

A NARRATIVE EXPLORATION OF THE EXPERIENCE OF  
RECURRENT MAJOR DEPRESSION

by

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## ABSTRACT

The purpose of this study was to explore in narrative terms the lived experience of people who have suffered from major recurrent depression, and have recovered or are in recovery. How people construct this experience was investigated through both the form and content of their oral narratives. Semi-structured interviews were conducted with seven participants who had received a diagnosis of depression, had experienced at least two depressive episodes, and had been free of depression for at least one year. The interviews were analyzed using the holistic macro narrative form analysis of Gergen and Gergen (1983, 1988) to locate story lines (form) and valued endpoints, turning points, narrative stance and themes (content) common to the narratives. A Romantic plot structure of repeated encounters with the problem of depression, and the growing wisdom of the heroic protagonist was identified in all seven of the narratives. The differences among the narrators' perceptions of their change process were accounted for by Frank's (1995) typology of illness narratives, and a further categorization was made into quest-automythology ( $n = 4$ ), quest-memoir ( $n = 2$ ) and quest-manifesto ( $n = 1$ ). The seven narratives can be seen as a resistance to the culturally preferred illness narrative of Restitution/Comedy since all narrators experienced recovery from depression as a continuing and incomplete process. Common patterns include early childhood experiences of abandonment, fear, and/or powerlessness, a lifelong search for belonging and connection, and a turning point in midlife which resolves this search and is accompanied by depression recovery. Agency is an important aspect of both the search and the turning point, but it is coupled with the greater capacity of the narrator to experience connection with others.

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# **A Narrative Exploration of the Experience of Recurrent Major Depression**

## **INTRODUCTION AND PURPOSE OF STUDY**

Experts estimate that approximately 60,000 empirical publications on depression have appeared since 1980 (Seligman & Csikszentmihalyi, 2000). For such a widespread and well researched phenomenon, depression, along with its causes and cures, is surprisingly difficult to define. Seligman (1975) described depression as “the common cold of psychopathology, at once familiar and mysterious” (p. 76). Although it is estimated that 5% of Canadians, roughly about 1 million people, suffer from the symptoms of major depression at any given time (Statistics Canada 2000), in fact, these numbers are difficult to confirm since most people who experience major depression do not seek treatment and even fewer seek treatment from a mental health professional (McLeod et al., 1992). We can find allusions to depression in sources as old as Hippocrates in the 5<sup>th</sup> century B.C., and the Book of Job in the Old Testament. It is one of the oldest known mental disorders, named as despair, the spiritual dark night of the soul, and melancholia, a sad story experienced countless times.

The purpose of this study was to explore in narrative terms the lived experience of people who have suffered from recurrent major depression. According to narrative psychology, people make meaning of their experiences by remembering and presenting them as narratives (Polkinghorne, 1988). We are storytellers, and in creating stories, we make use of the cultural stock of narratives and myths: “it is through embedding one’s actions within one or more of the [cultural] forms that one’s actions take on meaning” (Gergen, 1988, p. 96). The form and content of our stories need to be socially recognizable in order for them to make sense to ourselves and others. Forms of stories common in Western culture include the genres of tragedy, comedy, romance, restitution, chaos, quest, confession, and regeneration (Frank, 1995; Frye, 1957; Hawkins, 1999).

Flick (1995) says it is through the exchange of narrative accounts of particular illness episodes that a community develops a social representation of that illness. Dominant medical discourse poses depression as an illness with a cure through medication, and outcome-based quantitative research does show that medication and psychotherapy significantly help in the treatment of depression (Keller et al., 2000; Lam

& Kennedy, 2004; Reynolds et al., 1999). Indeed, North American society prefers this Comedic structure in illness narratives, what Arthur Frank (1995) refers to as Restitution narratives: a healthy person becomes sick and then recovers. Underlying the Comedic or Restitution narrative are not only the interests of the pharmaceutical and psychiatric industries, but also modern North American notions of optimism, and the individual locating of self as hero. The most famous recent published memoir of depression, William Styron's *Darkness Visible*, follows a classic Comedic or Restitution story line, with a dramatic turning point and a happy ending. Similarly, most qualitative studies of depression conclude that depression can be overcome definitively (Schreiber, 1996, 1998; Skarsater et al., 2003).

