned of her suicidal ideation and attempt and the second shift occurred later in the recovery process. Once her parents learned about her struggles Ananda explained that they assumed the role of “friend” enacted increasingly permissive parenting behaviour, which seemed steered by parental fear of upsetting Ananda. Initially, Ananda viewed this as a welcome change in their relational dynamic as it resulted in increased freedom and privileges. However, over time, as Ananda moved along in her recovery journey, her parents returned to their role as “parent”, which was described as difficult for Ananda. At this point parental expectations seemed to shift, such that they began to expect more of her and requested that she “grow up”. Ananda described her internal processes at this time, commenting on how difficult it felt to adjust back to the parent-child relationship.

Relational dynamics also differed following her suicide attempt, which was the point at which Ananda perceived her parents became over-involved in her life. Parental realizations regarding the depth of Ananda’s struggles seemed to energize action specific to spending more time with her, checking in with her about her mood, and generally becoming increasingly involved in her life. At first she enjoyed how they prioritized her safety and well-being; however, over time she experienced this as intrusive, and desired autonomy in her self-care. She told her parents, “I need to start doing things on my own now or else I’m never going to learn” (SC 53). Ananda expressed a sense of cognitive understanding regarding her parents’ fears about safety,
recognizing that their relationship specific actions were motivated by a desire for safety reassurance. Such actions were further energized by compromised trust in the relationship given that Ananda kept her struggles hidden from them for three years. It was her view that her parents found it difficult to trust that she would be honest with them about how she was doing. Thus, together Ananda and her parents appeared to be navigating the adolescent-parent relationship in the context of depression and the threat of suicide.

As a part of negotiating the adolescent-parent relationship, Ananda also described some more recent adjustments in her relationship with her mom. Specifically, she commented on how she has ascribed meaning associated with de-valued importance as a result of her mother’s recent decision to return to work, after taking time off to support Ananda. In the self-confrontation interview Ananda stated,

…So it’s more resentment but more understanding in that resentment…I kind of felt again, like I said before [I felt] like I wasn’t important, like her job was more important than I was. And so then again it was reinforcing that I’m not important, I’m not important (SC 18/19).

Thus, Ananda and her parents continue to navigate how to be in relationship with one another, with the arrival at new places in recovery resulting in shifts related to action and meaning.

Safety project. One of the projects Ananda and her parents engaged in centred on the goal of keeping Ananda safe. Indeed, this seemed to be the initial recovery project of Ananda and her parents, as well as one that continued throughout much of the journey. Her parents came to learn about her mental health struggles when Ananda’s father walked in on her as she was attempting suicide. At this time they worked together to prevent Ananda from taking her life. Ananda did this by opening up and providing information about her experience and feelings of sadness and
numbness; her father asked for information and expressed confusion about Ananda’s feelings, with the goal to understand her struggles. This instance served as the entry point to accessing formal help, with her father arranging for Ananda to see their family doctor. In this way they appeared to work together to both keep Ananda safe in the moment and over time, as well as begin to address her low mood.

In addition, Ananda’s mother changed her job in order to be increasingly available to spend additional time with Ananda. For Ananda, the meaning associated with her mother’s actions included feeling valued and understood. There were other times of crisis and hospitalization throughout Ananda’s recovery journey. She explained ongoing joint action with her parents specific to supporting her in hospital and involving other family members in the network of support. In these ways Ananda appeared to feel cared for and as though her parents understood the seriousness of her situation.

A process of understanding and perspective taking. It seems that Ananda has been in a process of understanding what it must be like, and have been like, for her parents to have a daughter struggling with depression. In parallel, her parents also appeared to be engaged in a process of understanding how she came to be depressed, and how she has felt throughout the journey. As Ananda engaged reflectively in the experience of the recovery journey, she seems able to hold two different perspectives on the same experience. She described internal processes characterized by frustration and annoyance in response to her parents’ actions subsequent to her hospitalization, namely becoming her friend. However, she also explained a cognitive process involving perspective taking, which allowed her to recognize and appreciate that her parents responded in the best way they knew how given their lack of familiarity with mental illness. She
described her cognitions and affect associated with adjusting to parental roles during depression and recovery:

…[I feel] some frustration, because my parents shouldn’t have become my friend, they should have kept parenting me and kind of stayed stable with their role. But then I can’t really blame them because they’d never really dealt with this before (SC 27).

Expression of emotion was a powerful part of understanding and perspective taking in the recovery journey. For example, Ananda explained how witnessing a family member’s emotion helped her to understand his/her own experience of having a daughter/sister with depression. Such perspective taking also served to enhance Ananda’s feelings of guilt and sadness. Thus, she described an internal experience of having feelings related to depression, which were layered with feelings about how depression negatively impacted her loved ones. In the self-confrontation interview Ananda demonstrated such a process:

And, um…[I feel] a lot of sadness that I hid this from them, a lot of anger that I didn’t come out and talk about it and that I had to get support when [my dad] walked in on me as I was attempting suicide. And just thinking about how much that would have hurt them (SC 15).

This multi-layered affective process speaks to the complexity inherent in perspective taking to understand the experience of the other.

**Support project.** Ananda identified a number of ways she and her parents worked together to achieve support goals. This first involved a shift in the family system, which emerged in response to the externalization of Ananda’s struggles. The subsequent joint actions occurred over time and formed a larger support project that was comprised of functional steps related to exploring specific coping strategies and patterns of needs expression and response.
Shifted sibling roles and the impact on identity. Ananda provided a historical account of the role she assumed as the younger sister in the family, and contrasted this to the role her brother played. In their younger years her brother received much of the parental attention because he was “the bad child”. According to Ananda, she assumed the role of the “well-behaved” daughter who was self-sufficient and independent in her self-care. Sibling roles shifted as a result of Ananda’s suicidal ideation and low mood, with parental attention being redirected toward Ananda. She ascribed meaning to this role reversal that reflected “evening things out” in the family system.

All family members engaged in joint action specific to these shifts in the family system. Specifically, Ananda’s parents recognized the need to pay more attention to Ananda, Ananda received and initially welcomed this increase in attention, and her brother adopted a more self-sufficient role. Initially it appears that her brother may have struggled with or resented having to be self-sufficient. However, through joint action involving Ananda speaking at support groups about her struggles and her brother attending such sessions, she believes her brother has come to a place of greater understanding regarding Ananda’s needs at that time.

Over time the family system has continued to shift as Ananda identified improved wellness and a decreased need for the same degree of attention from parents. However, her parents seemed to continue to struggle to adjust to the decrease in Ananda’s needs.

A: Um, if I don’t talk, he’d [dad] be like, “Are you in a low?” If I talk too fast, “Are you in a high?” So, um, it’s just, any symptom he thinks he can pick up on, he thinks there’s something wrong, so if I’m talking too fast he’ll automatically think that I’m manic, and if I’m talking, if I’m not talking at all, I’m just tired, he’ll think that I’m
depressed, so he just finds any little reason and analyzes everything and over thinks it, and over analyzes it.

R: Um hm. And so how...how do you usually respond when he says those things to you?
A: I tell him to kind of back off a little bit and to just let me be, 'cause I’m fine (CON 88/89).

Thus, it appears that shifting family roles and structure has been an ongoing element of how the support project has been enacted.

**Exploring possible coping strategies.** Together Ananda and her parents seemed to explore possible coping strategies, and then continued to utilize those strategies that were helpful. For example, spending time at the in nature, trying family counselling, having family fun without talking about mental illness, and getting a family pet were some jointly enacted approaches to coping. Each of these joint actions resulted from the awareness, either on the part of Ananda or her parents, that Ananda was struggling. The joint goal of helping Ananda cope with depression was enacted in a similar manner across actions/coping strategies; namely, there was the (a) identification of a need, such as to be calm or to spend time together, (b) identification of a possible strategy by one member of the family, and (c) agreement on the part of the other family members to give the strategy a try. Ananda’s emotional expression, such as sadness or pain, and her parents’ response, such as stating a plan, was a primary way in which Ananda described how they worked together to cope with depression and ultimately work toward recovery goals.

**Expression and response support pattern.** Ananda described an “expression-response” interaction, which was enacted in a number of ways during the recovery journey as part of the support project. For example, sharing in supportive and encouraging messages was a joint action
relevant to Ananda’s story of the role of her parents in recovery. Ananda identified a number of specific instances in which she was struggling and her parents responded with words of support, offering her a new perspective. It seems her parents perceived a need for a gesture of support, which Ananda outwardly rejected. She noted that she rejected her parents’ words at first by expressing anger, which was motivated by her view of self as independent and a desire to rebel. In this way, the expression-response interaction was characterized by opposing goals; namely her parents’ goal seemed to be to offer assistance and Ananda’s goal was to cope independently, which was consistent with her self-perceptions.

However, over time Ananda described an evolution in her internal processes as a result of reflecting on her parents’ intentions. She came to realize that they loved her, wanted to help, and had their own experience of having a daughter with depression. According to Ananda, one element facilitating this reflection and subsequent realization was observing her parents crying. This was an instance in which the “expression-response” pattern was reversed, with Ananda’s parents being in the role of expressing emotion and Ananda assuming the response role, which involved reflecting on parents’ experience and coming to a new understanding. As such, Ananda became more receptive to her parents words, and was able to integrate them into the way she approached her struggles.

Ananda identified specific messages her parents expressed that have shaped her cognitive process regarding her struggles. The common theme of these parental messages was about belief in her ability/capacity, and the presentation of a different way to think about the situation. Ananda described the meaning associated with this parental action:

R: What about the moment when you were describing what you gained from the message from your mom and…?
A: Um, also again a lot of motivation because it motivated me quite a bit to get up off my butt and fight. So, positive, positive feelings of motivation, people believing in me (SC 121).

In these ways, the expression-response interaction pattern shifted from one of offering (parent role) and rejecting (Ananda’s role), to one of offering and receiving/integrating. Thus, part of the larger support project, Ananda and her parents appear to have engaged in a joint process related to the expression of needs. Sometimes Ananda directly expressed her needs, and other times her parents, in attending to her emotional state, suggested a way to meet an unexpressed need.

**Recovery achievement and celebration project.** Ananda described how important it has been in the recovery journey that she and her parents recognize and celebrate her accomplishments. It seems her parents’ desire to celebrate was energized by feelings of pride associated with Ananda’s efforts and her improved state of well-being. Celebrations have involved sharing time together, and recognizing progress was reflected in joint engagement with typical developmental tasks, such as learning to drive. These latter actions appear to signal a new dimension of the recovery journey, while also reflecting participation in normative tasks associated with the transition to young adulthood, which may also suggest a greater state of wellness.

Another element associated with recognizing accomplishments has involved Ananda’s decision to publicly share her stories with others. Ananda chose to become involved with patient support group for individuals with mood disorders. As a part of her involvement, she shared her story with others, which has also been jointly enacted with her parents. Specifically, her parents have attended these group support sessions and have heard her describe her story of depression and recovery, as well as express her gratitude for the parental support offered during this
journey. According to Ananda, such joint action was meaningful to her parents because it provided an opportunity to hear the ways in which they helped Ananda move toward recovery.

**Assertion.** For Ananda, recovery has been jointly enacted from the point at which her parents became aware of her struggles. Ananda and her parents joined together to mobilize actions specific to wellness and recovery goals. These actions were nested in the context of the larger family system, with implications for the roles of all family members. Indeed, negotiating the familial structure and associated roles was an intentional process that spanned the recovery project, and continues to remain salient for all family members in the presence of mental health improvements.

**Case 2. Brooke**

**Context.** Brooke is a 17-year-old female who was formally diagnosed with depression when she was approximately 15 years old. She reported struggling with low mood and feelings of isolation for a number of years prior to the diagnosis. In fact she mentioned making a self-harm gesture at the age of nine in reaction to her feelings and the ongoing conflict in her family home. Brooke’s mother became aware of her struggles when she was in grade eight and arranged for her to see the school counsellor and later, a doctor for mood concerns.

Brooke’s parents separated when she was a toddler. She lives primarily with her mother, but there is flexibility in her living arrangements, which means she often spends time at her father’s place as needed. According to Brooke, both of her parents have also had depression. It was unclear if her parents’ depression was treated, and their mental health status at the time of Brooke’s interview was also uncertain; however, Brooke noted that her mom has received counselling many times over the years. Brooke has an older sibling who, due to behavioural challenges, was living in a foster home at the time of this interview.
At the time of this interview, Brooke was attending high school, although at times her attendance was sporadic/intermittent. At age 14 she dropped out of school for a period of time. This coincided with the time in her life where she was struggling the most with low mood and social isolation. She reported using Ecstasy at times, which impacts her relationship with her mother. Brooke receives regular counselling from a therapist at a community counselling centre, and is also connected with her school counsellor. When asked in the telephone screening interview to use a few words to describe how she sees her life right now, Brooke replied, “Doing a lot better, I set goals.” And, although she still identifies herself as depressed, she says “…at least I have a grip now” (CON 145). She went on to explain,

Well, I just realized like all the factors now that are making me depressed and like why I’m like that and stuff, and I’m more mature and I guess I have a better understanding of what goes on around me and stuff (CON 148).

Later, in the self-confrontation interview she commented, “I was happy then [during that part of the research interview] because I was remembering how, like, changed I am now, and how much, like, I’ve recovered and like the steps I’ve taken” (SC 45).

**Summary of key case findings.** Brooke appeared to identify a number of joint actions, and associated projects, she and her parents engaged in together during the recovery process (see Table 5). Overall, they seemed to be about navigating the adolescent-parent relationship and giving and receiving support in the context of familial mental illness and separation in the family system. Generally speaking, Brooke described different ways she joined each parent in enacting recovery-related action, while also commenting on aspects of her relationships that she wished were different.
Table 5.

**Key Projects and Processes: Brooke**

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<th>Superordinate Projects</th>
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**Relational field: Finding a place in the family system.** Historical family dynamics were a part of Brooke’s story and set the early context for some of the adolescent-parent relational undercurrents Brooke referenced throughout her story. She commented, “…when my parents split up when I was really young and them fighting and stuff all the time and how it, like, affected me and [my sibling] in the long term” (SC 27). She discussed a family structure that emphasized her older sibling, who had mental health and behavioural issues. Brooke described tension in the home between her mother and sibling, which was associated with internal experiences of jealousy and sadness. These feelings seemed to contribute to beliefs about self as unwanted. Combined, these internal processes served to energize self-harm gestures. She elaborated,

Alright, well, I guess [my sibling] always had mental problems and stuff so my parents would always like, it felt like they were paying more attention to [my sibling] or something so I was like, felt like kind of cast out and it made me like, you know, feel unwanted and
stuff, so. And that was when I was very young. I remember when I was 9 I used to like
hold knives to my throat and stuff and I was just like…I, I don’t know, I was just jealous
and very sad and stuff (CON 11).

It appears the Brooke perceived herself as a lower priority in the family system, and that her
experience was unrecognized or minimized. As Brooke communicated increasingly about her
struggles, her sibling reacted with dismissal and her parents began to give Brooke more attention.
Brooke perceived her sibling’s reaction as motivated by jealousy. Despite a tense relationship
with her sibling, Brooke identified feeling lonely when her sibling moved into foster care, which
also reflected Brooke’s description of feeling closest to her sibling in the family. Thus, there
appears to be a complicated picture of the family dynamics that pre-dates Brooke’s official
depression diagnosis, but suggests an initial recovery related project that involves finding a place
in the family system.

Navigating the adolescent-parent relationship: General. Brooke’s description of the
way her parents have been involved in the recovery process followed two approaches. In one
way, she grouped her parents together and discussed them as a parental unit, and in the second
approach she highlighted the clear distinction in the way each parent joined her in action related
to recovery. The former grouped approach was reflected throughout Brooke’s story of her
parents’ involvement in recovery and is adopted in the projects outlined in throughout this case
analysis.

Unique/distinct parent roles. When Brooke spoke more broadly about her relationships
with both of her parents, she often compared and contrasted their parenting behaviours. Their
different approaches to parenting resulted in differences in the way she jointly engaged with each
of them, and in the internal processes steering action. Brooke described her father as laid back
and supportive of her decisions, which she experienced as comforting and safe. Such a relational context seemed to facilitate open communication without fear of repercussions. In some ways, this relationship seemed to reflect a friendship rather than a typical parenting relationship. In contrast, Brooke described her mother as “overbearing” and “bitchy”, which was associated with angry affect on Brooke’s part. When Brooke was open with her mother, she prepared herself for a negative and reactive response. Thus, it appears that Brooke openly shared her thoughts, ideas, and experiences with her parents, but was also engaged in a cognitive process involved in assessing the kind of response she would receive depending on with which parent she engaged. Specifically, she noted that having this awareness was helpful because it served to steer decision-making processes regarding parental support. She explained,

R: …what’s it like to kind of have both those parent roles?

B: Well, that is pretty convenient because like, depending on the topic I could decide if I wanna go to like whatever parent for it. Like you know, like if I need help or support I decide, like if I want to get bitched at and thrown into counselling or just like genuine, laid back like advice based on experience and whatever feels right and the intelligent choice (CON 98).

These distinctive relationships allowed her to be supported in different ways throughout recovery, which Brooke noted as a generally positive experience.

*Shared mental illness diagnosis.* One way in which Brooke viewed herself as connecting with her parents was through their shared experience of mental illness. This was an internal cognitive experience that contributed to goals related to navigating the relationship. Specifically, Brooke reported that both of her parents struggled with depression in their lives, and having access to this information about her parents was helpful. She ascribed meaning to their lived
experience in three ways. First, she saw their shared mental illness experience as a means to facilitate parental understanding of her experience. And second, their presence and availability for support was viewed as a sign of hope for her own future. She asserted,

It actually kinda comforts me in a way because they’ve been through a lot, lot worse than me and…that fact that they’re still here and that they’re trying to be there for me, is like…I don’t know it’s like enlightening (CON 55).

Lastly, parental suggestions regarding coping were ascribed additional clout due to their own history with depression. She viewed her parents as more knowledgeable about depression because they lived through it.

However, Brooke felt her parents were not living up to her expectations regarding the degree to which they understood her experience. For example, when she engaged jointly with her mother about living arrangements and her mother kicked her out of the house due to lost patience, Brooke felt confused and hurt. She believed her mother should understand Brooke’s struggles instead of responding reactively. This internal process appeared juxtaposed with another process that centred on Brooke’s recognition of the way her parents’ struggles acted as a barrier to supporting her the way she hoped. In the same vein, Brooke acknowledged feelings of gratitude for their efforts.

**Navigating the adolescent-parent relationship: Mother-daughter.** Brooke spoke about the process involved in determining how to be in an adolescent-parent relationship with both of her parents. However, the way in which Brooke articulated her story emphasized the difficulties inherent in navigating a relationship with her mother, rather than her father, in the context of depression. Their relationship was described as conflictual at times, which was energized by anger and resulted in arguments.
Brooke reported that she misdirected her angry feelings toward her mother at times, which left Brooke feeling remorseful. In addition, Brooke explained that she used Ecstasy, which acted as a barrier to sustained improvements in mood, and further energized conflict in her relationship with her mother. It appears that Brooke felt out of control of her angry feelings, which she attributed to depression and drug use. Feeling out of control seemed to motivate Brooke’s desire for her mother to express patience in their joint action. Indeed, she commented,

Be patient with your child, like, um, obviously there is a time where everyone’s gonna lose their temper but don’t like make any long term, don’t like harm anyone long term…Don’t feel as if you have to punish your kids all the times when they have mood swings or something because they can’t help it. Like people who are going through this like can’t help it…And, make sure you like understand what they’re going through (CON 159).

This view was coupled with Brooke’s ability to take her mother’s perspective; Brooke acknowledged how difficult it was to engage jointly with her, and how her mother’s behaviour was likely steered by frustration.

Brooke acknowledged that at other times their relationship was characterized by support and caring. Joint actions that were categorized in this way included times at which her mom took her out for a drive or on a leisure outing. Such shared activities served as opportunities to spend time together creating memories, and building their relationship. Brooke ascribed significance as positive affect to this kind of “intangible” support. When asked to elaborate on the meaning of these shared actions, she stated, “…it really does cheer me up when we do this kind of stuff, so like we have good memories to keep and stuff” (CON 130). Furthermore, she interpreted such efforts as indicative of parental love and care.
There appeared to be a desire for closeness on both Brooke and her mother’s part, which energized connection actions; however, they found it difficult to consistently achieve the goal of closeness and connection. Brooke noted that her own fluctuating mood was one factor that negatively impacted their relationship. In addition, Brooke’s perception of her mother as “bitchy” and reactive likely impeded their efforts toward connection. Brooke articulated complex affective processes associated with her relationship with her mother, including anger, sadness, and loneliness. She imagined that her mom similarly experienced these feelings associated with their relationship. At times these shared feelings and a desire for closeness appeared to bring them together, but at other times seemed to keep them disconnected.

**Flexible living arrangements.** The distinctive way each of her parents engaged with Brooke in the recovery process was highlighted in Brooke’s explanation of her living arrangements. Specifically, Brooke described her living situation as one that had been jointly created with her parents. In interactions with her parents, Brooke has found a way to live as part of the family in a manner that was flexible and responsive to her needs, as well as responsive to the ongoing challenges in her relationship with her mom. Brooke identified her primary home as with her mom, but explained that their tense relationship sometimes motivated Brooke to stay with her father. More specifically, this happened as a result of one of two situations: (1) Brooke felt like she needed space, or (2) her mom lost her patience and kicked her out of the house. Brooke ascribed feelings of appreciation to the flexibility in living arrangements, a reality to which Brooke and both of her parents appeared amenable. Ultimately, the flexibility allowed her to feel reassured that she always had a home.

Although Brooke described these arrangements as positive, the transiency of her residence at times raises the question about the degree/extent to which her parents were involved
in recovery efforts. Brooke’s desire for more patience and understanding from her mother suggests that how the “flexibility” in her living arrangements may emerge due to parental rejection.

**Support project.** Brooke and her parents enacted joint actions specific to formal and informal supports, which were ultimately linked to recovery and wellness goals. Obtaining professional counselling support, engaging in a process of giving and receiving familial-level support, and getting involved in activities were the primary avenues for joint engagement related to the support project.

**Getting professional help.** Involving professional help was the first joint action Brooke identified in her story, which was steered by her mother’s realization of and concern about Brooke’s distress. Her mother mobilized a plan to link Brooke with the school counsellor and the doctor. Initially, Brooke was uninterested in seeing a counsellor as she saw herself as a private person. As a result, her engagement in these actions was characterized by reluctance and half-hearted agreement. As a means to ensure counselling session attendance, Brooke described how her mom drove her to school and walked her to the counsellor. Although they appeared to be working toward the same wellness goals, Brooke experienced her mother was “overbearing” at times and expressed annoyance. Brooke seemed to make sense of her mother’s overbearing style by attributing it to the way she communicated care/love. She stated, “…she is kind of like overbearing at times, but I know it was because she cares but, it was just annoying” (CON 42).

Over the years since her first contact with a therapist Brooke and her mom have worked together to get professional help. Her mother assumed the role of determining what kind of help was needed, making the arrangements, and involving Brooke. Brooke’s role focused on going
along with her mom’s plans, even though she did not always feel like opening up or did not always find it helpful.

Professional help has involved individual counselling for both Brooke and her mom, family counselling (involving Brooke’s sibling), and adolescent-parent sessions. Over time, Brooke’s internal experience of sharing personal feelings in session with a professional and her mother has evolved to a place of comfort. Brooke also acknowledged that at the time of family counselling, her mother was feeling very overwhelmed and sad about the challenges with Brooke’s older sibling. Brooke recognized that she and her mom were both struggling, and in this way seemed able to empathize with her mom. Despite acknowledging that she was not fully on board with family counselling, as Brooke reflected on it she commented on the benefit of joint action specific to involving professional support.

**Giving and receiving tangible and emotional support.** Brooke and her parents seemed to be involved in a family-level support project, which involved both tangible and intangible elements. Examples of tangible support included money, a place to “crash”, and a meal; whereas emotional support was more about listening and offering advice, and sharing time together. Sometimes Brooke explicitly sought out support from her parents and she described them as responsive to her requests. For example, on occasion Brooke called her dad, told him that she was feeling miserable, and asked him how to cope. He suggested that she come over to his place for dinner and a movie. When invited to comment on the feeling and meaning associated with such a gesture, Brooke stated, “[It feels] Good because like…I don’t know, like if the simple things can like cheer me up then, I don’t know, that’s a good sign” (CON 126). The availability of her father’s support was valuable to Brooke, however, she noted that it did not serve to enhance their emotional connection.
Sometimes Brooke initiated joint support action with her mother when she requested relationship advice or asked her how to handle a particular situation. Such actions were energized by Brooke’s belief that her mother was wise. She noted that when she felt receptive in the interaction with her mother, this enabled her to really listen to her mother’s advice. However, she also noted that sometimes she was not open to her mother’s advice and in these cases, communicated her request to be left alone. In the interview, Brooke was clear that she always makes her own decisions. However, she acknowledged that her decision making usually involved listening to her parents’ advice, reflecting on how it fits with her own views, and then making what she believed was the wisest choice. In this way, Brooke and her parents are engaged in joint action specific to informal support.

*Coping through getting involved in activities.* One project Brooke described related to recovery in the context of the adolescent-parent relationship centred on participating in activities as a means to coping with low mood. The way in which Brooke and each parent went about this joint action was different, but both parents appeared to emphasize the importance of getting involved as a step toward the goal of feeling better. Brooke’s dad tried to get her involved in physical activity and explained that it has a positive effect on mood. He suggested they take a martial arts class. This coping strategy was jointly enacted for a period of time and was associated with positive outcomes in Brooke’s view.

In an effort to work towards wellness goals, Brooke’s mother similarly suggested she get involved in activities, and took action to arrange for her to join a youth group. Brooke also experienced these joint efforts as helpful because they provided opportunities to socialize, which was something that significantly improved her mood. Brooke has been receptive to and appreciative of her parents efforts to get her involved in activities as a way to help her cope. This
appears to be an important interactional dynamic characterized by offering and arranging on the part of her parents and receiving and welcoming on the part of Brooke. Indeed, this dynamic seems to stand out against the push-pull dynamic described in other projects associated with this case.

**Identity project.** As a part of living with and recovering from depression, it appears that Brooke has enacted an identity project. Actions comprising this project included both solitary processes, such as reflecting on her self-perceptions, as well as joint processes with parents. Brooke described herself as quite shy and socially isolated when she was younger. She did not like these characteristics, which motivated action toward the goal of becoming more outgoing and social. Part of the shift in sense of self was manifested in joint counselling sessions with her mother. Brooke described that making the conscious decision to be more outgoing translated into becoming increasingly open with her mother in counselling sessions. In the self-confrontation interview she explained, “I was just thinking back to family counselling and…I am actually happy that I went to counselling…because it did help me in the long term and, I’m a lot more open now” (SC 30). Brooke further commented on how participating in the self-confrontation interview emphasized shifts in identity. Thus, although this identity project appears to be largely steered by Brooke’s internal desire to be different, it involves joint action in the context of the adolescent-parent relationship. Ultimately, this joint action contributed to shifts in Brooke’s self-perception over time. In addition, although not explicitly stated by Brooke, it is possible that other life events mentioned in Brooke’s story, such as her parents’ separation and parental mental illness, may have contributed to Brooke’s self-perception. It is important to acknowledge these additional contextual variables in commenting on processes related to identity.
**Assertion.** Brooke described recovery efforts as joint action that occurred in unique and distinct ways depending on which parent was involved in the joint action. Further, action appeared to be energized by different internal processes as determined by the parent involved in the endeavour. In these ways, joint action specific to recovery appeared to manifest in fragmented ways, which may reflect the degree of fragmentation in the larger family system. However, despite conflict and feelings of anger and rejection, Brooke commented on the specific ways she joined her parents to work toward larger recovery goals.

**Case 3. Celia**

**Context.** Celia is a 19-year-old female who was officially diagnosed with depression one year prior to this interview, although she believed she had been struggling with depression for many years. She had been seeing a psychologist since her diagnosis and was also prescribed medication, which she found unhelpful and has since discontinued. She described a daily process of self-medication with marijuana – a strategy she has found helpful in coping with her anxious thought processes. When asked to use a few words to describe how she viewed her life at the time of this interview, she said: “feeling happy; excited for the first time; hopeful”. Celia was also invited to comment on where she felt she was at with depression; she stated,

(Sighs) I can see significant progress, I can, I can reach a certain point, even, every single, honestly, every single day I learn something new about myself, something more positive about myself, whether it’s just me recognizing something more positive about myself, or being able to think about something more positive, um…1 to 100, 1 being when I started my depression, 100 being me being completely out of it…1 honestly say…I’m in the high 80s. Ya. I still, I mean I still have bad days but…I’m not sitting there dwelling in it, it’s so
hard but I work really, really hard at it. Really hard. And I’m making progress…Ya, so I’m almost there I think (CON 115).

At the time of this interview Celia had just moved out of her “adopted” mother’s home into a place of her own; she was living at home at the time of the initial research screening interview. Celia formed this relationship with her adopted mother, Maeme⁴, when she was 16-years-old and views her as a parent figure. At this time of the interview Celia was attending a post-secondary education institution and working part-time.

**Summary of key case findings.** Overall, Celia described a relational field with Maeme, which characterized by Celia’s fears of abandonment, and associated actions of resistance and/or rejection, and Maeme’s persistent and consistent support. The projects described in Celia’s story seemed to centre on navigating and maintaining a non-biological caregiver relationship amongst a relationally fractured history, as well as the process involved in giving and receiving tangible and emotional support (see Table 6).

Table 6.

*Key Projects and Processes: Celia*

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<th>Superordinate Projects</th>
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<td>II. Development and maintenance of a new adolescent-parent relationship</td>
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<td>III. Support project</td>
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⁴ Pseudonym used to refer to Celia’s adopted mother.
**Relational field: Fear of abandonment.** Celia’s family background was comprised of abandonment, rejection, and transiency. Specifically, she described a history of abandonment by her biological parents, with her mother leaving her at age 13 and her father being unfit as a replacement. With regards to biological siblings, she made reference to an older and younger sister as well as a younger brother, each who reside in separate homes. As a result of these disrupted relationships, Celia found alternate living arrangements over the years, including living with her older sister and “house hopping”. Such transiency required Celia to adopt a self-sufficient approach to being in the world, which seemed to be steered by the fear of rejection and questions of worthiness. These internal processes emerged in other parts of Celia’s story, particularly in response to joint action toward shared goals; indeed, this appeared contradictory and foreign to Celia.

When Celia was 16-years-old she formed a relationship with the mother of her close friend and began an adopted mother-daughter relationship with this woman, whom she refers to as “Maeme”. At this time, the fractured relational backdrop of Celia’s life had featured so centrally and she expressed difficulty in opening up and believing she could depend on another person. Specifically, Celia described how the experiences of earlier relationships with her biological parents have shaped her way of being in her current relationship with Maeme:

…I was thinking, like one of the worst fears I have because both my parents…have told me that they wish they didn’t have me…(pauses), so…um, one of my worst fears is her telling me that she regrets taking me in or something (SC 29).

A relational field characterized by abandonment and rejection has implications for the way in which Celia worked toward recovery, both independently and with Maeme.
Development and maintenance of a new adolescent-parent relationship. Celia’s relationship with Maeme was unique in this study in that it formed in Celia’s adolescence, rather than at birth, and is young in years (three years). It appears that many of the projects Celia and Maeme jointly enacted were nested in, and impacted/influenced by, a larger project that was about the development and maintenance of a new parent-child relationship. Celia stated, “…she reinvented the term ‘parent’ for me” (CON 102). Throughout Celia’s narrative she described ways in which both she and Maeme have been navigating their relationship. Celia identified feeling an “immediate bond” with Maeme but went on to describe a jointly enacted process of forming this relationship that also began with judgments and rejection on her part. She explained an automatic internal process, which reflected the belief that Maeme was not someone who could be depended on. Celia stated,

…at first it was, it wasn’t lovey dovey thing right away, that was always something that matured… I was a really, really, really hateful person, I would, I would look at somebody and judge them and make, like, just horrible, horrible, think horrible things or view them differently um, and I remember actually doing that to Maeme when I first met her (CON 71/72).

However, Maeme engaged in a consistent and persistent manner with Celia, enacting actions such as, asking how she was feeling, expressing understanding, and reiterating that Celia would always have a room in their home. According to Celia, Maeme’s approach and actions helped Celia shift her perspective and become increasingly open to caring and affection.

Celia continued to express openness to Maeme, both explicitly and implicitly, by noticing and appreciating Maeme’s efforts and interacting with her even when she would rather be alone. With regards to the latter, it was unclear if Celia joined Maeme because she felt an obligation to
do so to preserve the relationship, or if there was another internal process energizing her
daviours. Sometimes Celia noted that she would specifically seek Maeme’s perspective and be
receptive toward her gestures of compassion, rather than continue to enact a solitary approach to
coping. Celia was clear that it became important to her to preserve this relationship and
explained that she would engage in actions with relationship preservation and maintenance as
steering processes. In some cases such internal processes translated into concealing or
minimizing actions specific to her feelings. For example, Celia explained how it was her
perception that telling Maeme how she continued to struggle would imply that Maeme lacked in
some way; she stated, “…I don’t want her to feel like what she did wasn’t enough. You know?”
(CON 84). She expressed feelings of appreciation and gratitude toward this woman and the
relationship they developed, while also asserting the belief that sharing the depth of her
experience with depression would negatively impact Maeme and their relationship.

Fear of abandonment energized actions in Celia’s relationship with Maeme, and further
reinforced her belief that she could not fully disclose her struggles. This was coupled with her
intense appreciation of the relationship that formed and how the relationship has served to
positively impact her life. In reflecting on her story in the self-confrontation interview, Celia
described her feelings:

…I kinda just wanna cry because I’m really lucky, like I’m really lucky and just hearing
the things, putting out there the things that she’s done for me you appreciate them more so
I’m just, I’m really lucky. I was feeling really lucky. (SC 1).

This adolescent-parent relationship development/maintenance project appeared to impact the
degree to which other recovery related projects were jointly enacted. Overall, Celia noted that
she was not completely open about her struggles, low mood, and negative thoughts with Maeme.
This seemed to be about goals specific to maintaining independence in her self-care, as well as protecting the relationship to ensure it continued.

*Staying connected.* In the midst of depression and Celia’s tendency toward independence and isolation, maintaining the connection between Celia and Maeme was described as a subordinate project of the adolescent-parent relationship maintenance project. She described herself as private and independent, which motivated solitary coping efforts and also allowed her to work toward keeping others away from her “negativity”. This self-isolating approach to being in the world seemed to act as a barrier to engaging in joint action with Maeme and being open to gestures of support. Indeed, Celia identified a number of instances in her story in which her struggles energized action specific to pulling away from Maeme. In Celia’s view, these were necessary actions to cope and to protect others. However, Maeme did not appear to join Celia in this isolating approach, and instead engaged in opposite action reflecting persistence in caring gestures. Celia explained,

…she’s still, like she’s still so adamant on staying in my life and even now that I moved out and am out in [Mainland suburb] she still comes over, like she fucking forces herself to come over and just be involved, you know (laughs), even if it’s just seeing me for a little bit, or she’ll text me or something, it’s just she knows that, that I do need her even if I try and kick her away. So I think the biggest thing that she’s helped with in this depression is still fighting for, to stay, to like, be involved, you know? (CON 79).

Celia appeared to describe this emphasis on staying connected as largely enacted by Maeme. Maeme’s phone calls, offers to purchase items for Celia, and random visits were actions she took to remain connected to and a part of Celia’s life. However, Celia joined Maeme by being receptive to Maeme’s gestures, even if reluctantly at times. It is unclear if Celia’s
receptivity was motivated by a sense of pressure as a means to preserve the relationship, or if this receptivity to such gestures was genuine even in the face of reluctance.

**Support project.** In the case of Celia, joint actions specific to the support project involved only informal support processes; joint action specific to formal intervention was absent in her narrative. Celia described a process of navigation related to support interactions with Maeme, which seemed to depend on the enactment of the relationship project. In addition, functional steps specific to the support project and associated recovery goals involved engagement with activities and undertaking an active stance in shifting perspective.

**Navigating giving and receiving support.** Celia described a subordinate project jointly enacted with Maeme throughout recovery, which involved a process of determining how to give and receive support. Maeme’s primary role was that of giving/offering support and Celia’s role centred on receiving support. Celia’s perception of safety and stability in her relationship with Maeme appeared to act as a functional step in making attempts to address depression independently. Indeed, Celia talked at length at the outset of the research conversation about the many independent steps she has taken on her own to cope with depression, such as journaling and reading self-help books. Celia’s tendency towards independence appears rooted in her early history, and is subsequently energized by internal cognitive processes specific to beliefs about being a “burden” to Maeme. However, Maeme’s consistent care and expressions of love were experienced as helpful in the recovery journey. Specifically, Celia identified many implicit and explicit caring gestures Maeme enacted that enabled her to feel valued and as though she belonged in the family. Overall, Celia ascribed meaning to Maeme’s repeated requests to visit, to share time together, and her offers to pick up special items that centred on evidence that Maeme could be depended on.
Maeme’s role in this navigating support project also involved showing interest in how Celia was doing, expressing understanding, offering comfort and reassurance, and providing tangible support. Persistence and consistency were two defining characteristics of the way Celia described Maeme’s actions. Although Celia noted that she often kept her struggles private, her internal processes reflected feelings of appreciation of Maeme’s care and thoughtfulness.

Celia’s role in enacting this project seemed to be characterized by a push-pull dynamic that reflected Celia’s tendency toward independence (processes motivating a push back), as well as her positive experience of Maeme’s care (processes energizing the pull towards). Celia’s specific actions related to this project included boundary-setting and/or minimizing behaviours, such as dismissing her feelings or stating “I don’t want to talk about it”, but also included invitational behaviours, such as requesting assistance and expressing affect. It seems that boundary-setting and minimizing were actions that enabled independence goals. It is also possible that by not imposing much on Maeme, Celia addressed her fear of losing the relationship. She described her perspective on receiving support in the following ways:

I’ll tell her if I don’t wanna go into further detail, or, or it’ll simply be, ‘it’s been a shitty day.’ I’m not going to lie to her, it’s just, it’s the amount of detail that I would go into, right? (CON 86)

and “… for emotional support and stuff, absolutely if I need to talk, if I need advice, absolutely I would go to her, I would always go to her” (CON 100). In this way it seems as though Celia knew that Maeme was available when needed, which occurred only when she felt she could not manage on her own. However, actions specific to reaching out were also shaped by Celia’s specificity regarding when and how much she was willing/prepared to open up about. In this way Celia appeared to remain true to her sense of self.
**Getting involved in activities.** Celia identified participating in activities at home and in their community as jointly enacted with Maeme during the recovery process. These efforts appear to be a subordinate project of the support project. According to Celia, Maeme adopted the role of initiating activities by making suggestions and giving Celia information about how to get involved, and then executing suggestions. Some of the activities Maeme suggested included going to the movies or getting their nails done. Other activities seemed to reflect goals specific to developing life skills, such as meal preparation and laundry, as a part of governance transfer processes. With regard to these processes, Maeme enacted the role of “teacher” and Celia enacted the role of “learner”. Celia perceived these activities as “simple” but referenced the associated meaning and significance in her life.

Reciprocity in joint action specific to governance transfer was described by Celia; she stated,

…she’d help, she’d teach me to make dinner or she’d teach me to do my laundry, stuff that I’d never learned before, um and I’d try and do stuff for her, I’d try and clean, I’d try and, try and whatever (CON 73).

In this quote Celia highlights both parties’ roles and the impact of such processes on Celia. There were a number of jointly enacted steps that contributed to such processes. First, Celia first had to be open to engaging in the activities Maeme suggested and she then had to express this openness to Maeme, and finally she had to participate in the activities. In addition, Celia was later motivated to return the favour to Maeme, which further suggests openness and engagement with Maeme’s efforts. Thus, in the midst of living with depression and an independent stance, Celia demonstrated receptivity to joint action with Maeme regarding getting involved in activities.
Developing an open and positive view. Celia described the way in which she and Maeme worked together around shifting Celia’s perspective from a negative and pessimistic view to one that was increasingly open and positive. Celia credited Maeme for helping her shift in this way. Celia described a very negative outlook she developed over the course of her life largely due to familial rejections and tensions. Her tendency toward independence and isolation seemed motivated by perceptions of others as mean and out to get her. However, through engaging with Maeme and her kindness, stability, and simple gestures, Celia stated she was able to shift her perspective to allow her to be open to a different way of seeing things.

I was [thinking]…about…like the destructive qualities that I have uhhh, I was just thinking about certain times that I’ve come to her and that I’ve cried to her about like insecurities about myself or, or why I viewed things a certain way. Why I couldn’t get out of that train, that, that thought process, that train of mind, um and she was just very compassionate and understanding and loving and would lay there with me, and it’s just how she reacted to my negative, she came and combat it with, with positivity, you know (SC 14).

These gestures seemed to challenge Celia’s ideas about the role of other people in her life.

Celia described self-destructive thought patterns, which were challenged by Maeme’s guidance and provided Celia with new insights. Celia stated, “…I was just thinking about how much she’s helped me through…how much she’s just helped me through the destructive things that I do to myself and with myself…she has shed light on those” (SC 13). It appears that Maeme’s role was both explicit through verbal means, such as making compassionate comments, and implicit through gestures, such as staying by Celia’s side during struggles. Celia’s role in this project seemed to be about being able to recognize and accept the simple gestures and not take them for granted, but rather to appreciate them as gestures of care. In these ways, Celia and
Maeme worked together to change Celia’s thought patterns to reflect a more open and positive view. Celia’s advice for parents of adolescents with depression involved comments regarding creating a positive atmosphere and encouraging their children to reach their goals. Similarly, Celia encouraged teens with depression to “…be patient and caring and loving and lenient with yourself” (CON 114).

**Assertion.** For Celia, the overarching recovery project appeared to be enacted both independently and jointly in her relationship with Maeme. Her perceptions of self as independent and others as rejecting appeared to complicate joint action, and thus emphasized a solitary approach as the default in coping with depression. However, joint action with Maeme was facilitated by the consistency and persistence characteristic of Maeme’s approach. Internal processes of fear of abandonment, as well as gratitude for the “parental” relationship featured centrally in Celia’s description of joint action and associated meaning.

**Case 4. Daljeet**

**Context.** Daljeet is a 17-year-old female who was diagnosed with depression when she was 12 years old and has been receiving formal treatment for about 4.5 years. Daljeet lives at home with her mother, father, older brother, and older sister and, at the time of the interview, was completing her final year of high school. She takes medication and attends regular counselling sessions with both a psychiatrist and a counsellor, which she finds helpful. Her parents often attend the appointments with her psychiatrist. In the telephone screening interview she answered “no” to additional mental health diagnoses; however, in the research conversation she made reference to “my OCD” and “my social anxiety disorder” and when asked to clarify, she stated that these were diagnosed disorders.
When asked during the initial screening how she saw her life, she said: “pretty hopeless, annoyed, and wet” [wet referred to being out in the rain shortly before the screening call]. Daljeet later identified variability in her mood these days, which she viewed as normal and healthy. In describing her current experience of depression and recovery in her life, she stated, I’d say it, it varies. But the varying is actually really good because before I was obviously dysthymic and I was always, always down, down, down, but now for sure I’m usually pretty up, I’m pretty high and happy and okay and functional, but I can be sad, but it’s not for, like, no reason at all…whereas before I would just be so down, down, down, and then someone, something like that would happen and I would just like flip out. I would just cut myself or like, do something horrible and incredibly bad, but now I can kind of get over it so it’s a lot better because I can be- most of the time I’m really up, but I can be down, which is healthy I think (CON 101).