However, most published memoirs and some qualitative studies of depression do not present this structure of "problem – intervention – happy ending," but rather, a recurrent series of episodes which may become more bearable, but not cured (Manning, 1994; Solomon, 2001; Smith, 1999; Unsworth, 1999). Importantly, there has been a recent acknowledgement in medical and psychological literature of the nature of major depression as a commonly episodic, recurrent or chronic illness (Angst et al., 1996; Glass, 1999; Judd 1997) rather than an isolated single episode from which lasting recovery can be expected with proper interventions. This new understanding of major depression strains the assumptions and parameters of the Comedic storyline. Most depressive disorders, once developed, have a lifetime course which may more closely follow tragic, tragicomic, or romantic storylines. This has implications for the treatment of depression, shifting from solely achieving recovery from acute episodes, to managing life-long vulnerability and preventing recurrence.

As well as exploring these possible discrepancies among dominant medical (pharmaceutical, psychiatric) and social discourses, recent research, and lived experience, this study addresses three gaps in the research literature. First, although there is a huge amount of literature on depression, there is relatively little research from the sufferers' perspective. Most social science research on depression is either survey research concerned with cause and cure, or outcome-based treatment trials concerned with effects of interventions. In particular, there are few narrative studies which look at how the sufferer-narrator uses story form and content to make meaning of their depression



experience. Secondly, the nature of “recovery” from recurrent major depression has not been explored qualitatively (with the exception of David Karp’s work) and can benefit from a closer look; do people experience themselves recovered from an illness, or rather, learn how to manage a lifelong susceptibility, and how do they account for and make meaning of this recovery? Lastly, in the rich field of illness narrative itself, there are many published physical-illness narratives (e.g. cancer, HIV, chronic fatigue) and substantial analysis of these, but in comparison, few mental-illness narratives and very little published commentary or analysis.

Karp (1994) sees the depression experience as a career which is characterized by critical turning points in identity similar to the “trajectory phases” of chronic illness outlined by Corbin and Strauss (1991). Corbin and Strauss suggest that understanding illness trajectories can be useful for medical professionals to better manage the course of chronic illness, and Karp says a similar case might be made for understanding depression trajectories. What he finds of interest is how the response of medical professionals is “itself one important factor in shaping respondents’ versions of the career path their illness has followed” (p. 28), in other words, how the depression experience is constructed within story parameters offered by medical discourse. Also, sufferers often say that part of the pain of depression is feeling isolated and misunderstood; therefore, a qualitative understanding of the experience may help professionals who treat clients with depression. Karp says, “Because the experience and course of an illness is a product of both the illness entity itself and the social response to it, minimization of suffering depends, in part, on being able to see the world from the perspective of those whom we try to heal” (27).

By identifying the interviewee’s narrative stance in his or her tale of living with depression—comic, tragic or romantic hero or victim, warrior, adventurer, sojourner – insight may be gained into their core beliefs around illness in general and depression. How these stories are constructed, the purposes of the structure, the content themes, the perceived turning points, and the relationship of the narrator to her plot, may reflect her understanding of self, agency, and change. A narrative understanding of the experience of living with depression may be helpful in planning psychotherapeutic treatment.

Therefore, the research question that will be explored in this study is, “How do people construct the story of their experience of recurrent major depression?”

## LITERATURE REVIEW

There is a vast body of literature on major depression. What is of particular interest for this study is how the concept and experience of depression is variously constructed in medical, psychological and lay communities both by researchers and sufferers. I first review definitions, causes and cures of depression as commonly presented in medical and psychological literature. Second, the experience of depression will be contrasted as it is constructed in medical discourse, and in qualitative research. Third, research on illness narratives will be reviewed in terms of analysis of storyline, turning point and character, and a brief discussion of genre and published autobiographical written narratives of depression will be given. Finally, the research question guiding this narrative inquiry will be reconsidered in the context of the literature review.

### **Depression: Definitions, Causes and Cures**

#### ***Defining Depression***

Pilgrim and Bentall (1999) point out that within the psychiatric and clinical psychology literature, there is often no working definition of depression, and a variety of opinions about what constitutes depression: "Different authors assign primacy to different psychological phenomena when writing about depression" (p. 262). For example, some say depression is a disturbance of mood (Becker, 1977) while others say that it is characterized by negative cognitions (Beck et al., 1979). Karp (1994) sees depression as an existential condition that involves a loss or reevaluation of the self. Lewis (1995) found that sufferers of depression define their condition as connected to a search for meaning. Some regard depression as a categorical concept, representing several discrete disorders differing in symptoms, cause and cure, while others regard it as a single disease that varies from mild to severe along a continuum (Fox, 2002). "There appears to be no consistent transcultural, transhistorical agreement about minimal necessary and sufficient pathognomic criteria for [depression]" (Pilgrim & Bentall, 1999, p. 263), since every culture has "varying criteria for describing everyday misery and distinguishing this from abnormal unhappiness" (p. 264). Indeed, the marketing of Paxil in Japan in 1999 has been accused of creating the illness of depression there: "Melancholia, sensitivity, fragility – these are not negative things in a Japanese context. It never occurred to us that