Creative arts are Daljeet’s passion and she has aspirations to pursue this field for her career.

From Daljeet’s description her parents became involved in recovery-related actions when she told her mom she had been feeling sad for a long time. Her mother also noticed a shift in Daljeet’s mood and suggested they go and see the family physician. However, her story of their involvement emphasized her hospitalization in grade 9 due to a suicide attempt using her medication. According to Daljeet, this event was a “turning point”, which signaled to her a need for change. She explained, …I took all my [medication] and I was obviously trying to kill myself and then when I was sent to the hospital and like, my entire family was there, they were so, so upset that I was like, “You know, I can’t do this anymore. I can’t be depressed. I can’t do this shit anymore.
I mean, I’m hurting everyone around me, not to mention myself, so I have to get better.” (CON 26).

**Summary of key case findings.** Daljeet identified a number of ways her parents were involved in the recovery process, and described recovery-related projects that appeared to centre on support and safety, as well as navigating the adolescent-parent relationship (see Table 7). In sharing her narrative as part of this research, Daljeet made reference to the participant-researcher relationship, commenting on how this relational context added another layer of internal processes specific to goal-directed action.

Table 7.

*Key Projects and Processes: Daljeet*

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<thead>
<tr>
<th>Superordinate Projects</th>
<th>Subordinate Projects and Processes</th>
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<td>I.  Support project</td>
<td>• Safety project</td>
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<td></td>
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<td>II. Navigating the adolescent-parent relationship</td>
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**Support project.** One of the superordinate projects jointly enacted by Daljeet and her parents included mobilizing supports related to safety and formal intervention, as well as at the familial level. Actions specific to this project seemed primary in Daljeet’s story of recovery in the adolescent-parent relationship, and were energized by a joint desire for Daljeet’s wellness, parental fear, and Daljeet’s feelings of gratitude.

**Safety project.** Directly following Daljeet’s suicide attempt her parents engaged in action with Daljeet that seemed to be about making sense of and/or understanding her suicidal gesture. Specifically, her parents stayed with her at the hospital, asked her questions about her decision to
try and end her life, and expressed feelings of sadness. Daljeet joined her parents by welcoming their presence at the hospital, expressing sadness for hurting herself and others, and stating a plan to change how she was coping with depression. However, witnessing her parents’ sadness and pain in the hospital prompted Daljeet to engage in efforts to shift the focus away from suicide and depression. It was important to her that she enact action related to boosting their spirits, which was motivated by internal processes related to discomfort in response to her parents’ sadness. She stated,

…I was like joking around and trying to make everyone feel better because I don’t like it when people are sad. Like I can’t handle it. So I was trying to make my [parents] laugh and feel better by like joking around (CON 27).

It seemed as though witnessing her parents in pain, and experiencing her own pain in response prompted Daljeet to make humorous comments in an effort to minimize pain and distress. In addition, these external and internal experiences appeared to stimulate a shift in her cognitive processes, which reflected the intention to take different steps to move beyond depression. In these ways Daljeet and her parents were engaging in actions related to current and future safety goals.

Actions related to the safety project emerged at other points in Daljeet’s story, specifically as it related to formal supports and medication. Daljeet described her father’s insistence that she no longer take medication as this was the means for her suicide attempt. The meaning associated with medication appeared different for Daljeet and her father. It was his view that the medication was dangerous, while it was Daljeet’s view that the medication was necessary for her coping. As a result, Daljeet expressed anger in reaction to her father’s perspective. She explained that this reaction was coupled with a cognitive understanding of his
“terrified” feelings related to future suicide risk. Thus, even though her father’s perspective and medication refusal angered her, she was also able to empathize with her father. Over time, trust developed in Daljeet’s relationship with her parents, which meant that the safety project became less omnipresent. Instead, other projects shifted to the forefront in the recovery journey and the action that was jointly enacted in these other projects fostered the development of trust, ultimately impacting the safety project and the degree of emphasis on safety goals.

**Accessing formal supports.** The safety project described by Daljeet in her story of her parents’ involvement in her recovery from depression was directly impacted by the action and meaning associated with involving formal supports. This project consisted of joint action specific to attending counselling sessions, expressing individual perspectives in the counselling session, and making requests for methods of support. Daljeet’s suicide attempt prompted her parents to become more involved in her depression care, and thus, they decided to attend her psychiatrist appointments. It appears that the action of attending sessions served as an important functional step toward obtaining a sense of reassurance about Daljeet’s safety and overall mental health. This was not a discussion that occurred between Daljeet and her parents, but rather was a plan stated by her parents. In this way they took charge of joining Daljeet in participating in formal intervention related to depression. Daljeet described initial internal processes that centred on fear of having them involved in this new way, as well as annoyance about hearing their perceptions of how she was doing and what she needed to feel better. She explained,

Well, at first it was really awkward because I was so young and I have like a social anxiety disorder so I had like panic attacks and so many times I was like, “Nope. I don’t want to do this. Nope I can’t do- nope. Nope.” And then I thought, like I kinda have to do this, like I
can’t go on feeling like this. I don’t want to. So I pushed myself to do it but it was really awkward and I felt really, like, nervous and scared about it (CON 22).

However, Daljeet’s internal experience shifted over time as a function of experiencing the ways in which it was helpful to have her parents attend sessions.

At the time of the research interview Daljeet viewed joint sessions positively because they (a) offered the psychiatrist another perspective on how she was doing, (b) helped Daljeet understand her parents’ perspective, (c) offered Daljeet a space to clarify her experience of depression, and (d) reassured her parents. All parties appeared to have a similar role in this project, namely to express his/her feelings and perspective on how things were going, with the shared goal to have Daljeet well. Although this role was shared, Daljeet clarified that she did not always openly disclose her experience in these sessions. Instead, at times her focus was on managing her internal experience of annoyance, fear, and discomfort in the room with her parents and psychiatrist.

When asked what Daljeet thought about how her parents’ experience attending the sessions, she commented, “I think they really like it actually. I think they think it’s like a good way to, to check in and touch base with me and my counsellor, and my psychiatrist” (CON 54). These comments speak to the way in which the affect and cognition related to joint action has evolved over time, such that the meaning has changed even though the overarching goal of the project may have remained the same. However, it also seems as though a new subordinate goal affiliated with the “accessing formal supports” project has also emerged over time, namely: to improve/enhance communication/each other’s understanding of the experience of depression in Daljeet’s life. This also seems connected to a larger relationship project, which emerged in Daljeet’s story of the recovery process.
**Simple gestures as a means to offer support.** As part of navigating the support project, the description of processes involved in giving and receiving of support in the adolescent-parent relationship emerged. This often consisted of simple gestures enacted by Daljeet’s parents and accepted by Daljeet. Some of these gestures included: making a bowl of soup, sitting with her when she had a hard day, and buying Daljeet’s favourite tea. These gestures of support appeared to be initiated by her parents in response to either a perceived need, such as noticing Daljeet’s non-verbal behaviours, or an explicit request. Daljeet explained,

> Um, well [my mother] always tries to help, all the time. Like, whenever, if I’m, I have had periods where I am really down, really low, and it’s usually around, like, exam time or stuff like that, like really stressful situations, and so, I’ll just call her up and be like, “Will you go and get me some [tea]?” ‘Cause [tea] is always the thing I want when I feel really sad or really down or whatever, so she’ll like go out and get like tons of [tea] and come and sit on my bed with me…even if I don’t want to talk, she’ll just like, sit there and we’ll, like, watch a movie together or something like that (CON 72).

Daljeet described internal processes characterized by feelings of appreciation and gratitude associated with her parents’ efforts to support her. She ascribed meaning to their efforts, viewing the efforts as evidence of her parents’ understanding and expressions of love. Daljeet described herself as open to receiving her parents’ gestures, and expressed satisfaction with their ability to “read [her] moods”.

**Navigating the adolescent-parent relationship.** Daljeet described the process of determining how to be in an adolescent-parent relationship with both of her parents. During the self-confrontation interview, Daljeet commented on the way her relationship with her parents has evolved over time throughout the recovery process. She stated,
Um, well I just felt a lot better and a lot happier about, like, what’s happening now and how I’m much, much better than I was before and how, before, I mean, it was like a lot of animosity towards my parents and it was kind of, like, an awkward situation for everyone ‘cause everyone was just kind of, like, not communicating and, like, butting heads a little bit, and not it’s, like, so much better and I was just really happy that now we’re connecting again (SC 64).

The joint actions of this project included, spending leisure time together and having conversations about depression and about career aspirations. Daljeet’s role in this project seemed to be about suggesting shared plans, agreeing to spend time with her parents, and expressing her future hopes/dreams. Her parents’ role also involved suggesting plans and agreeing to share time together, while also working to make space for Daljeet’s dreams by openly listening to her hopes and stating their support of her dreams.

Daljeet’s relationship with her father was further singled out in her story as she described their special bond and her belief that she is his “favourite child”. She explained,

…”so I think I’m the only one that spends time with him. So I think that’s why I’m his favourite child ‘cause I’ll be like, “Oh Dad, let’s go for a walk, or let’s go to [local attraction].” You know? And I genuinely want to spent time with him and I’ll initiate it, which I think is very important ‘cause I think he really likes that (CON 84).

Her perception of the unique relationship with her father appeared to support Daljeet to engage in actions specific to the relationship. She stated,

…”We, we just connect really well. We understand one another and we can kind of just talk with one another and like sometimes I go and lie on his bed and read my book and he lies
on his bed and he reads his book and we just kind of lie there together in silence reading books. And it’s just kind of like a nice connection that we have (CON 81).

Feeling understood enabled Daljeet to feel connected to her father, which fostered a sense of comfort and safety in the relationship. When Daljeet felt safe and understood she was more likely to share her experiences/feelings with her parents; sharing her feelings seemed to build trust in her relationship with her parents. As trust built in the adolescent-parent relationship, this positively impacted other projects, such as the safety project. Overall, it appears that more openness led to more trust, which fostered feelings of parental reassurance regarding Daljeet’s safety.

Daljeet also commented on the larger family system in describing the distinct relationship she has with both of her parents. She believes her parents treat her differently than her siblings, which was experienced positively by Daljeet. One domain in which this seems to play out is around career aspirations. Daljeet believes that her parents have given her permission to pursue theatre as a career, which is not something they would support her brother or sister to pursue. It is Daljeet’s view that this special permission emerged as a result of Daljeet’s struggle with depression and is further energized by her parents’ desire not to overwhelm her. Daljeet stated,

Well, it’s just like, if they pushed me like they push the other two, I don’t think I could handle it and I think that would actually be a really bad experience for everyone ‘cause I really don’t’ think I could hand it, ‘cause I would definitely go into whatever they told me to go into. And then I would hate it. I would just hate it (CON 58).

In this quote, Daljeet references her self-awareness regarding her tendency to go along with what her parents want, even if that was not what she thinks would make her happy. This tendency seems to be tied to preserving/maintaining the relationship and is further motivated by her desire
not to upset anyone. The fact that her parents make room for her career aspirations allows her to feel like she can cope.

**Communication as a functional step to addressing depression.** Communication was emphasized throughout Daljeet’s story. It was her view that communication served as a necessary functional step toward wellness goals in the context of depression. However, she acknowledged her reserved and private sense of self was enacted through a tendency to hide her feelings. One primary domain in which this step was enacted with via the action associated with accessing formal support; much action related to communication efforts occurred here. In this way it becomes difficult to separate the adolescent-parent navigation project from the support project, as communication in the counselling sessions often served as a vehicle for achieving relationship goals. Specifically, her parents’ decision to attend her psychiatrist appointments enabled Daljeet to understand the degree of disparity in the view she and her parents held of her mental illness, which raised feelings of anger for Daljeet. However, this joint action also enabled Daljeet to realize that she had not been open with her parents about how she was feeling. Her lack of openness acted as a barrier to her parents’ ability to obtain an accurate perception of her mental health. She explained,

…my mom would come in and she’d be like, “Oh, Daljeet has been doing much better.” And I’d be like, “No, I’ve been pretending to be doing better. You don’t know what you’re talking about.” You know? And at first it just kind of annoyed me because they didn’t know what was going on and then I realized that they didn’t know what was going on because I didn’t tell them what was going on or lied to them about what was going on. So it wasn’t their fault they didn’t know, it was mine (CON 37).
Daljeet described how this realization supported her to move beyond her awkward feelings in these sessions to enact disclosure as a means to aid her parents in understanding her experience. Specifically, jointly attending psychiatry sessions helped Daljeet understand her parents’ perspective, which supported her to realize how her veiled communication was acting as a barrier to everyone being “on the same page”. As a result of (1) her parents expressing their perception of things and (2) Daljeet listening to their perspective, she was able to understand the disconnection in experience. As a result, Daljeet made a choice to more clearly and openly communicate with her parents. Thus, accessing formal supports – a separate project – facilitated communication efforts, which contributed to relationship goals.

Daljeet described another instance during a counselling session in which she was able to engage in communication actions related to needs identification, which appeared to foster the adolescent-parent relationship. She stated,

Um…I think I told them, like, in one of our counselling sessions with the psychiatrist that when I’m sad or angry or something I just need a little bit of space for a while and then I’m usually okay and then they kind of understood that that makes sense. ‘Cause when I’m sad or angry they’re like, “Oh! What’s wrong? Why are you being so sad?” I’d just get angrier or sadder (CON 49).

In this example two recovery-related projects again overlap, with one action (attending psychiatrist appointments together) making another action (communicating about needs) possible. It appears that the role of Daljeet and her parents in enacting communication was the same; namely, everyone expressed his or her perspective and internal processes associated with the present moment or a point in time. However, it is at the level of the goals where there appears to be a distinction between Daljeet and her parents. Specifically, it seems Daljeet’s goal related
to this action may have been more about letting her parents know what she needed and how she was actually doing; her parents’ goal seemed to be more about updating the psychiatrist on how things were going and/or reporting on progress related to Daljeet’s mental health, as well supporting Daljeet more broadly. Daljeet’s corrections in response to her parents’ perception of functioning were more about ensuring she and her parents were “on the same page”, rather than ensuring her psychiatrist was up-to-date.

Communication as a functional step in enacting relationship goals has also shifted over time. Daljeet reported becoming increasingly open about her internal processes, rather than continuing to remain private. Actions related to communication also expanded beyond the psychiatry session to include interactions at home, which also seemed to signal increased trust in the adolescent-parent relationship. The safety and support of the counselling session no longer appeared necessary to enact communication processes. According to Daljeet, communicating about your experience with someone you love and trust is the most important action a teenager can take related to recovery. When invited to share advice for teens with depression, she encouraged them to try and talk about their feelings. It was her view that keeping feelings inside makes a person “sadder” and the experience of depression worse.

**Joint action in the participant-researcher dyad.** In Daljeet’s self-confrontation interview, she made reference to internal processes experienced during the research conversation. These internal processes were related to her relationship with her parents, and also the relationship and interaction with this researcher. Thus, her self-confrontation interview largely alternated between (1) identifying her cognition and affect associated with being a member of the participant-researcher dyad and (2) referencing feelings specific to her experience of recovery in the context of her relationship with her parents. Daljeet’s process of reflection in
this interview seemed to be a smooth weaving together of her experience in the two relational contexts, namely the adolescent-parent and participant-researcher as she described recovery as jointly enacted.

Daljeet acknowledged and articulated a host of feelings associated with telling her story to the researcher. Her desire to answer each question fully was associated with feelings of nervousness. She ascribed significance to certain questions posed in the conversation, and this significance seemed to amplify her awareness of how “well” she was answering the questions. In one instance during Daljeet’s reflection on her feelings in the conversation, she commented,

Um…[in that minute I was] probably very flustered and probably just a little bit irritated, not at her or the question, but at myself because I can’t remember. I get irritated at myself a lot because I can’t remember things (SC 71).

As a result of these affective experiences, Daljeet described the desire to “turtle” (i.e., hide inside) at the outset of the research interview. However, she explained in the self-confrontation interview, that as the research conversation progressed she realized that it was not “so bad”, which allowed her to feel increasingly comfortable.

Fear of judgment was also a part of Daljeet’s experience of relaying her story to the researcher. This experience was not unique to the participant-researcher relationship, but rather something Daljeet acknowledged as relevant in many of her relationships. At times Daljeet acknowledged a thought process that seemed related to impression management goals. It was important to her that she come across as confident in the research interview, which she found difficult to enact at times, such as when she was describing her “weaknesses”.

So, I think in that instant I was um, I was feeling a little bit awkward ‘cause I was talking about my weaknesses now and then I was like, you know, I come off as, like, such a
confident person what if she doesn’t believe that I actually do have all these like weaknesses and anxieties (SC 113).

Indeed, she felt concerned a number of times throughout the interview about how the researcher would respond/react to what she had to say. It seems that in this participant-researcher dyad many of the same relational influences arose that arise in her other relationships.

**Assertion.** Daljeet described a process of recovery that involved joint action with her parents, which was associated with internal processes that evolved over time. At the outset joint action was associated with feelings of anger and annoyance, as well as pain due to realizing how she impacted her parents. However, through negotiating goals specific to safety and support, using the counselling sessions as a means to enact communication processes, and re-building trust in the adolescent-parent relationship, Daljeet ascribed positive affect and cognitions with jointly enacted recovery. Concerns regarding how she was perceived by others, as well as fear of judgment, appeared to be an ongoing internal process for Daljeet that shaped recovery endeavours in various relational contexts.

**Case 5. Eleanour**

**Context.** Eleanour is a 17-year-old female who was diagnosed with depression when she was 16 years old. She reported struggling with symptoms of depression for at least one year before she took steps to seek formal help and receive a diagnosis. Initially Eleanour sought professional help with the assistance of a friend. Eleanour saw a few counsellors before she was connected with her current counsellor, who is affiliated with a local mental health team. At the time of this interview she had been seeing her counsellor for approximately 6.5 months. She was also taking medication for depression, which was monitored by the mental health team psychiatrist. When asked to identify a few words to describe how she viewed her life, she stated,
“lonely, hopeful, busy”. She also articulated a process-based perspective on where she was at with depression; Eleanour elaborated,

Um…….I’m definitely on a slow upward incline (laughs) away from depression, but I’ve kind of accepted that it will be something I do have to deal with in, at least in the near future, it’s going to be something I do need to deal with, um that I wish it could just go away but, um, but it is something that I need lots of support with. That I am getting better (CON 89).

Eleanour was living at home with her mother, father, and younger brother and sister at the time of this interview. She was completing her last year of high school, and despite periods of school non-attendance due to symptoms of depression, Eleanour was going to be graduating with her peers.

Throughout her story of recovery Eleanour emphasized feeling alone in advocating for her mental health needs, such as arranging counselling and medication treatment. She commented,

Um, at first I was mostly um alone…I just, I hadn’t told my parents what was going on and I, I guess they had some idea but I just, I was frustrated with them ‘cause we were constantly fighting and eventually when I told them they brushed it off and for the longest time. I wanted to get medical help because like it was just something I couldn’t deal with on my own (CON 17).

However, Eleanour articulated actions she engaged in jointly with her parents, sometimes with positive outcomes and other times with outcomes that were undesired.

**Summary of key case findings.** Despite feeling largely alone in advocating for services to support her in addressing depression, Eleanour articulated a number of ways she and her
parents worked together around recovery related projects. These goals/projects seemed to centre on coming to terms with the diagnosis, communicating about the experience and need for intervention, while engaging in meaning making and managing the impact of depression on the family (see Table 8). Differing perceptions of the problem (initially) and the degree of impact (later and ongoing) appeared to be the main barrier to working together around recovery goals.

Table 8.

Key Projects and Processes: Eleanour

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<thead>
<tr>
<th>Superordinate Projects</th>
<th>Subordinate Projects and Processes</th>
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| I. Recognition of the problem project | • Meaning-making around depression diagnosis  
• Managing the impact of depression on the family |
| II. Support project | • Supporting Eleanour in the context of the adolescent-parent relationship  
• Accessing formal support  
• Communicating about experience and needs |

**Recognition of the problem project.** Eleanour described the process involved in getting all parties, namely Eleanour, her mother, and her father, to share a view of the presence of depression in Eleanour’s life, ultimately working toward the recognition that there was a problem to be addressed. This was the first project Eleanour and her parents jointly engaged in related to recovery from depression. The project involved a series of argumentative interactions between Eleanour and her parents. Eleanour interpreted these interactions as symptomatic of a larger mood/mental health issue in her life. However, her parents had a different view and instead made sense of these conflictual interactions by attributing it to problems Eleanour was having with her sleep. At this time, Eleanour described herself as “very sensitive” and indicated that she felt dissatisfied with her life and with her parents’ response to her struggles. Her efforts to involve them in coping with depression were motivated by the belief that she could not deal with the
struggles independently. However, Eleanour experienced her parents as dismissive, making statements that minimized her distress. According to Eleanour, they told her, “You are fine” and suggested she try and get more sleep. This mismatch in perception of the issue contributed to a delay in involving formal supports. Eleanour stated, “…I guess the biggest problem is [my mother] didn’t imagine she’d need to be prepared for this so she didn’t know like what to do so she was completely unhelpful or unable to reach out get me help” (CON 43).

Eleanour and her parents continued to enact actions specific to the “recognition of the problem project” throughout Eleanour’s journey to recovery. Indeed, at the time of the interview Eleanour stated that, after much intervention and a period of time during which all parties agreed there was a mental health issue, her parents believed that Eleanour’s struggles have resolved and things are fine. Again, the issue of mismatch in perception emerged as Eleanour was not sure if she had improved, and instead wondered if the problem still existed. She explained her internal process,

I don’t know if it’s for themselves or for me that they say like, “No, you’re doing fine, like, you’re way better now.” When really I, I sort of wonder, am I better? Or would this [making a change in the treatment plan] help me? And they’re just like, “No, no, you’re fine now.” (CON 56).