we should try to remove them” (Schulz, 2004, p. 41). Seeing the vast cultural differences in psychiatric diagnoses, Pilgrim and Bentall conclude that Western medicine’s diagnostic concepts are shaped and reinforced by drug company marketing and research strategies.

In clinical terms, the DSM-IV-TR (American Psychiatric Association, 2000a, pp 356, 375) requires the presence of depressed mood or loss of pleasure, and four other symptoms of a possible nine (significant weight loss or gain, sleep disturbance, delayed response, fatigue, excess guilt, difficulty concentrating, suicidal thoughts) which significantly interfere with normal functioning for two or more weeks, before “Major Depression” is diagnosed. For a diagnosis of “Recurrent Major Depression,” all the above criteria apply except that there have been two or more major depressive episodes with at least 2 months of remission in between.

Thase (1995) further mapped the biological characteristics of recurrent major depression by demonstrating that, compared to one-episode major depression, sufferers have more sleep disturbance, over activity in the neuroendocrine system responsible for producing the stress hormone cortisol, and early morning awakening and worse moods in the morning.

### ***Theories of Causation of Depression***

*Psychosocial Theories:* Freud hypothesized that melancholy resulted from an individual perception of loss of love, and the introjection of anger and grief towards himself. Seligman’s (1975) learned helplessness theory explained depression in terms of individual lack of control over their environment. Abramson et al. (1978) revised the learned helplessness theory to include an attributional component, at first observing that depression occurs when the individual experiences negative events as uncontrollable, and attributes them to causes which are internal to the self. Aaron Beck’s (1979) model of hopelessness also begins with the cognitive distortions of depressed patients. Depressed people commonly ignore positive information, and at the same time inflate the meaning and significance of negative information. This cognitive understanding of depression continues to underlie recent depression research. For example, the “scar hypothesis” suggests that the first episode of depression produces a cognitive diathesis or “scar” that increases risk for relapse. Certain stress triggers particular to the patient may combine

with the cognitive diathesis to produce a tendency to cycle into dysfunctional thinking when under stress (Clark & Beck, 1999; Ingram et al., 1998).

*Biological:* Since the late 1960s, there has been substantial research into biological causes of depression. The “amine hypothesis” of depression developed from this time. Amines are a type of chemical neurotransmitter which transmits impulses from one neuron to another in the limbic system, a portion of the brain that influences emotion. “The amine hypothesis of depression states that the loss of drive and the negative emotions that characterize depression result from the depletion of amines (particularly norepinephrine and serotonin) in the limbic system” (Nolen-Hoeksema, 1990, p. 13). It is possible to obtain images of the biochemical and physiological processes as they are occurring within the brain through positron emission tomography (PET). The PET studies on individuals with major depression as contrasted with normal control subjects have consistently found abnormalities in the hippocampus, prefrontal cortex and the amygdala (Farley, 2004).

### ***The concept of depression recovery***

Frustrated with the lack of precision of the terms of recovery, relapse and remission in depression, Frank, Prien and Jarrett (1991) developed a model to clearly define clinical terms. According to their model 1) remission refers to a relatively brief period during which the individual is essentially returned to his or her normal baseline condition and exhibits no more than minimal symptomatology, 2) recovery refers to a sustained period (usually a few months) during which the criteria for remission continues to be met, 3) relapse refers to the return of symptomatology after a remission but before the achievement of the sustained well interval required for a recovery and 4) recurrence represents the appearance of an entirely new episode of depression. These terms are verified by the DSM-IV-TR (APA 2000a). By complete recovery, it is meant that the patient no longer meets diagnostic criteria for Major Depression Disorder in DSM-IV-TR and that few depressive symptoms remain.