Despite sensing that the problem is not gone, Eleanour chose not to engage in action that suggested she continued to struggle. This action was motivated by internal processes, namely worry about the impact on her parents. In this way, Eleanour and her parents were still working together around acknowledging the problem, with the shared goal of having Eleanour be well. However, the way they worked toward the goal appeared to be at odds. Eleanour’s parents wanted to believe she was already well, which energized statements asserting that she has
recovered from depression. Eleanour wanted to continue to access treatment to ensure she was well. Eleanour’s desire for ongoing treatment appeared to be motivated by fear of depression. She explained,

…it’s been like a bit of a struggle. Like some days are, are hard and some days are completely fine. I guess I have a never ending worry that one day I’m gonna get worse, or I’m gonna drop back to as bad as I was. And that worry comes up every time I have like a bad day or if something feels like a bit of a setback (CON 8).

*Meaning-making around depression diagnosis.* Eleanour and her parents were also involved in a meaning-making project, which centred on adjusting to and making sense of the depression diagnosis. This project also occurred throughout the journey from diagnosis to ongoing treatment. The actions of this project often had direct implications for other projects, such as accessing formal support. For example, Eleanour believed her mother’s worries about the meaning associated with a diagnosis of depression motivated diagnosis rejecting behaviours and energized alternate perspectives, such as viewing the challenges as a sleep problem. When Eleanour’s parents rejected or minimized her concerns in these ways, she began to wonder, “Is this real? Maybe it’s not that big of a deal.” or “Maybe this is something I’ve made up?” It appears that Eleanour and her parents had different ideas Eleanour’s struggles; however, all parties seemed to share the goal of making sense of her symptoms/experience.

Eleanour described her parents’ internal processes associated with their daughter’s diagnosis of depression. She noted surprise and uncertainty as the associated parental affect, which energized parental minimizing behaviours. Eleanour made sense of this response by believing it was difficult for them to acknowledge and accept. As a result, Eleanour felt guilty for negatively impacting her parents, but also expressed the desire that they engage in a process of
coming to understand her experience. Eleanour’s persistent requests to be taken to the family physician was a role she enacted in this meaning-making project, which was seemed to be about making the diagnosis real. However, this role was met with a challenging parental affective response; Eleanour noted,

…so I think when my doctor did say “She needs to, she should be on an antidepressant and I’m going to like prescribe one” um, [my mother] was like super upset and like, I don’t know, that made me feel…um…like, I don’t know, like just made me feel bad that this was like shaking up her life somehow (CON 30).

Feelings of guilt were pervasive in Eleanour’s story of jointly enacted recovery processes. Such feelings emerged in interactions with parents, and also as she recalled such interactions as a part of the research conversation.

Over the course of the recovery journey, Eleanour and her parents have engaged in action specific to making sense of the meaning associated with: certain symptoms, depression and the impact on the family, and a diagnosis of depression more generally. Eleanour described periods of improvement with her depressive symptoms after much formal intervention, but she also saw depression as something that would be a part of her life in some way for a long time. In contrast, it was Eleanour’s view that her mother believed that depression was no longer an issue. These differences in perceptions have implications for joint action related to the overarching/superordinate “recovery project”.

*Managing the impact of depression on the family.* Eleanour described joint action related to managing the impact of having depression on the rest of her family. Eleanour expressed her desire to be able to talk openly about her struggles and her experience, however, she was acutely aware of the negative impact such openness appeared to have on her parents, her
mother specifically. Eleanour and her parents have engaged in actions specific to managing the impact. Eleanour explained,

…Um, my mom and dad used to fight about me a lot and my mom would take it out on me, and so I always felt really bad that I was causing the divide between them…Um, right now they’re, they’re very good, that’s almost why I don’t want to, that’s why I’m sort of settling for this sort of like, just sort of stopping where it is [remaining status quo with treatment] because they, they, they’re not fighting. They think they’re doing a good job and everything (CON 69).

Minimizing and questioning were two steps taken to manage the impact on the family. Both Eleanour and her parents enacted minimizing behaviours; specifically, Eleanour kept her true experience of struggles with symptoms of depression to herself and her parents dismissed her concerns or reassured her that she was fine. Eleanour explained her internal processes associated with her parents reassurance behaviours, she stated, “…I don’t know if it’s for themselves or for me that they say like, ‘No, you’re doing fine, like, you’re way better now’, when really I, I sort of wonder, am I better?” (CON 56). Questions such as, “Why can’t you pull yourself together?”, which were directed at Eleanour from her parents, also appeared to be goal-directed toward managing the impact of depression on the family. Eleanour joined her parents by going along with their perception of things, which was motivated by cognitive processes involving the desire to avoid an argument.

**Support project.** Enacting action specific to support goals was complicated by ongoing joint engagement with other related projects, such as managing the impact of depression. The desire for more support and understanding was an underlying internal process for Eleanour associated with this project. In describing how the support project was enacted, Eleanour seemed
to attempt to balance feelings of dissatisfaction and expressions of wishes with the
acknowledgement of her parents’ efforts.

**Supporting Eleanour in the context of the adolescent-parent relationship.** Despite
feeling as though her parents were less supportive overall, Eleanour was able to identify some
ways in which her mother and father enacted support gestures and aided in the recovery process.
Early parental action reflected a tendency to be accommodating, which appeared to be steered by
uncertainty or ignorance. Eleanour stated,

…they didn’t know how to support me but like when I’d say like, “I really need you to…”
sometimes I’d be like, or if my mom was like angry or stressing me out, I’d be like, “I
really need you to stop talking, like can you just stop pushing me please?” They would
listen and be sensitive to the fact that I couldn’t deal with certain stresses or pressures
anymore (CON 78).

Eleanour appreciated the way they responded to her expressions of needs during this period of
the recovery journey. Her mother’s suggestions to involve Eleanour’s counsellor were met with
two internal responses on Eleanour’s part. One response centred on a perception of the
suggestion as a supportive and caring gesture. A contradictory internal process reflected
dissatisfaction with her mother’s behaviour as it suggested passing responsibility for support
onto another person. It was Eleanour’s view that her mother’s actions were again motivated by
uncertainty about how to offer support in times of struggle. Instead, Eleanour longed for the
opportunity to have an open conversation with her mother about how to be a support when
Eleanour was experiencing anxiety.

Support in the context of Eleanour’s relationship with her father manifested differently
than joint action with her mother. She viewed her father as a better listener and saw their
relationship as a place in which discussing stressful experiences was welcomed. Thus, joint action specific to support in her relationship with her father involved different elements, which resulted in an increasingly positive experience for Eleanour.

There were many ways Eleanour wished her parents would have supported her as a part of this project. Thus, for Eleanour, joint action related to support in the adolescent-parent relationship was associated with feelings of frustration and a sense of being misunderstood. Her longing for more support and understanding was salient in Eleanour’s narrative. Internal processes associated with the telling of her story also emerged as part of the self-confrontation interview. Eleanour identified feelings of embarrassment associated with the way in which she chose to describe her mother in the research conversation. She made clarifying comments about how her mother was not a “mean person”, which appeared to be steered by embarrassment. In the research interview she appeared to attempt to enact a balanced presentation of her mother, and stated,

Um…she is helpful sometimes, in the sense that like I know she wants me to get better and she’s like supportive but um…for a long a time it was like she didn’t know how to react or she just like um…essentially she like just wasn’t educated in the matter. She like just doesn’t know what’s going on with me, or like how is, how is best to support your child in these situations (CON 34).

It appears that Eleanour’s internal process, which included contrasting feelings and cognitions, shaped the way in which she shared her story of joint recovery in the context of this research project.

Longing for connection and support was further identified in Eleanour’s expressed desire to spend more time together as a family. It was her view that her family was “pretty close” and
she found enacting family activities, such as watching TV or playing a game, was helpful in the recovery process. In expressing her wishes, Eleanour stated,

…make more time for me, um, in the sense that, not even like, time as in like actual time, but like be in the mood to be around me. Like sometimes they come home and my mom is like extremely agitated after work and she comes home and takes it out on me and I don’t need that. I want her to have time to be around me in a, in a pos- in a really positive manner (CON 90).

Overall, despite the fact that Eleanour and her parents were working toward the same goal, namely to provide/receive support, their perceptions of helpful actions and the meaning associated with action differed. This resulted in challenges in working toward recovery.

**Accessing formal support.** Eleanour identified the many ways she wished her parents had played a different role in her recovery journey. Specifically, she expressed the desire for her mother to be more understanding and supportive. Indeed, Eleanour’s tense relationship with her mother was central to the story of how her parents have been involved in her recovery journey. This tension was particularly salient in accessing formal support, which was one of the projects that Eleanour and her parents engaged in as part of the recovery process. This project began when Eleanour recognized there was a problem with how she was feeling. She went to see her school counsellor, who then connected her with a counsellor in the community. Eleanour explained that her parents also began to realize something was going on when they were fighting with her all the time and Eleanour was always fatigued. One of the actions Eleanour and her parents took related to this project was going to the family physician, with sleep issues as the presenting concern. Eleanour’s mother took her to the family physician who diagnosed Eleanour with depression. However, it was Eleanour’s view that her mother was not ready to accept the
diagnosis and thus focused on Eleanour’s problems with sleep saying, “We will work on it [the sleep]” and stating a plan to return to see the physician in a few weeks. When Eleanour’s issues with sleep did not improve, she and her mother returned to the family physician who recommended medication.

Eleanour described patterns of persistence on her part to access formal support, such as expressing her needs and suggesting plans, and resistance and reluctance on the part of her parents, including dismissing Eleanour’s concerns and disapproving of plans. These patterns of joint action related to accessing support were woven throughout the family’s involvement with health professionals. Eleanour explained that she and her parents were never on the same page.

The main actions Eleanour took related to this project included: expressing her opinion about helpful and unhelpful strategies, continuing to request formal assistance/intervention, and being argumentative with her parents (particularly mom) when she was met with resistance. Driving Eleanour to and from appointments, attending sessions, expressing opinions regarding helpful strategies, and suggesting the family “work on things” (rather than have professional involvement) were the actions Eleanour’s mother took related to this project. Eleanour’s advice for parents of teens with depression emphasized involving formal intervention; she stated,

Um, the biggest would probably be just to listen to them and ask them about their problems and then to understand that you, that you can’t solve their problems, you may not be able to solve their problems or they might not be able to solve their problems alone. That there’s no shame in getting outside help (CON 87).

Later in her recovery journey Eleanour was connected with the local mental health team, where she continued to receive counselling support. Eleanour viewed this as instrumental in helping her move toward recovery.
Going on medication to treat depression was also one of the joint processes involved in accessing formal support. Proceeding with medication involved a process of requesting (by Eleanour) and rejecting (by mother), ending in reluctant acceptance by Eleanour’s mother. Eleanour stated that she really wanted to take medication, but she could tell her mother was reluctant and sad. For example, she noticed her mother was very quiet in the car ride home after the physician appointment during with medication was prescribed, and did not offer to take her to pick up the medication. Initially Eleanour was uncertain about what to make of her mother’s silence, but later took it to mean that her mother was struggling with her own experience of realizing/acknowledging that her daughter had depression. Eleanour wondered if her mother felt that being prescribed medication for depression made it real.

**Communicating about experience and needs as a functional step.** Communication processes appeared relevant throughout all projects described in Eleanour’s story. Indeed, working toward recovery necessitated communication between Eleanour and her parents. However, enacting communication efforts appeared impeded by conflict in the adolescent-parent relationship, as well as by differences in perception of both the problem and the steps necessary for recovery. Eleanour expressed the desire to be able to disclose her experience to her parents, which motivated action specific to describing her struggles. However, Eleanour felt her efforts were met with misunderstanding, which steered minimizing or diminishing parental behaviours. Eleanour explained,

> I like to tell her things but like, um, I tell her things because I wish she could understand but she doesn’t and ‘cause it makes her feel like…like she’s happy that I can tell her, even though what she says back isn’t necessarily what I want to hear or need to hear (CON 37).
Her mother’s responses to Eleanour’s disclosures reinforced existing difficulties for Eleanour in opening up, and thus further served as a barrier to open communication as a means to enacting recovery goals.

**Assertion**. In enacting recovery-related actions, Eleanour placed herself at the centre, crediting her persistence in advocating for her needs as the element essential in addressing recovery goals. Her efforts were set within the larger relational frame, which appeared to both complicate and contribute to recovery processes. Parental fear and apprehension about a depression diagnosis seemed to act as a barrier to accessing formal intervention, and simultaneously energized joint action specific to recognizing the problem. Eleanour’s desires for connection and support continued to motivate her to engage jointly with parents around recovery.

**Case 6. Fiona**

**Context**. Fiona is a 19-year-old female who was diagnosed with depression when she was 13 years old. She identified the onset of her parents’ involvement in her experience of depression as occurring after she was hospitalized for a suicide attempt. Fiona has been receiving counselling and taking medication since she was diagnosed, and has found both treatments helpful. When asked to use a few words to describe her life, she said, “I don’t know. Compared to what it used to be, it’s very stable.” She lives at home with her mother and older brother in a small urban city on the east coast of Canada. Her parents separated soon after she was diagnosed (2008) and her father was absent from her story of recovery. Indeed, when invited to comment on her father’s involvement she noted that he has not been a part of her recovery process. Her brother was also largely absent from her story and Fiona explained this absence by referencing his own health struggles/issues. At the time of the interview Fiona was enrolled in university classes. When asked to describe where she saw herself in the recovery process, she stated,
…most days now I am pretty good, like, I don’t really get depressed anymore, like I’ll still get like sad and stuff over stupid things (laughs) but, like, for the most part I’m not like depressed. So I’m doing pretty good now. As long as I take my pills and stuff and keep going to therapy and all that, like working through your stuff, so ya. Pretty good (CON 124).

Summary of key case findings. Fiona described much joint action with her mother related to addressing recovery goals. Fiona’s mother was a central support figure in her narrative, which was associated with internal experiences of comfort and guilt. Together they enacted processes specific to navigating the adolescent-parent relationship, which was complicated by parental mental illness and Fiona’s concerns regarding the impact of having depression on her mother (see Table 9). Joint action specific to support was also salient in Fiona’s story, with an emphasis on sharing time and participating in activities. Over time, governance transfer processes appear to have been enacted, with Fiona gaining increasing independence as trust has developed in adolescent-parent relationship and Fiona’s mental health improved. Fiona viewed these latter processes as normative and positive.

Table 9.

Key Projects and Processes: Fiona

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<th>Superordinate Projects</th>
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<td>I. Adolescent-parent relationship project</td>
<td>• Jointly dealing with depression, and the impact on the parent</td>
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<td></td>
<td>• Spending time together as a functional step</td>
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<td>II. Support project</td>
<td>• Safety project</td>
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<td></td>
<td>• Boosting Fiona’s mood</td>
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<td>• Accessing formal help to address depression</td>
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<tr>
<td>III. Independence/governance transfer project</td>
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**Adolescent-parent relationship project.** Overall, Fiona described her mother as integral to her recovery journey, often stating the belief that she could not have coped without her. It was Fiona’s view that the constancy of her mother’s support served to facilitate joint action specific to recovery. The adolescent-parent relationship features centrally in Fiona’s narrative of recovery and is a superordinate project within which subordinate projects are nested. Internal processes specific to guilt and gratitude energized action in the relationship project. The adolescent-parent relationship project has remained relevant to recovery processes since the outset of Fiona’s diagnosis, and although specific projects have evolved over time due to improvements in Fiona’s mood, the relationship project continues to be enacted, incorporating novel processes.

**Jointly dealing with depression, and the impact on the parent.** Fiona described internal processes associated with the impact living with adolescent depression has had on her mother. Fiona’s feelings about her mother’s consistent support during her journey of recovery from depression were varied, and included comfort, reassurance, annoyance, and guilt. Feelings of guilt were particularly salient throughout the self-confrontation interview. Specifically, Fiona expressed guilt about how her behaviour/needs related to depression negatively impacted her mom and her mother’s life. When Fiona was invited to comment on her thoughts/feelings during the self-confrontation interview she stated,

F: (pause) Um…guess I was like feeling a little bit guilty about like doing all that to my mom, like, like taking a lot out of her just to take care of me and stuff.

R: So you were feeling guilty as you recalled what your mom, all that your mom had done for you?

F: Ya.

R: What type of thoughts were you having at that time?
Um...just kind of like realized how much she actually did, because I haven’t really thought about it that much before but ah, ya, like she’s done a lot (SC 6/9).

Fiona went on to express regret about her behaviour, stating, “I just shouldn’t have done that.” (SC 13). In addition to identifying feeling guilty at moments in the research conversation as she relayed her story, Fiona noted that such internal processes emerged in interaction with her mother at times during the journey. Guilty feelings energized reassurance-seeking behaviours on Fiona’s part and together she and her mother had conversations about how the recovery journey has impacted her mother. In this way they were addressing the goal: to clarify the impact of Fiona’s recovery process on her mother and her mother’s life.

It was Fiona’s belief that her diagnosis of depression and the care involved held her mother back from living her own life. Such beliefs seem to reinforce existing feelings of guilt. However, her mother clarified her own experience of parenting a daughter with depression, emphasizing that she did not have any regrets about her approach/choices. Fiona experienced such clarification as reassuring, although her persistent feelings of guilt associated with her own perception of the impact on her mother remained. These feelings were further reinforced when her mother received a diagnosis of depression subsequent to Fiona’s diagnosis (exact date unknown). Fiona described her internal cognitive processes, specifically her belief that it was her fault her mother received this diagnosis. She explained that health professionals told her mother that she had depression because of her daughter. It is unclear how this information was relayed to Fiona and if there was some magnification or distortion associated with the story of her mother’s diagnosis.

Mutual support related to depression became relevant joint action in Fiona’s recovery process once her mother also received a depression diagnosis. Despite her mother’s diagnosis,
she continued to enact the same support role related to recovery. However, Fiona began to enact a different role, which reflected her desire to offer care and support to her mother. This desire motivated Fiona to carry out the same support actions her mother had in caring for Fiona, namely trying to be available to her mother at all times. In this way it appears that both Fiona and her mother were trying to assume the role of constant support to the other as each dealt with depression in their own lives. Her mother’s response/reaction to Fiona’s efforts were not a part of her narrative. However, Fiona’s story included only brief mention of her efforts to care for her mother, and instead emphasized her concerns about how her diagnosis has impacted her mother over time.

This project appeared to be ongoing as Fiona shifted into a new sense of wellness. Fiona continued to work to manage the impact on her mother by clarifying how her support needs have decreased. When prompted to describe how these more recent conversations about the impact of Fiona’s depression on her mom unfold, she stated,

Um, she just basically says that she like doesn’t regret doing anything she did and like she’s glad she was there for me and stuff like that, but I just try to tell her now like, “You don’t have to do that anymore, like, like I’m old enough now, I should be able to take care of myself.” (CON 30).

It appears that both Fiona and her mother are coping better and thus, are shifting away from exploring the impact of depression toward a process of navigating how to engage more fully with their own lives given that each of their struggles with depression are not as significant as they were in the past. Fiona is enacting this new dimension of the recovery journey by pursuing post-secondary education, spending time with her boyfriend, and recognizing the progress she has made.
Spending time together as a functional step. Spending time together sharing in activities and conversations appeared to act as a functional step in achieving relationship goals specific to the larger adolescent-parent relationship project. Fiona described a positive relationship with her mother prior to the depression diagnosis, which seemed to allow them to continue to share in activities during the recovery process. Their shared interests facilitated joint leisure time, which ultimately contributed to the relationship. In addition, Fiona noted that she could discuss any topic with her mother, which suggests a level of connection and trust. Both parties assumed the role of initiator in shared activities and/or conversations about life topics. Engaging in actions related to sharing time seemed to foster the relationship, which ultimately served as the backdrop for the other recovery-related projects and processes Fiona identified in her story. Fiona stated she could talk to her mother about anything and that their conversations covered many different topics; such conversations were initiated by either party. As a result of her improving mood, Fiona described a shift in the utilization of this step, with time together decreasing in favour of spending more time pursuing their own activities and independent relationships. The meaning Fiona attributed to this shift reflected her perception of the normal progression of an adolescent-parent relationship and her improved mood.

Support project. According to Fiona’s narrative, the support project was a superordinate project and often involved clear roles for each party; namely, Fiona’s mother enacted the role of offering/giving support to her daughter during difficult times and Fiona enacted the role of receiver. Fiona described her mother’s execution of this role as unending and consistent, which was evident in her availability for conversations, comfort, or coping recommendations. However, Fiona described some variability in the way she enacted her role in this project. Specifically, she noted that her actions fluctuated between accepting support and disagreeing with/rejecting
support gestures. The former action appeared to be energized by feelings of agreement, while the latter action was energized by anger. Although both she and her mother were working toward the same goal, namely to do what was best/most helpful for Fiona in a difficult moment, Fiona explained that they sometimes disagreed on what would ultimately be most helpful.

Usually in times of distress Fiona’s mother stated a plan or made a request, such as “Take your medication”, and in cases of disagreement Fiona expressed anger and disagreement with the request by withdrawing. Fiona described rejecting behaviours, even in instances in which she may have initially reached out to her mother. In these cases her distress motivated her to approach her mother for support, but her thoughts about the support she wanted sometimes conflicted with her mother’s ideas. In this quote, Fiona highlights the sometimes push-pull interaction between her and her mother around support,

…well I really didn’t want to do any appointments at the time so I was just like really angry the whole time and my mom would just always push me to like do it and, for good reasons I guess, but at the time it was just not what I wanted to do (CON 83).

In the latter portion of this quote Fiona references how she has gained greater understanding about her mother’s perspective upon reflecting on instances in the past. Indeed, much of Fiona’s reflection emphasized the way she came to see the good/helpful intentions behind her mother’s efforts, even if she did not recognize it initially. Internal processes reflecting gratitude seemed to accompany much of Fiona’s story regarding jointly enacted recovery processes.

Fiona described monitoring behaviours enacted by her mother related to Fiona’s mood. Such behaviours enabled her mother to know when Fiona was struggling, without Fiona explicitly informing her. Fiona explained,
…well she always could tell when I was having like a particularly bad day and well she’d usually try and like give me space but she’d still like keep a close eye on me but like when I actually went to her, she’s really supportive and like basically do anything to make me feel better (CON 51).

Being in tune with her daughter’s mood and the behavioural clues about her mental state required her mother to pay attention in an intentional way, reach out to Fiona despite being rejected in past instances, and express openness to her daughter’s mood/experience. In other cases, Fiona noted that she reached out to her mother, which was motivated by Fiona’s struggle with low mood. In this way Fiona expressed her feelings, opened up to her mother, and believed that her mother would understand and act as a support. Informing her mother of her struggles involved a risk on Fiona’s part because there was a chance her mother’s plans for support differed from the support gesture(s) she was looking for, such as in the case of suggesting a hospital visit.

Safety project. Part of the larger support project also involved a safety project, which was jointly enacted as a part of Fiona’s story of recovery. There were times when the goal of keeping Fiona safe became particularly prominent, and other times when it rested in the backdrop of the support project. During these salient moments, Fiona informed her mother of her safety concerns, which was steered by feelings of sadness and fear. This required a certain level of self-awareness on Fiona’s part. In response, her mother expressed concern for her daughter’s safety, communicated understanding, and asked for information from Fiona.

Sometimes Fiona’s mother took her to the hospital and other times she just sat with Fiona until the urge to harm herself passed. Fiona appreciated her mother’s approach to supporting her in these instances. However, Fiona also acknowledged that she would engage in concealing or
minimizing behaviours, such as lying about how she was feeling, if she did not want to go to the hospital and believed her mother would take her there. Thus, she answered her mother’s request for information by minimizing her safety risk/low mood in order to influence the “plan” her mother might suggest in an effort to help Fiona. This is a complex interaction pattern related to safety goals and exemplifies how separate parties can enact joint goals differently.

In cases where they did not go to the hospital despite Fiona’s low mood, she noted that her mother would enact a monitoring role related to safety. In this quote, she described her internal processes associated with her mother’s role: “It’s kind of like a comfort I guess, sometimes it was annoying (laughs) but for the most part it was, it was nice knowing that there was someone who actually cared enough” (CON 57). Such monitoring behaviour suggests her mother was balancing trusting Fiona’s description of her experience with remaining present and engaged in a non-intrusive manner. In a similar way, Fiona was also engaged in a balancing process, with a focus on balancing the degree of her disclosures with her desire for autonomy.

**Boosting Fiona’s mood.** Fiona described how her mother worked toward the goal of lifting her daughter’s spirits when Fiona was feeling low. Actions of this project also appear linked to the larger support project, but are differentiated from projects involving actions related to safety and accessing formal support. Suggesting plans and using humour were two functional steps her mother utilized in working toward lifting Fiona’s mood. Fiona joined her mother in enacting this project by being open/receptive to her mother’s suggestions. Such action seemed to be steered internally by feelings of appreciation. Fiona liked it when her mom made these efforts, even if they did not always have the intended outcome. It is unclear if Fiona shared the goal of lifting her spirits, or if her actions were connected to the adolescent-parent relationship and contributing to the maintenance of this relationship.
Finding enjoyment amongst depression. According to Fiona, finding enjoyment amidst depression was a jointly enacted goal, associated with action initiated by her mother. This appears to be a smaller project in Fiona’s story of recovery and is subordinate to the larger support project. According to Fiona, her mother was motivated to suggest Fiona return to swim class by her understanding of how much this activity used to mean to Fiona. Initial internal processes associated with her mother’s efforts reflected feelings of reluctance, and also anger when her mother insisted on transporting Fiona to and from her classes. Fiona’s affective response was largely steered by the difficulty she was experiencing with getting out of bed due to depression. Her mother was persistent and insistent in her role in arranging pleasant activities, which seemed to be motivated by the belief that swimming would be helpful in the recovery process. Indeed, Fiona described an improved affective state following her swimming class and now views her mother’s insistence as positive.

Accessing formal help to address depression. Another one of the joint projects Fiona described was about accessing formal intervention and was characterized by actions such as: attending therapy and taking medication. According to Fiona, her mother’s role in this project involved consistently driving Fiona to and from all of her appointments to ensure she was able to take advantage of counselling/psychiatric support. Additionally, her mother participated in certain appointments with Fiona, such as those with her psychiatrist. In this way Fiona’s mother was able to share and obtain information relevant to Fiona’s care/treatment. Fiona’s internal processes associated with her mother’s role shifted over time from initial feelings of awkwardness to a later view of it as normal. Over time, Fiona explained that trust has been built in the adolescent-parent relationship, which has allowed her mother to step back from
participating in counselling sessions. However, she continues to enact her transportation role and also remains vigilant in Fiona’s medication monitoring.

Fiona’s role in this formal support project centred on adhering to the plans laid out by her mother, such as being driven to appointments, and by her psychiatrist and further reinforced by her mother, such as taking medication. In this project, Fiona’s internal processes seemed to reflect agreement or acquiescence as she did not identify resistance or refusal with the plans laid out by others. She also participated in psychiatry and counselling sessions, and ultimately held the view that these actions have helped her in the recovery process. Fiona’s ability to engage in actions related to participating in mental health treatment was facilitated by her mother’s transportation actions; thus, accessing formal support was jointed enacted.

**Independence/governance transfer project.** Fiona described a more recent project involved in the recovery project, which was related to Fiona’s care of self and mood-related needs. Fiona’s story of the recovery process has her mother placed at the centre. She described how joint action was central to enacting recovery-related projects. However, Fiona described actions she and her mother have engaged in more recently that signal a shift away from solely joint care efforts and instead move toward self-care. One example of such action is demonstrated by her mother’s decreasing involvement in Fiona’s psychiatric appointments such that she only drives Fiona to and from the meetings and no longer attends sessions. Fiona ascribed meaning to her mother’s action that is associated with increasing trust in Fiona and her ability to take care of herself. Fiona joined her mother in this change in action by agreeing with the shift and continuing to independently attend and participate in her own mental health appointments. Another example was highlighted in Fiona’s description of how her mother has begun leaving her alone overnight, which was something her mother never did in the past. Although not
explicitly outlined in Fiona’s narrative, this shift in behaviour likely required her mother to recognize markers signifying a decrease in safety risks and/or felt an increased sense of trust in her relationship with Fiona. Fiona’s internal processes associated with this transition to greater independence was characterized by positive affect.

Revising the role Fiona’s mother played in this project has required a series of smaller shifts in the cognitions and affect steering her action. For example, her mother had to recognize the signs that Fiona no longer needed her to attend sessions and/or that she was capable of this element of treatment on her own. She had to believe in Fiona and take a risk by stepping back. Although not explicitly stated in Fiona’s narrative, her mother must have felt more comfortable/assured than at the outset of treatment in order to revise her role in this project.

**Assertion.** According to Fiona’s narrative, recovery was jointly enacted in the adolescent-parent relationship and involved a series of smaller projects related to support processes. It appears as though her mother often assumed the role of leader/initiator regarding specific coping measures, which seemed to rest on the strength of the adolescent-parent relationship. Parental mental illness factored into navigating the adolescent-parent relationship, with concerns regarding the impact of adolescent depression on parental health. Guilt and appreciation were common internal processes that served to steer Fiona’s actions related to recovery. Although recovery continued to be jointly enacted, it appears as though Fiona has assumed an increasingly autonomous role, which reflected a jointly negotiated endeavour that occurred over time between Fiona and her mother.

**Case 7. Gillian**

**Context.** Gillian is an 18-year-old female who was formally diagnosed with depression about 1.5 years before this interview. She believes she has struggled with undiagnosed anxiety
since she was a child, and also received inpatient treatment for an eating disorder during her teenage years (date unknown). Gillian lives at home with her mother, father, younger brother, and pets. Her parents have been involved in addressing her mental health since she struggled with anxiety as a child, and continue to play a role as she prepares to transition into adulthood.

Counselling and hospitalizations at crisis points have been a part of the formal intervention Gillian has received for depression. When asked to use a couple of words to describe her life at the time of the telephone screening interview, she stated, “I’m working on it, trying to make things go up”. She later described depression and recovery in her life as an ongoing endeavour:

Um, I think it’s like better than it was but then like obviously I’m still working on it ‘cause it’s not something that like just kinda goes and comes and stuff like that. But I think that like it’s getting better over time that I like work on it. And like, it’s still really hard, but it’s definitely better than it was before (CON 108).

At the time of this research interview, Gillian graduated from high school and was completing a certificate program at a local community college.

**Summary of key case findings.** Gillian’s story of jointly enacted recovery processes with her parents highlighted two overarching projects specific to relationship and support goals (see Table 10). However, communication processes appeared central to the enactment of such goals, with Gillian and her parents negotiating an interactional style that reflected Gillian’s desire for autonomy and her parents desire to be supportive and helpful.
Table 10.

*Key Projects and Processes: Gillian*

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<thead>
<tr>
<th>Superordinate Projects</th>
<th>Subordinate Projects and Processes</th>
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<tr>
<td>I. Adolescent-parent relationship</td>
<td>• Fear of burdening parents as a barrier to joint action</td>
</tr>
<tr>
<td>II. Support project</td>
<td>• Navigating communication processes</td>
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<td></td>
<td>• Balancing autonomy needs in the context of open communication and safety risks</td>
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<td>• Engaging in formal treatment</td>
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<td></td>
<td>• Safety project</td>
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Gillian’s actions specific to communicating about her needs were steered internally by chronic worries about burdening her parents and being a difficult child. Thus, she sometimes did not inform her parents when she was struggling, and instead isolated herself or tried to address her issues on her own.

**Adolescent-parent relationship.** Although not the focus of Gillian’s story of recovery, her relationship with her parents seemed to reflect a joint project related to recovery efforts. This project appeared to act as the backdrop for additional recovery-related action. She described the way in which she was engaging in action specific to gaining independence from her parents prior to her diagnosis of depression. Such action appeared to be motivated by Gillian’s belief that teenagers find parents uncool. However, she explained that through jointly coping with depression, she and her parents have become much closer. It seems as though the actions comprising the support project, which was also a joint recovery-related project, were inextricably linked to this larger relationship project. Affect laden internal processes appeared salient in Gillian’s story of the relationship project, with layered affect complicating interpersonal dynamics.
Fear of burdening parents as a barrier to joint action. Internal processes centering on the fear of being burden to her parents were prominent throughout Gillian’s story. Such processes seemed to energize concealing behaviours on Gillian’s part, which meant she often refrained from reaching out to her parents in times of need. Her parents were aware of Gillian’s fears and beliefs regarding the possible negative impact of her struggles on her parents. In response, they shared their view of Gillian and her needs, expressing feelings of love and care, denying any negative impact. In providing an example of such interactions, Gillian stated,

I think I’m difficult because I know they don’t think I am, like they’re always like, “Don’t worry about it”, like I’ll tell them sometimes…I’ll be upset or something and I’ll tell them the next day and they’re like, “Oh, why didn’t wake us up?” And I was like, “Well, I didn’t want to bother you guys.” And they’re like, “No, always bother us when you need to.” So they’ve always like pushed me to like, “You can bother us.” You know? So then, I know they don’t think I’m difficult, but it’s just kind of like blowing it up a little bit in my head (CON 54).

Despite parental reassurances, at the time of the interview Gillian remained concerned about how her struggles impact her parents.

Support project. Gillian described joint action with her parents specific to giving and receiving support, both in the adolescent-parent relationship and also in the context of formal intervention. The role of her parents in the support project centred on monitoring and inquiring about Gillian’s mood, suggesting coping plans and helping her enact them, expressing understanding by listening openly, changing support behaviours in response to Gillian’s expressed needs and requests, and stating plans related to safety. Gillian’s internal processes associated with her parents’ role included both (a) feeling lucky to have such involved parents
who try to help, as well as (b) desiring increasing autonomy in self-care. Mixed emotions related to her parents’ role in enacting support are highlighted in this quote:

…I feel like they’re really supportive and they want to like try and help me a lot so I think that’s really nice. Although sometimes it like almost bothers me a little bit because they’re trying to like, they like, it’s like, I just almost don’t want to talk about things- I mean like, it’s not like they push me to talk about things, but it’s just that I know that they’re always thinking about like what I’m doing so much, like they’re protective, so then I’m always like, oh, I wish, like sometimes I’ll be like oh I wish I had less protective parents, but then like at the same time I’m like, I’m kinda glad I have parents that care (CON 51).

Gillian’s role in the support project involved determining her support needs, practicing how to make requests for support, considering and trusting her parent’s perspective, and asserting her boundaries.

Gillian commented on how her parents were also always “watching out” for her, which Gillian perceived as helpful as she navigated her life with depression. Gillian described how her parents conveyed their availability and support by welcoming her to sit with them and watch television or inviting her to go on a walk with the dogs. Sometimes her parents invited Gillian to talk about how she was feeling, but they also demonstrated acceptance of her boundaries by listening and remaining silent if she stated she did not want to talk. In these instances, they simply sat or walked together, which Gillian perceived as supportive. This was also viewed as a means of distraction from negative thought processes, which aided Gillian in coping with depression.

Ensuring school attendance was another goal that was jointly enacted as part of the support project. Gillian’s desire to ensure regular school attendance was energized by the
recognition of how positively it impacted her mood. This recognition was also balanced with an understanding of when she needed to take one day off for self-care. However, it was difficult for Gillian to consistently engage in self-motivated school-morning related action on her own. Thus, Gillian described the way she explicitly asked for parental support related to this goal. Specifically, she requested that her parents fulfill an accountability and motivating role related to this goal. It appears that her parents were able to enact this role following Gillian’s explicit request.

**Navigating communication processes in the adolescent-parent relationship.**

Communication processes were pervasive throughout Gillian’s story of joint action related to recovery. It appears that communication was the primary recovery-related action that occurred jointly between Gillian and her parents. However, this action also seemed to contribute not only to the support project, but also to the relationship project. Indeed, Gillian indicated that being able to talk to her parents when she needed to was the element that contributed most significantly to the improvement in their relationship.

Communication served as the functional step through which support goals were achieved. Such processes evolved over the recovery journey, reflecting a shift from problematic communication, which undermined support efforts, to processes with clearly outlined roles for Gillian and her parents. This transformation in processes was an active endeavour involving Gillian and her parents. At the outset of the recovery journey, Gillian described withdrawal behaviours, which were energized by the desire to be independent and separate from parents. It was Gillian’s view that this was a normative approach consistent with becoming a teenager. At the same time, it seems her parents enacted probing parental behaviours, “pushing” her to talk to them at times; their efforts appeared to be steered by feelings of worry related to her well-being.
In these ways, Gillian and her parents’ support-related goals appeared to be in conflict. Gillian described internal processes at this time that were characterized by frustration and anger. In addition to acting as a barrier to communication, these internal processes also seemed to undermine the adolescent-parent relationship.

Over time, as Gillian and her parents continued to navigate recovery from depression, communication patterns evolved such that Gillian was able to express her wishes/needs and her parents were able to listen. One route that facilitated this evolution was joint participation in formal intervention. With the assistance of a counsellor or psychiatrist, Gillian commented on how she was able to ask for the kind of support she needed from her parents. Together Gillian and her parents negotiated a process of communication that allowed Gillian to assume the role of initiator of/leader in conversations specific to her mental health/mood and her parents enacted a follower role. Gillian explained that when her parents allowed her to take the lead in initiating conversations, she was more likely to reach out to them. In this way it felt as though communication was on her own terms, thus in her control. She stated, “…they’d always be pushing me to talk about things and it would just make me frustrated with them, but now that I can just like bring up stuff when I want to, I’m a lot more open with them” (CON 15).

Navigating communication processes continues to be relevant to the recovery journey as Gillian’s internal experience of expressing needs, or even having needs, is associated with tremendous guilt. Such affect seems to contribute to a negative cognitive process, which reflects her beliefs about being a burden to her parents. Thus, although Gillian and her parents appear to have found an interactional style related to giving and receiving support, Gillian’s internal processes continue to impact her willingness to ask for parental support.
Balancing autonomy needs in the context of open communication and safety risks.

Gillian referenced how her stage of life, namely being a teenager, meant that she desired increased space and privacy in her relationship with her parents. Autonomy needs emerged primarily as it related to communicating with parents about her feelings/experience. Gillian appeared to be navigating how to communicate openly with her parents in a manner that felt right, as this contributed to achieving support goals. It seems as though Gillian engaged in a mini self-assessment as one aspect of navigating this process. Specifically, she described the way in which she would check in with herself to ascertain her mood before proceeding in a conversation related to recovery and depression with her parents. For example, Gillian explained, “…like then I like think about it more, like okay do I want to talk about it? Or do I not? So then like I do talk about things with them when I’m like feeling like it” (CON 45). This seemed to require a level of self-awareness regarding emotional state, and in this way self-awareness seemed to act as a functional step in deciding whether or not to open up. According to Gillian, a “neutral mood” was seen as the ideal context within which to initiate open and personal conversations with her parents.

Autonomy needs also emerged in Gillian’s description of actions specific to the safety project. According to Gillian, her parents became “overinvolved” in her life directly following her self-harm/suicidal gestures. Their behaviour appeared to be steered by feelings of fear for Gillian’s safety. Although Gillian commented on understanding her parents’ perspective, she also described her own conflicted internal processes associated with her parents’ action; she noted,

…they’d be like looking around my room and like checking through everything and that would like bug me so much. So then it would like make me frustrated at them, but at the
same time I didn’t want to be frustrated with them because I know they’re trying to help, so that would just be like, it would just be like this constant conflict like, “Oh my god, they’re so frustrating, but they’re just trying to help.” (CON 95).

Such processes seemed to also impact relationship goals as her feelings of frustration energized withdrawal actions, which interrupted connection between Gillian and her parents.

**Engaging in formal treatment.** Gillian and her parents jointly initiated the formal treatment project when Gillian was a child struggling with anxiety. Although the early action specific to formal treatment was not a focus of Gillian’s story nor of this research project, she referenced an early role enacted by her parents related to organizing and accessing formal intervention. This role appeared to continue for Gillian’s parents when she began to struggle with depression in her later adolescent years. Gillian joined her parents in this project by participating in counselling sessions, sharing her feelings and experiences first with the counsellor, and later with her parents in joint sessions.

Gillian’s story highlighted the way in which formal intervention existed both as a project, with goals related to coping with depression and getting well, and as a functional step in communication goals. With regard to the latter, navigating communication processes was a primary joint endeavour between Gillian and her parents, and counselling sessions served as a vehicle toward enhancing communication; this ultimately contributed to both the support project and the adolescent-parent relationship project. Specifically, Gillian viewed the counselling room as a supportive context within which to identify concerns and make specific requests for parental support. Gillian discussed how her counsellor aided her in expressing her support needs, such as having the permission not to talk about her feelings, to her parents who also attended the session. She explained,
…I talked to that counsellor separately and mentioned that so then they helped bring it up in conversation and that helped a lot I think. ‘Cause it’s hard to like say like “I don’t want to talk to you necessarily.” Especially if it’s your parents and they’re like trying to make sure you’re alright, but I think I had that extra bit of help then that was a plus (CON 44).

Thus, in formal intervention contexts Gillian was able to describe her internal processes, make support requests, and clarify perceptions of the impact of depression jointly with her parents.

Action enacted in the context of formal intervention further contributed to the support project and adolescent-parent relationship beyond the counselling session. Gillian elaborated on how practicing communicating about needs and boundaries with parents in counselling sessions ultimately enabled her to initiate similar conversations outside of the session. She described instances in which her parents asked how she was doing to which she was able to state a boundary (“I don’t want to talk about it now.”). Gillian commented on how she perceived her parents as respecting her boundaries when they did not “push” her to talk. As a result, she felt more positively about the relationship, and indicated that she was more likely to reach out to them in the future. Thus, action enacted jointly in the counselling sessions facilitated successful experiences of support, as perceived by Gillian, and enhanced the sense of connection she felt in her relationship with her parents.

**Safety project.** As a part of her story of jointly enacted recovery, Gillian described periods of hospitalization due to concerns regarding her safety. It appears that Gillian and her parents worked toward opposite goals in instances in which safety related action was being enacted. Specifically, Gillian commented on her lack of desire to get better or to engage in action related to getting better. However, it was Gillian’s view that her parents wanted her to get better, and thus enacted protective actions, such as requiring that she be hospitalized. In this way,
Gillian’s parents took control over Gillian’s mental health care, removing Gillian’s autonomy in this life domain. The conflict in goals and subsequent behaviour was associated with feelings of frustration on Gillian’s part and feelings of sadness on her parents’ part. However, as Gillian reflected back on these instances during the research conversation, she commented on feeling appreciative about her parents’ actions. Thus, the meaning associated with the safety project has shifted for Gillian over time.

**Assertion.** Navigating communication processes was fundamental to the way in which Gillian described recovery as joint, goal-directed action in the context of her relationship with her parents. Developing and maintaining a sense of autonomy in the recovery journey appeared to be a goal that motivated Gillian’s joint actions. Gillian’s ability to ask for support in a way that met her autonomy needs and her parents’ ability to respond by assuming the role of follower, and for each to trust one another in the process, appeared to contribute to successful experiences of support and to the adolescent-parent relationship.
Chapter 6: Discussion

This dissertation sought to understand how adolescents describe processes of recovery as jointly enacted both successfully and unsuccessfully in the adolescent-parent relationship. In particular, it explored the actions, projects, and internal processes associated with adolescent perspectives on recovery as embedded in a primary relational context in an effort to better understand how this relationship is important to recovery. This discussion builds on the findings outlined in the cross and within case analysis by drawing on existing relevant literature, highlighting connections with previous research, and detailing new contributions to the field of adolescent recovery from depression.

This chapter begins with a brief review of the research problem that initiated the rationale for this research, and then details how the findings from this research address the guiding research question, as well as complement and deepen existing literature on depression and recovery in adolescents. An exploration of the implications of these findings in theoretical and counselling domains follows. Finally, the chapter closes by addressing study limitations and pointing to further avenues of research related to understanding recovery in adolescence, particularly as it relates to salient relational contexts, including parents, peers, and health professionals.