For adults, the typical episode of depression lasts from 12 to 20 weeks (Solomon et al., 1997). It is estimated that up to 90% of depressed patients can be treated effectively through antidepressant medication, psychotherapy, or a combination of the two (Gold, 1995). But this claim is somewhat misleading, since “for the majority of people with

major depressive disorder, recurrence after recovery is the rule” (Mueller et al., 1999, p. 1000). About 80% of formerly depressed individuals will have several relapses back into major depression during their lifetime (Mueller et al., 1999; Solomon et al., 2000). In other words, depression episodes can be treated effectively, but most patients will relapse. Lewinson, Zeiss and Duncan (1989) published one of the first studies documenting the high rates of depression relapse and recurrence, finding that 45% of those with one episode of depression could expect a second. In recent years the chronic and persistent course of depression over the life span has been taken more seriously (Kennedy, Abbott, & Paykel, 2003; Keller, 2003; Kessler, 2002). At least 60% of individuals who have had one depressive episode will have another, 60 -90% of individuals who have had two depressive episodes will have a third, and 95% of individuals with three episodes will have a fourth episode (Keller & Hanks, 1995; Solomon et al., 2000). According to Monroe and Harkness (2005), the distinction between first and subsequent episodes could prove critical in understanding the origins of depression. “With the emerging awareness of the high rate of recurrence of depression, challenges for understanding how life stress and biological susceptibility coalesce in precipitating a depressive episode are magnified and expanded” (p. 417).

### ***Treatments***

Antidepressant medication is the cheapest and most common way to treat depression in North America. It has the disadvantages of side effects, low patient compliance, and high probability of relapse. However, combining drug treatment with psychotherapy may reduce the risk of relapse for patients in recovery (Blackburn & Moore, 1997; Frank et al., 1990; Segal et al., 2002). The two psychotherapies with the most empirical support for treating depression are cognitive behavior therapy and interpersonal psychotherapy (DeRubeis & Crits-Christoph, 1998; Hollon & Shelton, 2001). Cognitive behavior therapy is a multifaceted approach which involves clients’ cognitions and their behaviours. It postulates that dysfunctional thinking styles worsen and maintain depression in people who are vulnerable to depression for biological or psychosocial reasons. The particular depressive thinking styles may also increase the risk for relapse. Beck et al (1979) and Clark and Beck (1999) are the foundational theorists

for this therapy. The best known interpersonal psychotherapeutic treatment of depression was developed by Klerman et al. (1984).

Several large outcome studies on using booster therapy sessions to reduce depressive relapse conclude that a form of continuous care may be the best model for preventing relapses, with a provision of brief counselling opportunities (Katon et al., 2001; Paykel et al. 1999). Fava et al. (1998) found that relapse was reduced from 80% to 25% in patients at a high risk for relapse who were given booster sessions of cognitive behavior therapy. Reynolds et al. (1999) provides important evidence for the prevention of recurrences of major depression. Their double-blind, placebo-controlled trial evaluated the efficacy of maintenance antidepressant drug treatment with the tricyclic antidepressant nortriptyline hydrochloride and interpersonal psychotherapy in preventing recurrences in older (average age 67 years) patients with recurrent major depression. Nine years was required to complete the trial. The authors of this study conclude that the combination of the medication and monthly psychotherapy was superior to either treatment alone in preventing recurrences of depression.

### ***Summary***

Major depression, unlike illnesses like cancer or diabetes, is not globally identified or diagnosed, but appears to be, to a large extent, culturally defined. Its symptoms in North America are pathologized in the DSM-IV code to facilitate diagnosis and treatment. However, there remains a bewildering variety of theories of depression's causes, psychosocial and biological, and its treatments. It has been recently acknowledged in the research as a recurrent or chronic condition, with current attention focused on how to prevent relapse in those who have suffered one episode.

### **Constructions of Depression**

#### ***Constructions of depression in medical discourse***

One puzzling aspect of the medical discourse on depression is the common treatment of major depression as an acute disorder with biomedical causes, rather than a chronic or recurrent multi-faceted condition. To say that "treatment successfully resolves symptoms in 70 – 80 % of people" ([www.canmat.org](http://www.canmat.org)) is misleading if one does not go on to read the fine print: although discrete episodes may be indeed treated, the probability of relapse is 50 -90% after the first and subsequent episodes, which has led more recently to

an acknowledgement of depression as a chronic illness. De Gruy (2005) points out a lag in primary care in its tendency to treat depression as an acute illness. He advocates using a chronic disease management model instead, as the basis for improved depression care in primary care settings.