Summary of the Research Problem

This research project emerged from a solid body of literature identifying both the significance of depression in the lives of youth and the fundamental role of parents in the illness and recovery trajectory. An understanding of how parents enacted recovery efforts jointly with their adolescent children is largely unexplored in this field. It is clear that depression in adolescence is a significant health concern with implications for functioning in adolescence, as
well as for the transition into adulthood (e.g., Health Canada, 2002). Gender-based trends (e.g., Fichter et al., 2009) with high recurrence rates (e.g., Essau et al., 2010), suicidal ideation (e.g., American Psychiatric Association, 2013), and challenges to interpersonal functioning (e.g., Hammen, 2009) are factors associated with the disorder, which makes depression an important health concern.

The significant role for parents in the onset and maintenance of depression has been well documented (e.g., Leavey, 2005; Lewandowski & Palmero, 2009), with factors such as parental mental health (Murray & Cooper, 2003) and family cohesion (e.g., Erdem & Slesnick, 2010) cited as predictive in adolescent mental health. Despite increasing emphasis on family-based interventions targeting depression at an individual and familial level (e.g., Carr, 2008; Moran & Diamond, 2008; Mufson & Sills, 2006), there is limited research describing how recovery efforts in the adolescent-parent relationship are enacted. This study emphasized this relational context and associated implications for recovery by investigating how adolescents described and viewed their parents as jointly involved in action specific to recovery goals.

**Summary of the Findings**

Existing literature on recovery efforts for youth, beyond treatment outcomes for various protocols (i.e., CBT, IPT), is limited. This research adds to the growing literature base on recovery from depression in adolescence by closely examining the recovery-related actions, goals, and processes of the adolescent-parent relationship. Findings highlight the joint- and goal-directed/intentional nature of recovery actions and projects in the context of the adolescent-parent relationship. According to these adolescent participants, they worked together with parents on projects related to recovery that included: navigating the adolescent-parent relationship in the context of depression and safety concerns and accessing and participating in
formal and informal support processes. Goals associated with relatedness and autonomy, as well as governance transfer were also identified, with issues of trust and guilt as regulating and energizing factors.

**Response to the Research Problem**

The findings of this study contribute to understanding recovery from depression in adolescence as embedded in the larger ecology of the lives of these young people. A relational emphasis on addressing mental illness has been advocated for in the recovery literature (e.g., O’Grady & Skinner, 2012; Onken et al., 2007; Ungar et al., 2008). However, research exploring such domains is in its infancy. Family level factors, such as family cohesion, have been identified as fundamental to the depression and recovery trajectory (e.g., Cumsille & Epstein, 1994; Erdem & Slesnick, 2010; Kangas, 2001). The current research responds to the call for additional investigation into how joint adolescent-parent actions and goals contribute to recovery efforts. By prioritizing adolescent voices about joint actions and goals in their relationships with parents, this study captured unique and rich stories of how adolescents and parents jointly constructed and participated in recovery goals, as experienced by the adolescent. Set in the larger framework in which participants described recovery as a joint and intentional project, findings from this study highlight the intricate and complex internal processes and meanings associated with recovery in the adolescent-parent relationship.

**Navigating the Adolescent-parent Relationship in the Context of Depression**

Relational connection with significant adults has been cited as a key component of managing depression. Support from a larger relational system has been identified as an important element in recovery (e.g., Leavey, 2005; Noiseux et al., 2010; Onken et al., 2007; Ungar et al., 2008), but the question of how this element is enacted has remained largely unanswered. This
research makes a contribution to gaining an understanding how one relational system, namely the adolescent-parent context, engages in joint, goal-directed action specific to recovery.

For many of the participants in this study, depression as a health issue changed the nature of their relationship with parents. Such a change in relationships with significant adults has been identified in earlier research exploring the lived experiences of adolescents with depression (e.g., Draucker, 2005; Farmer, 2002; Leavey, 2005), and has emphasized experiences of isolation, minimized/diminished suffering, and a sense of disconnection. Although similar experiences were expressed by the adolescents in this study, the findings diverge from existing literature by clearly describing a component of active engagement in the adolescent-parent relationship. Specifically, the current research highlighted a process in which adolescents and their parents worked together toward recovery-related goals, thus engaged in a relational endeavour. It is possible that focusing on this relational context as it related to recovery created space for these discourses of active relational engagement.

Research suggests that individuals engage in an active process of meaning-making around living with depression (Kangas, 2001). In this study, the meaning participants and parents ascribed to depression impacted the way in which they worked together on tasks specific to being in relationship with one another. For example, many parents and participants appeared to view depression as an issue that could be addressed through a series of steps, such as organizing and participating in counselling and commencing medication treatment. This view seemed to facilitate joint action(s) as initiated when adolescents informed their parents of challenges and concerns, with the goal to collaborate with parents around managing issues. Collaborating in this way reflects intentionality specific to both preserving and enhancing the relationship while treating depression. With regards to this relationship navigation project, participants described a
process of using communication and actions related to support goals as avenues to address relationship goals. Processes specific to enacting such goals appeared to be regulated by trust and emotional safety, and energized by feelings of guilt regarding negatively impacting parents.

**Trust as a regulating force.** Research exploring adolescent perspectives in the onset and process of living with mental illness has documented changing social status subsequent to diagnosis, wherein adolescents felt they were viewed by others as less able to be self-determining (e.g., Leavey, 2005). Similar experiences were described by participants in this study, and were directly linked to navigating the adolescent-parent relationship. However, the change in social status seemed to be less about stigma, as reported by Leavey, and more about issues of trust. The salience of trust as a mechanism impacting social status at the familial level was highlighted in examples of relational processes subsequent to parents learning about their daughter’s mental health struggles. Specifically, some participants cited these instances of parental awareness as a point at which trust in their relationship with parents was broken or challenged. Relational ruptures can damage trust in familial relationships and often become a focus of targeted intervention in attachment-based family therapy treating depression (e.g., Moran & Diamond, 2008). In the case of these adolescents’ stories, it seemed that for some parents, learning of the degree of their daughters’ struggles seemed to rupture the relationship, challenging existing levels of trust. According to these adolescents, it became difficult for parents to believe that they could be independent in their mental health care.

Research has found that increases in depressive symptoms predict decreases in perceptions of independence support in the adolescent-parent relationship (e.g., Van der Giessen et al., 2014). Findings from the current research illustrate similar processes as evidenced by participants’ stories of increased parental involvement in the adolescents’ lives subsequent to the
recognition of depression symptoms. These findings further deepen our understanding of such processes by suggesting that trust, as impacted by depressive symptoms, was directly linked to autonomy-granting. Specifically, parents were seen as reducing opportunities for autonomy in an effort to ensure their daughters were safe and accessing relevant care.

Although these adolescents expressed understanding regarding their parents’ autonomy-reducing actions, they also expressed the desire for independence and self-determination, particularly related to treatment choices. For some, being self-determining regarding medication reflected their knowledge of self (e.g., “I know that I need the medication to help me sleep”) and was an important aspect of working toward wellness goals. Internal processes associated with decreasing autonomy included annoyance and frustration, which sometimes energized rebelling actions, such as verbal fights and/or withdrawal and disengagement. However, opposite action was also enacted in response to reductions in autonomy, and appeared to be steered by a sense of understanding about parental rationales and associated decisions. In these cases, adolescent actions included going along with parents’ plans/requests, participating in joint counselling sessions, and attempting to engage in open communication outside of formal treatment. In these ways, participants appeared to be working toward goals regarding maintaining the adolescent-parent relationship, while also working to rebuild trust.

**Attending to the perception of the parent experience.** Awareness of the impact of depression on their parents’ lives was salient in the participants’ stories. This awareness was linked to a number of different instances in which they (a) observed a parent emoting in response to their daughter’s mental health, (b) perceived the impact on the lives of parents, or (c) worked to take the perspective of their parent(s). Witnessing expressions of emotion impacted participants in different ways. For some, the meaning they ascribed to parents’ expressions of
sadness was that of care, concern, and love. When viewed in this way, participants were motivated toward changing actions, such as refraining from suicidal gestures and communicating more openly about their experiences. In these ways, participants appeared to contribute to relationship goals while also enacting actions specific to recovery.

In a review of family-based psychosocial treatments for youth with depression, Tompson et al. (2012) highlighted findings demonstrating links between parental expressed negative emotion and negative mental health outcomes. Although the current study was qualitative in nature without a focus on outcomes, findings provide a fuller understanding of such links by elucidating adolescent meaning-making processes associated with parental expressed emotion. Specifically, participants also appeared to take ownership of their parents’ emotions, perceiving themselves as to blame. This was particularly true for participants who found it unhelpful and distressing when they saw their parent express emotions. Internal processing in these cases emphasized self-directed blame, which compounded existing feelings of guilt and remorse for struggling with depression. Tone and Tully (2014) referred to such experiences as risky empathy, which has been associated with increases in the likelihood of internalizing disorders. Specifically, they identified three dimensions of problematic empathy citing “…reactions to others’ distress that (a) are excessively aversive, (b) involve excessive cognitive perspective taking, and/or (c) result in self-focused comforting responses or self-focused rumination about one’s role in the observed distress” (p. 1553). Participants commented on both the pain they experienced as a result of observing their parents’ emotions, as well as a process of rumination regarding their perceived role in the distress of their parents. Thus, this research points to both adaptive and maladaptive responses to observing parental emotion, which has implications for both the adolescent-parent relationship and recovery goals.
Research investigating parenting behaviour has demonstrated that positive behaviour, such as approving, validating, and humour, is associated with lower levels of depressive symptoms (Schwartz et al., 2012). In contrast, negative parenting behaviour, for example, angry affect, annoying and argumentative verbal statements, is associated with higher levels of depressive symptoms. Some participants in this study referenced difficulty coping with parents’ expressions of anger and/or when arguments ensued. Although a qualitative study precludes casual links, participants viewed parental anger and/or arguments as a barrier to working together toward recovery goals. In such cases adolescents often disengaged or withdrew, and/or perceived their parent as unsupportive or not a resource in coping with depression. Such disengagement behaviours further appeared to impact actions specific to enhancing the relationship and/or fostering connection.

**Guilt as energizing action.** Parents and adolescents were engaged in joint action specific to understanding the impact of adolescent depression on parents. According to Schwartz et al. (2012), parenting behaviours and the associated emotional quality shapes the “emotional climate of the family” and thus, impacts adolescent psychosocial development (p. 59). In interactions with participants, parents’ displayed observable behaviour (crying) to which adolescent participants reported ascribing self-blame meaning. Responsive action generated by adolescents was either (1) resolve to do better, (2) shifting the focus (from hurt to humour), or (3) concealing behaviours, all of which appeared to be affectively steered by guilt. The latter two responses are consistent with Draucker’s (2005) findings related to how adolescents attempt to block or minimize/conceal their experiences in an effort to maintain the façade of normality. In the case of this research, shifting and concealing behaviours acted as functional steps designed to decrease the burden on parents. Parental emotional expressions resulted in distress and amplified
feelings of guilt, thus illustrating risky empathy processes and “maladaptive affective responses” (Tone & Tully, 2014, p. 1554).

**Balancing connection and autonomy project.** These adolescents expressed goals specific to meaningful connection with parents throughout the recovery project. Desire for connection has been described in other studies of adolescent mental illness and attachment (e.g., Bostik & Everall, 2006), and such connection has been linked to self-identified positive outcomes for adolescents with depression (e.g., Draucker, 2005). According to adolescents in this study, connection represented caring, support, and interest, and was jointly enacted by actions such as: sharing in tasks of daily living, enjoying simple leisure time, and communicating about struggles and successes. Alongside opportunities for connection, these participants identified the goal for self-determination and self-care as it related to recovery from depression. In this way, adolescents sought a balance between connection and independence, which featured centrally in efforts regarding navigating the adolescent-parent relationship. Such findings illustrate contemporary perspectives on independence needs in adolescence specific to the adolescent-parent relationship, which emphasize both relatedness and autonomy as relevant to the tasks of adolescence (e.g., Beyers et al., 2003). In addition, findings from this research deepen our understanding of how this developmental task is enacted in the context of adolescent depression (e.g., Inguglia et al., 2014; Pavlidis & McCauley, 2001).

In a confirmatory factor analysis (CFA), Beyers et al. (2003) identified connectedness as one of four factors associated with autonomy in adolescence. Defining characteristics of this factor included closeness, reciprocity and trust in parent-adolescent relationships, and a perception of parents as available and easy to communicate with. Connectedness was further unpacked by findings from the current study with participants describing it as a jointly enacted
project comprised of intentional action designed to achieve closeness, trust, and comfort in the adolescent-parent relationship. Many participants in the current study referenced views of their parents as available and receptive to discussing their concerns/struggles. However, this was not a process that seemed automatically present at the outset of the recovery journey, but rather emerged as a result of shared cognitions regarding the desire to connect, as well as repeated actions associated with coming together and attempting to share experiences/perspectives.

There were variations in the degree to which action directed at sharing time was perceived as successful. For example, participants described instances in which their parents stated possible plans (e.g., “Let’s go for a walk”) and the participants did not feel up to it or were seeking time alone. In these cases, participants either rejected their parents’ plans or agreed but felt annoyed. Parent attempts at, or gestures of, connection were generally appreciated by adolescents in the larger scope of their relationship. However, as a part of separation and space-seeking, adolescents pushed back against offers at times. In one case, a participant described her parent as enacting dismissive actions, which also seemed to act as a barrier to engaging in joint action related to connection goals. Overall, experiences of connectedness were the result of intentional and goal-directed action between adolescents and parents over time.

The desire for space and self-determination was also prominent in the stories of these adolescents as they discussed aspects of navigating the relationship with their parents. Competence, self-governance, and self-directed behaviour are components of autonomy in adolescence (e.g., Beyers et al., 2003). Research has demonstrated a link between increased parent connection and lower rates of depression (e.g., Erdem & Slesnick, 2010), as well as increased autonomy and lower rates of depression (e.g., Van der Gissen et al., 2014; Yap et al., 2014). However, the complexities inherent in the balance between connection and autonomy in
an adolescent-parent relationship with a history of safety risks and mental health concerns have been largely unexplored in the research. How can parents and adolescents negotiate a constructive/adaptive balance when trust and safety have been compromised via depressive symptomotology? Findings from the current study illuminate possible processes enacted in the adolescent-parent relationship related to navigating autonomy and connection goals in the context of depression. Specifically, this research suggests that for certain adolescents and parents achieving some manifestation of balance in such a context requires the passage of time, which represents distance from the safety threat, and the adolescents’ demonstrated capacity for self-governance.

Affective steering related to action appeared high for parents directly following a safety threat. Participants identified fear, terror, and confusion as emotions their parents experienced during and directly after suicidal gestures/events. As such, parents adopted an increasingly vigilant/constricting stance regarding participants’ bids for autonomy. Such a stance may serve to compromise successful interpersonal functioning for these adolescents as research emphasizes the importance of both connection and independence within the family (e.g., Tompson et al., 2012). Thus, the affective and cognitive steering actions specific to safety goals may impede parents’ ability to also enact actions related to broader and less acute goals pertaining to supporting healthy interpersonal functioning in their child, such as fostering opportunities for self-governance.

**Emotional safety as a regulating force.** Previous phenomenological research exploring adolescent perspectives on living with depression identified a sense of “emotional homelessness”, which was characterized by feeling unworthy and unsafe in relationships with family members (Farmer, 2002). With regard to the current study, emotional safety was raised by
participants as a factor that either (a) facilitated communication and connection in relationships with parents when present, or (b) served to impede both when threatened. According to participant stories, indicators that emotional safety existed within relationships with parents included (i) adolescents feeling comfortable to open up to parents, (ii) adolescents perceiving openness in parent responses to disclosures, (iii) parents respecting boundaries when the adolescent did not want to share/disclose, and (iv) adolescents believing that parents were genuinely interested in spending time together. These indicators suggest links to a quantitative body of research on parental warmth, which has been characterized by: positive regard for the adolescent, pleasant shared interactions, and involvement in the adolescent’s activities and has been associated with lower levels of depression (Yap et al., 2014). Thus, findings from this research suggest additional possible dimensions of parental warmth by identifying a role for emotional safety.

In these cases, safety was enhanced through spending connected time together. However, in order to be receptive to spending time together, emotional safety needed to already exist to a certain degree. Thus, emotional safety was needed for and enhanced by connection with parents. Many participants referenced experiences of spending and enjoying time with parents. Some adolescents were able to make explicit requests for time together and others expressed receptivity to parent suggestions of shared time. In these ways, parents and adolescents worked together to organize time for connection. Thus, participants did not assume a solely passive role in this joint goal, but instead adopted an agentic approach to accessing feelings of affection. According to participant stories, parental suggestions regarding joint actions specific to connection were rarely met with rejection. Thus, both parents and adolescents largely appeared
to be active in fostering relational connection, which suggests a sense of agency in addressing the potential experience of emotional homelessness as described by Farmer (2002).

There were two case exceptions to an overall sense of agency in parental connection where participants instead felt their opportunities for connection with parents were lacking. In these cases participants’ cognitions regarding parent receptivity to shared time impeded self-directed/initiated action related to the goal of connection. More specifically, these participants held the belief that their parents were uninterested and/or annoyed with/by the participant. Van der Giessen et al. (2014) described the negative beliefs characteristic of adolescents with depression and asserted that such belief patterns act as barriers to recognizing and utilizing support from others, and further serve to increase the likelihood of anticipating rejection from others. It is possible that internal processes similar to those described by Van der Giessen et al. were relevant to the cases included in this study and served to steer these adolescents’ actions related to shared time with parents. However, such internal processes were experienced as true for these adolescents, and thus irrespective of objective perspectives, are relevant to and valuable in understanding joint recovery-related action. It is possible that these adolescents who perceived a lack of opportunities for parental connection felt emotional safety in the relationship was lacking, which prevented or acted as a barrier to connection.

When emotional safety was not present, adolescents identified a tendency to disengage and/or push back with angry expressions. Previous research has found that lack of disclosures on the part of the adolescent can compromise connection in relationships (Simonds, Pons, Stone, Warren, & John, 2014). The current research is illustrative of such findings by highlighting a circular interaction pattern in which failure to disclose restricted the relationship, but disclosures
depended on emotional safety, which further depended on connection within the adolescent-parent relationship.

**Identity and autonomy project.** Independent, self-sufficient, and private were qualities most of these participants used to describe themselves prior to the diagnosis of depression. They asserted that in order to cope with depression, they had to change the way they related to themselves and others. Such a process aligns with the idea of relational transformation as described by Simonds et al. (2014), which emerged in adolescents’ narratives of the experience of depression and anxiety and the involvement of services. Transformation was linked to “loss of self”, which occurred via an interruption of the way the adolescent related to self and others (Simonds et al.). Such experiences of loss have been cited by other authors in the field (e.g., Leavey, 2005). The current study elucidates additional dimensions relevant to relational transformation by emphasizing how adolescents’ internal processes energized their engagement in joint action. Specifically, navigating this transformation was steered by affect such as annoyance, awkwardness, and hopefulness, as well as cognitive processes involving the acknowledgment of the need for support to make change. Needing support challenged these adolescents’ existing beliefs about how to engage with self and others. Ultimately, these internal processes translated into continuing with concealing behaviours (Draucker, 2005), such as silence and withdrawal, as well as attempting revealing behaviours, such as expressing aspects of their experience in sessions with professionals and parents.

From a Contextual Action Theory (CAT) perspective, identity is socially embedded and thus joint action constitutes the social construction of identity (Young et al., 2011b). Both concealing and revealing behaviours involved joint action with parents. As a part of the identity project, participants engaged in action specific to preventing parental awareness, which was
experienced as congruent with their sense of self prior to the diagnosis, namely independent and private self perceptions. When participants shifted the way in which they related to others, they then engaged in revealing behaviours, which were met with a variety of parental responses. Parents joined adolescents in working toward support and recovery goals by also enacting revealing actions, including listening, asking for clarification, and sharing their own experience and perceptions. At times, adolescents took risks opening up to important adults, and parents made attempts to join their daughters by attending sessions, expressing their perspective on concerns, and listening to their daughter’s perspective in sessions. In these ways, identity was co-constructed. Over time, the meaning associated with openly communicating both within and outside the counselling session evolved. This reflected a shift in initial identity congruent behaviours, such that participants identified the value in opening up and receiving support and commented on how communicating openly allowed them to interact more easily with parents around depression care tasks.

**Governance transfer processes.** A relevant task associated with the adolescent transition to adulthood is governance transfer, which occurs in the context of the adolescent-parent relationship. It has been defined as the process of transferring responsibility for domains of life from the parent to the adolescent (e.g., Young et al., 2008). Findings from the current study expand the literature base on governance transfer (e.g., Young et al.) by elucidating such processes in the context of adolescent depression. This study identified transportation and tasks of daily living as examples of governance transfer domains. In addition, findings demonstrated that governance transfer was enacted in the transferring of responsibility for the management of depression-related care. Participants described the way in which their parents were involved in their depression care, which initially emphasized parents as central, acting as a driving force in
arranging and organizing formal treatment, giving medication reminders, and participating in
counselling sessions. Such involvement was met with both resistance and acceptance on the part
of the adolescent. Resisting behaviours, including arguing and remaining silent in session,
appeared largely steered by annoyance and a sense of intrusiveness. Accepting behaviours,
which also included silence as well as communicating perspectives, were steered largely by the
belief that parental efforts emerged from a place of caring.

Regardless of the adolescents’ behaviours, parents figured significantly in early tasks of
depression care. Actions shifted as time passed and some parents decided to no longer participate
in sessions, instead transferring responsibility for engaging in formal treatment over to their
daughter. It is unclear how this was negotiated, but some adolescents described positive affect
associated with their parents’ decision and ascribed meaning that reflected parental gestures of
trust. In this way, it seems that the social status participants in this and other research
experienced as decreasing at the outset depression (e.g., Leavey, 2005) was regained over the
course of joint action directed at coping with depression.

Support Project

Second only to the adolescent-parent relationship navigation project, the support project
was central to the way in which these participants described recovery-related joint action. This
aligns with previous qualitative research highlighting adolescent views of parents as “partners”
in the recovery process (e.g., McCarthy, Downes, & Sherman, 2008). Within the support project
of the current research there were two categories of support, namely formal support and informal
support. The former support category refers to treatment that occurred within the health care
system, including counselling and psychiatrist appointments, and the latter refers to support
efforts that were enacted in the adolescent-parent relationship. In both categories, parents joined
their daughters in working toward treatment goals at an instrumental, such as transportation or arranging extracurricular activities, and emotional level, such as participating in treatment sessions or listening to their daughters’ experiences.

**Joint action involved in formal intervention.** Parents’ instrumental support actions specific to the larger formal support project were referenced in most adolescent stories of jointly enacted recovery-related endeavours. Transportation was commonly cited as the primary instrumental role, and participants explained how such a role facilitated access to treatment, which was seen as an agent of change toward healthy coping. Descriptions of how travel was arranged and/or negotiated were not provided, but adolescents identified feelings of gratitude as associated with such efforts. Similar perspectives have been described in qualitative research on young adults’ retrospective accounts of living with depression, citing respect for parents and their support efforts/gestures (McCarthey et al., 2008). Some participants in the current study described the reassurance parents experienced as a result of ensuring their daughters made it to and attended counselling appointments. Such reassurance seemed to address parental feelings of worry and fear regarding their daughter’s health and safety. At times, participants reported feeling annoyed with parents for making them attend such appointments. However, all participants cited benefits received via participation in formal intervention, including the opportunity to learn strategies and obtain support about communicating with parents.

The parental role for providing such instrumental support is largely absent from the recovery literature. This seems to be in favour of emphasizing possibly more significant roles for parents, for example, providing an emotionally warm climate in the family home (Schwartz et al., 2012). The findings from this research highlight a clear avenue for joint action related to recovery roles that facilitates further recovery action, and ultimately supports the overall goal of
coping with depression. In recognizing the different levels on which parents and adolescents join together, it is possible to expand our understanding of the relational embeddedness of recovery action.

Family-level treatment for depression in youth has demonstrated positive outcomes via interventions targeted at repairing ruptures (e.g., Moran & Diamond, 2008) and addressing role conflict and interpersonal skills (e.g., Young et al., 2009). Findings from the current study illustrate these outcomes and also provide a fuller understanding by illuminating the features of jointly enacted therapy that these adolescents saw as contributing to positive change in the family, as well as in the experience of depression. Participants described a process of evolution in the social meaning and internal processes associated with parental involvement in formal treatment. Initially, joint sessions were viewed as problematic and intrusive, leaving participants feeling annoyed and uncomfortable. Such internal processes often acted as barriers to adolescents’ open participation in session. However, as joint treatment continued, some participants commented on how they came to recognize the value in parental involvement. Listening to their parents describe their perception of their daughters’ functioning and challenges highlighted the degree of disconnect in perception. Specifically, participants witnessed the contrary view their parents held about progress and health. Thus, consistent with literature detailing the processes of family therapy and interpersonal therapy, as well as the benefits of these treatments, (e.g., Moran & Diamond; Young et al.), the sessions became a place for clarification and needs requests, as well as an opportunity share in a perception of the issue, such as depression symptoms and experience, and necessary next steps.

Ultimately, joint sessions with parents provided access to information from which participants and parents had previously been excluded. As the meaning associated with joint
sessions began to change, so did participants’ internal experiences and session specific action. Participants shifted from discomfort, silence, and withdrawal, to a place of familiarity and increased comfort, verbal contributions, and overall engagement, ultimately viewing joint sessions as positive and facilitative of change efforts.

**Joint action involved in informal support.** In some cases, barriers to joint efforts and a collaborative spirit around recovery emerged when the meaning associated with depression included fear and shame. Adolescents described minimizing or concealing actions, which were steered/directed by fear, with the goal to avoid burdening their parents. In a qualitative study of adolescent experiences of depression, Draucker (2005) referred to such actions as preserving “the façade” in favour of presenting as if everything was normal or fine. Adult/parent behaviours also categorized in this way included: blocking out, not paying attention, and squelching (Draucker). The findings from the current study did not elucidate any cases in which adults joined adolescents in maintaining the façade.

An additional interactional pattern highlighted in Draucker’s (2005) research centred on instances in which adolescents engaged in veiled disclosures regarding their struggles, which was termed “poking holes in the façade”. There was one case in the current study in which an adolescent sought to poke holes in the façade by raising red flags with her argumentative behaviour in parental interactions. Her parents appeared to engage in action opposite to their daughter, such as blaming other causes and minimizing symptoms, thus working toward a contrasting/contradictory goal that emphasized the façade of normality. Family member efforts to ignore the problem in hopes that it would resolve independently has been described in similar qualitative literature exploring family experiences of recovery in the field of addictions (O’Grady & Skinner, 2012).
Recovery-Related Joint, Goal-directed Action in the Participant-Researcher Dyad

Participation in the research conversation was a jointly enacted endeavour, with action directed toward addressing the goal of conveying and understanding the adolescents’ experiences of jointly enacted recovery efforts. Thus, not only was the adolescent-parent relational context of relevance, so too was the participant-researcher relationship. The methodology of this research is rooted in Contextual Action Theory (CAT), which most closely aligns with a constructionist ontology in which knowledge is viewed as co-created in interaction/relationship with others (Young et al., 2005). Participants in this study were aware of and commented on the research relationship, describing how their action in the research conversation was steered by and associated with internal cognitive and affective processes. Attending to this relational context is important both because it is relevant to enacting principles of quality and trustworthiness in qualitative research (see Morrow, 2005) and because it is a relational field in which joint action specific to recovery processes was enacted.

Through asking questions, nodding in response to participants’ comments, paraphrasing and clarifying, I, the researcher, enacted my role in action specific to conveying the adolescents’ stories. As the researcher, I chose to pursue particular elements of the story, which was steered by internal processes of confusion, interest, and the desire to understand the participant’s view. By answering the questions, elaborating on recovery processes, and reflecting on internal processes, the participants enacted their role in this joint endeavour. At times, participants commented on their associated internal processes, which included feelings of awkwardness and comfort, fear and uncertainty, and hope. By highlighting the way in which researcher and participant joined together, this research illuminates additional relational processes associated
with recovery-related efforts, which likely has implications for other relevant relational contexts, such as counsellor-client.

Theoretical Implications

Recovery as it relates to mental illness generally, and to mental illness in adolescence more specifically, has been conceptualized in a number of ways (e.g., Frank et al., 1991; Friesen, 2007; Jacobson & Greenley, 2001; Leavey, 2005; Noiseux et al., 2010), which has resulted in confusion and a lack of clarity regarding research and implications for clinical practice (e.g., Frank et al.). The findings of the current research contribute to enhancing clarity regarding such conceptualizations in three ways. First, the findings from this research highlight the relational embeddedness and joint nature of recovery processes related to depression in adolescence, and supports a growing body of conceptual/theoretical literature regarding social recovery (Simonds et al., 2014) and recovery as nested within relationships (e.g., Leavey; Noiseux et al.; Onken et al., 2007). Further, these adolescents described recovery as an intentional and goal-directed process that included and depended on shared goals and joint action in relationship with parents. As such, recovery was not only nested in family relationships, it was also an active process that was energized by joint endeavours related to shared goals, including relationship, wellness/health, safety, and intervention. Despite feeling well supported generally, participants requested that their parents place additional emphasis on working together in navigating a return to wellness and full engagement with life, particularly related to understanding their lived experiences and sharing time/experiences. Although they sought independence in the journey, this was balanced with the desire for connection with their caregivers. By highlighting the joint and goal-directed nature of recovery in the stories of these adolescents, this research supports and enhances relationally-based theories of recovery.
Second, this research adds to a growing literature base on the area of recovery in adolescence specific to mental illness (e.g., Draucker, 2005; Friesen, 2007; Leavey, 2005). Much of the current literature focuses on adult experiences and models of recovery, which emphasize self-determination and independence (e.g., Davidson & Roe, 2007; Friesen). The developmental and contextual realities of adolescents who are part of a larger family system and continue to depend on their parents to meet daily needs, such as housing, financial, and transportation is not addressed in the adult-based recovery literature. Typically mental illness recovery literature emphasizes a view of recovery as a personal endeavour, with underpinnings of self-determination and individualization (Friesen). The findings from this research highlight how recovery is also jointly enacted for adolescents in the context of the adolescent-parent relationship, and demonstrates how this relationship shapes the recovery journey. Parent internal processes, actions, and goals related to their daughters’ recovery impacts the degree to which recovery involves self-determination and individualization. Thus, self-determination remains relevant but exists as part of a larger relational field where connection and relatedness are also pertinent.

Lastly, the findings of this study also illuminate the role of goal-directed action in recovery processes, thus emphasizing how adolescents and their parents identify and work toward recovery-related goals. Contextual Action Theory (CAT, Young et al., 2005) provides a unique and complementary lens through which to understand recovery, identifying the associated actions and projects and unpacking recovery at the level of behavioural elements, internal steering processes, and social meaning. In this way, CAT deepens our understanding of recovery as a transactional process involving the individual and the relational community (e.g., Onken et al., 2007) to include an emphasis on joint agency in enacting specific goals that are energized by
affective and cognitive processes. Further, CAT offers a means through which to clarify some of the complexity inherent in recovery by identifying goal-directed actions as they are enacted in the moment, over a brief period of time, and spanning a broader time frame, such as in a project or career. Specifically, this research suggests that these adolescents viewed recovery as jointly enacted with parents in projects related to the adolescent-parent relationship, giving and receiving support, and issues of identity and governance, each of which were steered by processes of trust and emotional safety, as well as feelings of guilt and gratitude.

**Counselling Implications**

It is important to note that this research did not focus on treatment and counselling outcomes, but rather sought to elucidate how adolescents described recovery as jointly enacted and goal-directed with their parents. The findings discussed in this section point to areas that may be efficacious for therapists and psychologists to consider in their work with adolescents with depression and/or their parents. As a qualitative, case-based study, the data and findings provide therapists with the opportunity to deepen their appreciation of the recovery process from the perspective of the adolescent. This research approach highlighted both the commonalities and nuances in experiences of adolescents as they engaged in joint action with their parents related to recovery goals.

Family level interventions, such as family therapy and interpersonal therapy, have empirical support regarding the effective treatment of depression by addressing interpersonal dynamics, such as role conflicts and family scripts (e.g., Carr, 2008). Although described as awkward and uncomfortable initially, most participants in this study found it helpful to have their parents involved in counselling sessions. Such involvement was seen to (1) facilitate clarity
regarding each party’s perspective on mental health, (2) facilitate adolescent-parent conversations about support needs, and (3) emphasize the joint nature of the recovery endeavour.

Adolescents in this study commented on their desire for parental action demonstrating understanding regarding the experience of living with depression. It may be efficacious to consider ways to incorporate psycho-education about depression for parents either as a component of family counselling sessions and/or in conjunction with supportive counselling for parents. Positive outcomes associated with family-based psycho-education interventions have been identified in the literature (e.g., Sanford et al., 2006).

These adolescents spoke about the importance of maintaining some sense of autonomy in their care, which may have been difficult for parents who felt fearful about their daughters’ safety and well-being. Parental support, in the way of individual counselling, may be indicated as a means to aid parents in coping with/managing their own feelings about risk and worry. A private avenue for formal support would allow parents the space to openly express their emotions and thoughts without concern about the immediate impact on their affected child. Just as the adolescents in this study highlighted the way their counsellor aided them in communicating needs and care, individual counselling may aid parents in working toward a similar goal. Access to such support may enable parents to work with adolescents to achieve the balance between support and autonomy these adolescents were seeking.

Parental emotional expression was identified as impactful on the adolescents in this study, with an emphasis on how ruminative patterns and self-blame were amplified in response to such displays. This points to a possible area of focus in formal intervention. Counselling sessions offer the opportunity to debrief challenging experiences/relational exchanges such that involved parties can clarify their perceptions and the meaning attributed to observable action,
such as emotional expression. This may serve as a means to address adolescents’ possible maladaptive responses to parental emotion, such as risky empathy (Tone & Tully, 2014).

This research highlighted the many ways parents and adolescents work together toward the ultimate goal of recovery from depression. It is possible for some of the joint action to be perceived as simplistic, such as transportation to and from appointments, however conceptualizing such action as joint and goal-directed offers the adolescent and parent another way to view these elements as ways they are working together to address depression. Such a shift in thinking may foster connection in the relationship and emphasize the ways in which adolescents are not alone in their coping efforts. This research illustrates how recovery can be considered as joint, goal-directed action. Conceptualizing recovery from the perspective of joint and intentional action is consistent with the ecological approach to understanding recovery in adolescence (e.g., Friesen, 2007) and offers a new way for health care practitioners to frame recovery efforts for adolescents and parents.

Limitations of the Study

This instrumental multicase study undertook an in-depth look at the joint goals and actions of seven adolescents and their parents related to recovery from depression. Although a case study approach enables depth and holds space for complexity in research and findings, there are limitations to the claims that can be made.

This study could have been strengthened by the inclusion of additional participants, which may have offered added support for specific projects and themes articulated in the findings. In addition, each participant story contained uniqueness and complexity that may be relevant to a deeper and more contextualized understanding of recovery processes associated with the adolescent-parent relationship. As such, the inclusion of additional and diverse
adolescents may have further enhanced the findings by incorporating additional voices and experiences. The findings represented here are not meant to be cross-cultural, but rather reflect the culturally specific experiences of female adolescents at this point in time living in Canada, and predominantly western Canada.

Self-selection bias (Braver & Bay, 1992) is relevant in this research study as random selection and assignment were not features of participant recruitment. Thus, this research includes the stories of female adolescents who were interested in the research topic, chose to participate in the study, had the support of their parents to do so, and met clear eligibility criteria. In effect, this restricted the possible participant pool and removed the possibility of the capturing stories from those whose contextual reality surrounding depression differed from the inclusion criteria. Similarly, the eligibility criteria for this research, such as the absence of active suicidality, also contributed to the limitations of this study in that the criteria further restricted the potential sample. It is possible that actively suicidal adolescents and their parents would engage in/enact different actions and goals related to recovery from depression than this sample of participants.

In typical executions of QAPM, researchers follow participants over time, thus observing action as it unfolds (e.g., Young et al., 2005). The temporal structure and prospective nature of the method are unique features, which serve to differentiate QAPM from other qualitative approaches to investigation. The design of the current research study was such that it involved one interview with adolescents providing a retrospective account of their experiences followed by the self-confrontation interview described earlier. Research has suggested that mood impacts on the perception and recollection of attachment-related events (e.g., Roisman et al., 2006). Such assertions, coupled with a longitudinal and prospective protocol associated with typical
executions of QAPM, raise important considerations in understanding the findings of this study. However, the social constructionism framework within which this research rests emphasizes the value in knowledge and experience as co-constructed in relationships with others (e.g., Spivey, 1997; Young et al.). In the case of this research, the adolescent’s perception/recollection and co-construction of experience in the research setting is relevant to and valuable in understanding recovery as jointly enacted in the adolescent-parent relationship.

In considering researcher-as-instrument (Morrow, 2005), it is important to acknowledge that the research assistants in this study, and the diversity of research assistants included as a part of the team, could have impacted the self-confrontation interview data.

In some ways the findings of this research reflect dimensions of adolescent-parent relationships in general. However, the mental illness context, with associated issues of risk and safety and the manifestation of depressive symptoms, serves to differentiate the way in which the findings are specific to these female adolescents with a diagnosis of depression.

**Future Research**

This study points to other action theoretical studies of recovery from depression that includes a prospective, longitudinal component. Such components are often characteristic of QAPM, however the limitations of this dissertation research acted as a barrier to executing the method in its typical form. Recovery as described and recalled by these participants was an intentional and joint process that was enacted over time. A view of recovery as a fluid, nonsequential process both exists and is advocated for in current research and literature in the field (e.g., Jacobson & Greenley, 2001; Onken et al., 2007; Ungar et al., 2008), and thus completing a prospective and longitudinal QAPM study would be well suited to study recovery as conceptualized in such a way. The impact of mood on the ability of individuals to recollect
attachment-related events (Roisman et al., 2006) further supports the execution of recovery research that occurs in real time.

In addition, the execution of a mixed methods study wherein recovery processes are monitored quantitatively and explored qualitatively simultaneously in the context of longitudinal research would likely make a significant contribution to the field of adolescent depression and recovery. Such a design would enable researchers to gain insights into how mechanisms of recovery, as identified via quantitative measures and outcomes, are further conceptualized and enacted by adolescents and others in their relational context.

Given the joint, goal-directed nature of the recovery journey in adolescence described in this study, future research building on this study could include a project designed to capture parent perspectives. Such a study may need to be conducted independently as both this and other studies have found that adolescents often appear reluctant to include their parents directly in research that explores their experience/perspective (see also Draucker, 2005). Thus, it may be efficacious to consider involving parents in conversations with a researcher or counsellor as a means to gather parent experiences. The latter approach has been utilized in previous research exploring suicide attempts as social goal-directed systems using QAPM (e.g., Valach, Michel, Dey, & Young, 2002; Valach et al., 2006). Overall, such an approach may serve to address the vulnerability concerns adolescents reference with regards to direct parent involvement, while adding parental views to an action theory perspective on recovery from depression in adolescence.

To expand on the contributions of this research in understanding how recovery processes are enacted jointly in relational contexts, future research could explore recovery as a joint, goal-directed project of adolescents’ relationships with peers. Peer support becomes increasingly
central in adolescents’ lives at this stage (e.g., Young, J. et al., 2005). In addition, research has demonstrated that adolescents with low levels of parent support are more likely to seek out peer support (e.g., Young, J. et al.). Expanding the relational context of recovery processes to include peers may serve to further enhance youth-based theories of mental illness and recovery, as well as contribute to a broader understanding of recovery to aid health care professionals in clinical intervention.

A final possible avenue for research related to this study would address the role of joint action related to recovery in the participant-researcher relationship. Many participants in this study commented on the way in which their internal processes specific to the research context steered their action in the interview. For example, participants commented on the desire to be perceived in a certain way, which may have prompted them to refrain from sharing certain details about their experience. Such participant accounts have implications for action as enacted in other relational contexts for which describing recovery-related action is key/required, such as therapeutic contexts. By focusing solely on the joint action and associated processes of the researcher and participant, it may be possible to elucidate additional insights relevant to accessing an understanding of adolescent experience. Such an approach may also contribute to a deeper understanding of researcher reflexivity/researcher-as-instrument, which is a common element of qualitative research practices (e.g., Morrow 2005).

QAPM has similarly been employed in the investigation of joint action and goals in the counsellor-client relationship, highlighting the utility of such an approach in understanding how clients engage in the therapeutic relationship around change goals (e.g., Young et al., 2011a). The successful utilization of QAPM in the young adult counselling relationship context, coupled with the reflective process participants in the current study identified as a part of engaging with
the researcher, suggests another avenue of research. Specifically, research exploring the reflective process involved in adolescents’ sessions with therapists or psychologists may elucidate additional insights relevant to supporting recovery efforts.

**Conclusion**

Several authors in the field of recovery, and recovery in the adolescent context, have advocated for additional attention to be directed to relational processes associated with recovery (e.g., Leavey, 2005; Ungar et al., 2008). Parents are identified as central in depression and recovery processes (e.g., Erdem & Slesnick, 2001; Kangas, 2001; Leavey, 2005; Lewandowski & Palmero, 2009), however our understanding of how parents and adolescents work together in such processes has remained limited. Findings from this research demonstrate how applying Contextual Action Theory (CAT) to recovery processes in adolescence provides an avenue for capturing and understanding the relational processes inherent in adolescent recovery from depression. Such a theoretical application combined with Qualitative Action Project Method and instrumental case study enabled access to layers of joint recovery-related action as enacted in the adolescent-parent relationship. By emphasizing three levels of action, namely behavioural observation, internal processes, and social meaning, CAT further deepened our understanding of how recovery action is linked to recovery goals, and is further steered and valued by adolescents with depression.

Findings from this research expand the existing body of literature regarding family-level factors as they relate to depression and recovery, which is largely quantitative in nature (e.g., Curry et al., 2011; Hammen, 2009; March & Vitiello, 2009; The TADS Team, 2007), by providing rich and detailed stories of adolescent perspectives on how they worked together with parents to enact recovery actions and goals. The emphasis on the adolescent-parent relationship
as a recovery-related project adds new insights into understanding how relationship goals are energized and steered in the context of depression such that the relationship impacts/contributes to additional recovery goals, such as giving and receiving support.

The design of this study was such that it connected with adolescent priorities related to and voices on recovery from depression as jointly enacted with parents. In this way, these findings serve to augment existing clinical and medical discourses in the field and further provide a fuller understanding of recovery constructs and experiences of recovery at the family level. The desire for connection and autonomy was a salient relational dynamic in this study, and associated actions, goals, and internal processes identified by these participants adds to existing literature on relatedness and autonomy in adolescence by including descriptions of the enactment of this developmental task in the context of depression.

In summary, findings from this study identified that recovery is jointly enacted through the navigation of the adolescent-parent relationship and engagement in formal and familial support processes. Joint and intentional actions specific to relatedness and autonomy, governance transfer, and attending to the parent experience were also identified as recovery relevant processes in the context of the adolescent-parent relationship. Overall, the findings emphasize the relational embeddedness of recovery from depression in adolescence, adding to our understanding of adolescent priorities in recovery and how adolescents see themselves as working with parents to mobilize toward wellness goals.
References


Fichter, M., Kohlboeck, G., Quadflieg, N., Wyschokon, A., & Esser, G. (2009). From childhood to adult age: 18-year longitudinal results and prediction of the course of mental disorders in


The TADS Team. (2007). The Treatment for Adolescents With Depression Study (TADS): Long-term effectiveness and safety outcomes. *Archives of General Psychiatry, 64*(10), 1132-1144. doi: 10.1001/archpsyc.64.10.1132


Appendix A: Recruitment Poster

STUDY OF **RECOVERY FROM DEPRESSION IN FEMALE TEENS**  
*Study runs from March 2013 – August 2013*

Are you a female between 16 and 19 years old?  
Do you have a diagnosis of depression?  
And, have you been receiving counselling or treatment for depression?

We are interested in learning more about the process of recovery (or “getting well” or “feeling better”) for female teens, and how they see their parents as a part of this process.

In this research study, female teens will have the opportunity to talk about their experiences of recovery from depression in an interview with the researcher. The total participation time is approximately 2 hours. You will receive a small token of appreciation for each interview (totalling $15).

**Principal Investigator:** Leah Wilson, MA, PhD  
**Student Research Supervisor:** Dr. Richard Young

If you are interested in learning more about this opportunity, please call us at XXX-XXX-XXXX or email us at XXXX@gmail.com and leave your name a telephone number where you can be reached. Someone from the research team will contact you.
Appendix B: Initial Contact Letter to Clinicians

Initial Contact Letter

Attention: Child and Youth Mental Health Clinicians

My name is Leah Wilson and I am a third year doctoral student in the Department of Educational and Counselling Psychology, and Special Education at the University of British Columbia. I am preparing to conduct my dissertation research, which will explore the recovery processes involved in teenage depression. Specifically, I am interested in how teenagers and parents work together to identify recovery-related goals, act on these goals, and how this affects/contributes to recovery processes. Thus, I am looking to talk to female youth (between the ages of 16-19 years), who are diagnosed with Major Depressive Disorder or Major Depressive Episode and are receiving counselling at your centre. Youth who have attempted suicide in the past 6 months are not eligible to participate in this study.

I would like to circulate the attached poster outlining more about the research to youth and families who are receiving counselling support through your centre to invite individuals to contact me to learn more about participating in this research. If you are interested in helping me recruit interested individuals, please post the attached poster in your counselling centre, or share this research possibility with your clients. This is completely voluntary. If you speak to a youth who is interested in participating and they request your assistance in contacting me, with their permission you can forward me their contact information and I will follow up. They are under no obligation to participate and can withdraw at any time with no penalty.

Please do not hesitate to contact me with any questions. I can be reached at 604-XXX-XXXX or at XXXX@XXXXX.com.

Sincerely,

Leah Wilson, MA, PhD Candidate
Appendix C: Invitation and Eligibility Letter

Invitation and Eligibility Letter

Adolescent-Parent Joint Projects in Recovery from Adolescent Depression

Principal Investigator: Leah J. Wilson, MA, PhD Student
Educational and Counselling Psychology, and Special Education

Research Supervisor: Dr. Richard Young
Educational and Counselling Psychology, and Special Education
(604) XXX-XXXX

You and your daughter have indicated interest in learning more about this research study. This letter and the consent forms (also included here) are designed to give you information about the study and to share the criteria adolescents participants must meet in order to take part in the study. After you have reviewed this information and have made sure you (female teenager) meet the eligibility requirements, please feel free to contact the researcher for more information or to let her know you are interested in participating. She will also have some questions to ask you to make sure you fit the purpose and criteria of the research study.

Taking part in this study is voluntary. It is up to you to decide whether you want to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time. If you decide not to participate, any data collected will be confidentially destroyed and will not be used in this study.

Purpose:
We are interested in finding out more about the recovery processes involved in teenage depression. Specifically, we are interested in how teenagers and parents work together to identify recovery-related goals, act on these goals, and how this affects/contributes to recovery processes.

For information about the study procedures, confidentiality and limits, risks/benefits of participating, and participant rights, please see the included consent and assent forms.

Eligibility Criteria or Requirements to Participate:
If you meet all of the below requirements, you may be eligible to participate in this study.

☐ You are a female teenager between the ages of 16-19
☐ You live with your parent(s) and they consent to your participation (if under 19 years)
☐ You received a diagnosis of Major Depressive Disorder or Major Depressive Episode
☐ You are currently in counselling (with a counsellor, psychiatrist, or psychologist) and have been for 4 months
☐ You have not attempted suicide in the past 6 months.

If after reviewing the requirements for participation in this study as well as the consent forms included in this information package you are interested in participating and/or would like more information, please contact the primary investigator, Leah Wilson, at 604-XXX-XXXX or XXXX@XXXXX.COM. She will ask you some additional questions and discuss next steps if you meet the requirements.

Thank you for taking the time to review these materials and for your interest in this study. In order to ensure your privacy, we will not contact you again if we do not hear back from you.
Appendix D: Telephone Screening Form

Telephone Screening Interview

Thank you for your interest in the study. Where did you hear about the study?

As you may know, we are studying the recovery processes associated with adolescent depression, specifically female depression, and the role of the teen-parent relationship in this process. Specifically, we are studying how teenagers and their parents work together towards recovery related goals. We are looking for teens who are willing to talk to us about recovering from depression in adolescence and what role parents play in this process.

_Do you have anything specific that you would like to know about this study, and what would be involved if you decide to participate?

We are looking for people who would be interested in coming to UBC for one meeting with our researchers. The purpose would be to discuss issues that are important to you related to recovery from depression. During the interview, you will be asked to have a conversation with a researcher about recovery from depression and how you see your parent as being a part of this process. You will then review 15 minutes of the video recording with one of the researchers and discuss your thoughts and feelings about the initial conversation.

Are you interested in becoming involved? There are a couple of things that I should let you know about; the first is that all the information will be kept strictly confidential, to ensure your privacy. Also, we will not be able to accept everyone who wants to take part in the study, so I have some questions that I need to ask to determine your eligibility. We can go through these now or I can call back in two days to complete the form if you would like some time to think about it. I will send you a copy of the formal consent form for you to review before you formally agree to participate. Would you prefer an email or hard copy? (Obtain contact details to forward the consent form).

IF INCLUSION CRITERIA IS NOT MET, AND AFTER CONSULTATION WITH RESEARCH COMMITTEE, THE RESEARCHER WILL STATE THE FOLLOWING:

"Thank you very much for your interest in this study. Unfortunately, because of the purpose of this study and the criteria required to participate, we will not be able to include you in this particular study. I realize this might be disappointing. Do you have any questions? I encourage you to talk to your counsellor and/or parent to discuss any feelings you might have. Thank you again for your interest. I really appreciate your time."
Date of Screening Call: ________________________________

Name: ________________________________

Date of birth: ________________________________ Age: ______________

Are you currently attending school? _______ yes/no. Grade: ______

Have you received a formal diagnosis of MDD/MED? _______ yes/no.

If yes, how long ago did you receive this diagnosis? ______________

Do you have any other mental health diagnoses? _______ yes/no.

If yes, what are these diagnoses? ________________________________

Are you currently receiving counselling services? _______ yes/no.

How long have you been receiving counselling support/treatment? ______________

If yes, who do you see for these services?

_____ School counsellor

_____ Youth clinic counsellor

_____ Local mental health team

_____ Other: ________________________________

What is the name of your current counsellor? ________________________________

Have you attempted suicide in the past 6 months? ______________ yes/no

Can you say in 3-4 words how you see your life right now?

_____________________________________________________________________

Telephone # where you can best be reached: ________________________________

What days/times are you available to come in for an interview? ________________________________

Now that I have gone over the eligibility questions, I will consult with my supervisor and then I will be in touch with you to arrange the first interview. Do you have any questions?
Appendix E: Adolescent Assent Form

Adolescent Assent Form

Adolescent-Parent Joint Projects in Recovery from Adolescent Depression

Principal Investigator: Leah J. Wilson, MA, PhD Student
Educational and Counselling Psychology, and Special Education

Research Supervisor: Dr. Richard Young
Educational and Counselling Psychology, and Special Education
(604) XXX-XXXX

Purpose:
We are interested in finding out more about the recovery processes involved in teenage depression. Specifically, we are interested in how teenagers and parents work together to identify recovery-related goals, act on these goals, and how this affects/contributes to recovery processes.

Study Procedures:
If you consent to participate in this study, your involvement will consist of one face-to-face meeting. During this meeting, your involvement will consist of participating in a video-recorded conversation with a researcher about your recovery from depression and the role of your parent/caregiver in this process (lasting approximately 30 – 45 minutes), then viewing a video playback of a 15 minute segment of the conversation in which you will be asked to recall your thoughts and feelings as you spoke with the researcher. This entire meeting will last approximately 1.5 - 2 hours. The total time involved in this whole project will be 2 hours. The interviews will be video and audio taped. You will be given a small token, totaling $15 in value, for your participation.

Potential Risks:
It is possible that talking about your experience of depression and recovery may be difficult or uncomfortable. Also, some people sometimes feel a little uncomfortable watching themselves on the video recordings.

Potential Benefits:
You may find that talking about recovery and the associated activities you and your parent have been working on with an interviewer is helpful.
Confidentiality:
Every participant’s identity will be kept strictly confidential. All documents, audio recordings, and video recordings will be identified only by code number and kept in a locked filing cabinet. The audio recordings and video recordings will be password protected. Only the research team will have access to the documents, audio recordings and video recordings. Participants will not be identified by name in any reports of the completed study. Quotes and phrases will be used for scholarly publications, and conference proceedings, and for literature published for health care providers – all identifying information will be removed from these quotes, and other included data, to ensure confidentiality.

Contact for information about the study:
If you have any questions or desire further information with respect to this study, you may contact Leah Wilson at XXXX@XXXXX.COM or Dr. Richard Young at (604) XXX-XXXX.

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598 or by email at RSIL@ors.ubc.ca

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:
Ethics Office, Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

Assent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without penalty. You may also refuse to answer any question posed to you by the researchers.

Your signature below indicates that you have received a copy of this assent form for your own records.

Your signature indicates that you agree to participate in this study.

Participant Name: ________________________________________________
Participant Signature: _____________________________________________

Note: You do not waive any of your legal rights by signing this form.
Appendix F: Parent Permission Form

Parent Permission Form

Adolescent-Parent Joint Projects in Recovery from Adolescent Depression

Principal Investigator: Leah J. Wilson, MA, PhD Student
Educational and Counselling Psychology, and Special Education

Research Supervisor: Dr. Richard Young
Educational and Counselling Psychology, and Special Education
(604) XXX-XXXX

Purpose:
We are interested in finding out more about the recovery processes involved in teenage depression. Specifically, we are interested in how teenagers understand and describe the role of their parent(s) in this process.

Study Procedures:
If you consent to your daughter’s participation in this study, her involvement will consist of one face-to-face meeting. During this meeting, her involvement will consist of participating in a video-recorded conversation with a researcher about her recovery from depression and how she sees the role of her parent(s) in this process (lasting approximately 30 – 45 minutes), then viewing a video playback of a 15 minute segment of the conversation in which she will be asked to recall her thoughts and feelings as she spoke with the researcher. This entire meeting will last approximately 1.5 - 2 hours. The total time involved in this whole project will be 2 hours. The interviews will be video and audio taped. She will be given a small token, totaling $15 in value, for her participation.

Potential Risks:
It is possible that talking about her experience of depression and recovery may be difficult or uncomfortable. Also, some people sometimes feel a little uncomfortable watching themselves on the video recordings.

Potential Benefits:
She may find that talking about recovery with an interviewer is helpful.

Confidentiality:
Every participant’s identity will be kept strictly confidential. All documents, audio recordings, and video recordings will be identified only by code number and kept in a locked filing cabinet. The audio recordings and video recordings will be password protected. Only the research team will have access to the documents, audio recordings and video recordings. Participants will not be identified by name in any reports of the completed study. Quotes and phrases will be used for scholarly publications, and conference proceedings, and for literature published for health care providers – all identifying information will be removed from these quotes, and other included data, to ensure confidentiality.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may contact Leah Wilson at XXXX@XXXXX.COM or Dr. Richard Young at (604) XXX-XXXX

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598 or by email at RSIL@ors.ubc.ca

**Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:**
Ethics Office, Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

**Assent:**
Her participation in this study is entirely voluntary and you or your daughter may refuse to participate or withdraw from the study at any time without penalty. She also has the right to refuse to answer any question posed to her by the researchers.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you give your daughter permission to participate in this study.

Participant Name: _______________________________________________________

Parent Name: _____________________________________________________________

Parent Signature: _________________________________________________________

**Note:** You do not waive any of your legal rights by signing this form.
Appendix G: Interview Protocol

Data Collection and Interview Protocol

After having responded to an advertisement/notice of the research study, met inclusion criteria in a telephone screening interview, and received verbal information about the study and informed consent, a female adolescent (between the ages of 16 – 19 years) will participate in the following sequence of activities on the UBC Point Grey Campus.

RESEARCH MEETING (conversation and self-confrontation interview)

The primary investigator and a research assistant (trained in the method used for this research) will conduct this data gathering session.

The interview will begin by seeking signed informed consent from the participant and her parent. The informed consent will be read aloud to the participant/parent while they have copies from which to follow. The participant and her parent will be asked if they have any questions. When any questions have been answered, the consent forms signed, and the participant and parent given copies to retain, the parent will leave the meeting and the data gathering portion of the meeting will begin. Video and audio recording equipment will be turned on.

The primary object of this data collection session is to: (a) record a narrative of the adolescent participant’s experience of recovery from depression and the role her parent(s) played in this process – as told to the primary researcher, and (b) solicit the participant’s reaction to seeing a videotape of her conversation with the primary researcher.

Conversation & narrative sharing: The primary researcher facilitates the narrative sharing of the participant’s story by asking the following questions:

“What was it about this research study that made you want to participate?”

“Tell me about what it has been like to have depression and cope with depression.”

“What are some important things you have done/experienced in this process?”

“Can you tell me the story of how your parents are involved in your recovery process?” OR “Can you tell me how you and your parents work together to help you cope with depression and move toward feeling better?”

“How do you spend time together?” (e.g., watching TV, family outings, meals)

“What kinds of things do you do together that have to do with recovery from depression?” (e.g., driving to appointments, talking about feelings)
“What kinds of things do you talk together about?”

“What kinds of conversations do you have about depression or recovery from depression?” OR “What kinds of things/activities do you do/work on together related to recovery from depression?”

“How do these conversations (or activities) usually go?”

“Can you recall any recent conversations that you had about this topic?” OR “Can you recall any recent activities or things you’ve done together related to recovery?”

This portion of the meeting will last for 30-45 minutes.

**Self-confrontation Interview.** Immediately following the conversation between the researcher and participant, the participant will review the videotape recording of the conversation with a research assistant (different from the primary researcher). In this procedure, the video is played in one-minute segments. After each segment, the research assistant stops the video and asks the participant, “What were you thinking and feeling during that segment?” Follow-up questions include inviting greater detail or if the participant has only answered part of the question. For example, “You have described your feelings, can you tell me more about what you were thinking?” “Is there anything else you recall about what you were thinking or feeling at that moment?”

**Debriefing.** Immediately following the self-confrontation, the following individual debriefing is provided.

“Again, I want to thank you for participating in this study. Are there any questions or concerns you have before we finish the session today? The information that you have provided will be very helpful to us in understanding the recovery processes associated with adolescent depression. Just a reminder, it is still your right to withdraw from the study at any time.”
Appendix H: List of Codes for Analysis Procedures

**Acknowledges**
- minimal statements such as um-hmmm
- yes, sure, OK, that acknowledges the statement by the other

**Advises**
- I think the best idea for you is to get a job in the short term and then think about your educational concerns in the long-term.

**Agrees**
- Yes, I agree, That’s true, You’re right, I concur, We see eye to eye.

**Ambiguous response**
- Response is unclear, not readily interpretable, has more than one possible meaning, hazy or fuzzy meaning

**Answers question**

**Apologizes**
- Sorry, I apologize, Oops, My-bad.

**Approves**
- positive evaluative or judging statement (affirms)
  - It’s a great idea that you’re ________________.
- Validates
  - “That’s fantastic” “It’s good” “It’s fine”

**Asks for clarification** (further explanation or expansion)
- Can you tell me more about that?
- I’m wondering which of your dilemmas seems to have the most importance for you right now. Can you give me more details about that situation?
- Can you expand on that?

**Asks for confirmation**
- Am I getting this right?
- Is that what you mean?
- So, you’ll be here for next week’s appointment?

**Asks for feeling state**
- How do you feel about that?
- What does it feel like when you ________________?
- Tell me more about that sadness.

**Asks for information** (more factual in nature)
- When was it that you moved out of your parents’ home?

**Asks for justification or reasons**
- Why was that?
- What was your rationale for making that choice?
Asks for opinion or belief
• What do you think about that?
• What do you believe to be the most important aspect of becoming an adult?

Asks for speculation or hypothetical scenario (challenges)
• What if . . . ?, Let’s say ________ happened?, How do you think you would handle ____________?

Clarifies
• Usually in response to asks for clarification. Involves giving more information to clear up an ambiguity or a misinterpretation.

Complains
• My employer gives me every crappy shift. It ruins my weekend plans.

Confirms
• So you are coming for dinner tonight. Response to a request for further information.

Continues other’s statement
• After an interruption
• Continues own statement after a pause

Demands
• Tells the other what to do.

Describes future
• My mother will be visiting next week.

Describes other
• It seems to me that you ____________. (is usually used with expresses perception)
• It sounds to me that your sister is really trying to work things out with the family.
• In the annotation – describe who the “other” is.

Describes past
• I told my mother that I was grateful for everything she has done for me.
• I went to college 5 years ago.
• When I was a kid, I was bit by a dog and now I can’t seem to get over it.
• I used to hate my brother.

Describes possibility or hypothetical situation
• If I can’t get into UBC I know I will be disappointed (sometimes used with other codes – i.e. describes self, expresses perception)

Describes self
• I suck at tennis
• I’m a generous person.
• It really wasn’t like me to behave that way.

Describes situation or event
Disagrees (denies)

Disapprove
  • Negative evaluative or judgment statement
  • “I don’t like them”
  • “She really should have known better than to behave like that.”

Dismissive or diminishing statement
  • Oh c’mon, Don’t be silly, That’s nonsense.
  • “Whatever”

Elaborates
  • Extends a previous statement
  • Provides more information, adds depth to a previous statement, gives a deeper explanation.

Encourages
  • Give confidence, cheer, hearten

Evaluative or judging statement
  • Focused on a phenomenon, or event, or person with approving or disapproving

Expresses anger
  • (irritation, exasperation, rage, disgust, envy, torment)
  • I was so pissed off with him.
  • I was furious.

Expresses belief or disbelief (concrete as opposed to tentative)
  • I just know things are going to work out
  • I don’t believe in God
  • I can’t believe this is happening to me.

Expresses desire
  • I need, I want, I wish….

Expresses disgust
  • (usually more of a facial expression, distaste, expression of not liking or loathing)
  • It totally grossed me out. It was disgusting to be in that cell with all those crack addicts.

Expresses dissatisfaction
  • School isn’t what I thought it would be.
  • Expression of dissatisfaction.
  • Sometimes coded with expresses sadness or some other emotion.

Expresses doubt
  • I’m not sure I can handle that.
  • I doubt I have the ability to get into university.
• Questioning, has emotional content
• Not about indecisiveness
• I don’t know about that, I don’t know if that fits for me (POSSIBLE OTHERS - disagrees, dismissive statement)

Expresses fear
• (horror, nervousness)
• Overwhelmed or expressing a lot of concern.

Expresses frustration
• It totally sucks that I didn’t get the job I wanted.

Expresses gratitude
• Thank you. I really appreciate what we are doing here. I’m thankful for this opportunity.

Expresses humor
• Tells a joke
• Says something funny (either intentional or unintentional)
• Contextual use of humour, use of wit, lightheartedness, kidding around

Expresses joy
• happiness, cheerfulness, zest, contentment, pride, optimism, enthrallment, relief

Expresses like
• liking of idea, object, person; not love

Expresses love
• (affection, lust, longing)

Expresses perception or opinion or hunch (Added April 2007)
• It seems to me that you may be quite similar to your dad in that way.
• Is usually a tentative statement or interpretation
• Correct me if I’m wrong but I think ______________________.

Expresses realization
• I realize that these people are very important to me.
• Client expresses an “ah-ha” moment in the present tense.
• Wow, I’ve never thought about that before. (add surprise to the code)
• “Oh no, really. I hadn’t thought about that consequence before” (add disappointment to the code)

Expresses sadness
• suffering, disappointment, embarrassment, shame, neglect, regret, sympathy
• I was so depressed about it.
• I was really hurt when my stepmother attacked me like that.

Expresses surprise
• more of a facial expression
• I was really surprised that she reacted that way.
• “Oh wow!”

Expresses uncertainty
• Is about decision-making. Not being able to sort something out. Not able to accurately predict.
• I’m not sure.
• I can’t decide what option to take.

Expresses understanding
• I get that. I see where you’re coming from.
• That makes sense. I see what you mean.

Expresses worry
• I’m worried about my exam.

Incomplete statement
• Can be questions, statements, or sentences.

Interrupts

Invites or elicits a response
• Use of hand gesture to elicit a response from a client.
• “You know what I mean?”
• “Right?”

Laughs

Paraphrasing
• Repeats previous statement
• Repeats a previous statement in your own words

Partial agreement
• “sort of” - specifying the amount of agreement.
• Half hearted agreement,

Pause
• A break in the sentence or dialogue.
• Silence, a pregnant pause.

Praises
• compliments, admiring remark, accolade, congratulates
• “Good for you”. “Look at you!” “Congratulations.” “It’s terrific that you have such great insight”

Provides information
• You can get an application on-line if you go to the website.

Reflects affect
• Capturing an image that is beyond what was previously stated
• beyond paraphrasing
• Advanced empathy, empathy
• You felt disappointment when you didn’t get into UBC this year.

Reflects cognition
• Advanced empathy, empathy
• That was a tough situation for you.
• “You didn’t think that was the right way to go”
• “So you’ve been thinking about a number of career options over the last year”

Requests
• Asks the person to do something. Asks for
• Could you sign this form?

States a plan
• I’m going to go to school next term
• I will be here next week for my appointment

Suggests
• I’d like to suggest that your father didn’t mean to hurt your feelings.

Unintelligible response
• Cannot be understood on tape or through transcription