In the British Columbia Medical Association's information brochure on Depression, and on the website for the Canadian Network for Mood and Anxiety Treatments, depression is referred to as a "treatable medical illness." Both sources present a multifaceted explanation of the causes of depression: biological, genetic, personality, childhood trauma, and adult life events. Conspicuously missing in this public medical education discourse is the societal influences on depression (income, employment, gender, and ethnicity) and the cognitive factors. The BCMA brochure makes one brief mention of relapse ("early treatment can help depression from reoccurring") while the CANMAT website stresses the urgency of treatment because of the recurrent nature of depression: "Treatment successfully resolves symptoms in 70 – 80% of people. Importantly, many people who suffer depression have more than one episode ... the chance of recurrence is 50% after one episode, 70% after two, and 90% after three."

Thomas-MacLean and Stoppard (2004) interviewed Canadian primary care physicians about their understanding of the etiology of depression, their diagnostic process and treatment of depression to explore the ways they constructed depression. Nineteen out of 20 participating doctors expressed the view that depression is physiological in nature and results from a biochemical imbalance (p. 281), yet there were many "disjunctures" in their use of the medical model as they struggled with their recognition of the social context of depression (gender, income, ethnicity). The researchers noted how the system is more "relevant to the care of acute disease than to the complexities presented by more chronic conditions such as depression" (p. 288), and how while medicalized discourse depicts depression as an objectively measurable condition, the physicians' accounts revealed that "depression defies neat conceptualization" (p. 288).

Rogers, May and Oliver (2001) interviewed British patients and GPs to explore lay experiences of depressed people and the experiences of clinicians who treat them.



They found that the extent to which the experience of depression “was formed around social and personal difficulties, in social contexts where sufferers were faced with multiple sources of disadvantage” (p. 326) was well understood by clinicians. This was frustrating for the clinicians, as they at the same time “reasoned about depression as a medical problem and constituted sufferers as patients like any other” (p. 327).

Srinivasan et al. (2003) investigated Canadian patient attitudes regarding causes of depression. A 9-item self-report questionnaire (10-point Likert scale) was administered to 102 patients with a depressive disorder to determine their perceptions of the biological, psychological, cognitive and spiritual causes of their depression. They found that no single cause dominated the ratings and only 2 domains, cognitive attributional style and stress or negative life events, were seen as even partly causing depression. The authors concluded that patient models of depression are largely nonbiomedical, which perhaps explains the low treatment rate and low compliance with medication for depression.

### ***Constructions of depression and recovery in qualitative research***

As described earlier, the course of depression and the nature of recovery from what has been finally acknowledged as a chronic or recurrent condition, has received much recent quantitative research attention. However, the process of recovery from the sufferers’ point of view has not been as thoroughly researched, particularly in light of the recent emphasis on depression’s chronicity. Among the handful of qualitative studies of depression and depression recovery, there emerges two views: depression as a condition that can be overcome or depression recovery as a lifelong process. Schreiber’s (1996) grounded theory study addressed the research question, “How do women describe the process of recovery from depression?” and concluded that depression in women is something that can be overcome with the right attitudes and interventions.

In this study, women who self-identified as having recovered from depression formed the initial sample, and as the theory emerged, theoretical sampling expanded the final sample to 21 women with a wide range of depression experiences. The sample was somewhat diverse in age (32 – 69), race (Euro and African American), and sexual orientation, but was homogeneous in the high educational level (most with university degrees/advanced degrees). Since a diagnosis of depression was not required, it is not clear how Schreiber is defining depression or even if the women were depressed; in other

words, whether or not the sample accurately represented women suffering from depression. The representativeness of the sample can also be queried since it is not shown where the participants were recruited from, and their understanding of depression seems to be a very particular (feminist) one.

Schreiber outlines the steps she took, based on the grounded theory approach of Strauss and Corbin (1990), of interviewing, the generation of categories, formulation of hypotheses, and formation of the model. The results of the study are shown in a theoretical model of depression recovery called “(Re)Defining My Self.” This model is interesting since although it could be called a “stage” model – there being six phases of recovery – it is not visualized in a typical linear (chronological) fashion, but rather as a jigsaw puzzle. This captures the real-life experience of women which was not in discrete chronological stages but rather, complex and simultaneous processes. The jigsaw metaphor also captures Schreiber’s main conclusion, which is that the movement of recovery from depression in women is from feeling incomplete and un-integrated, to feeling whole and integrated.

Schreiber’s research identifies a central feminist theme of women’s depression being at least partly due to unrealistic role expectations as wives, mothers and daughters, and caring for the well-being of others without meeting one’s own needs. She suggests that women’s recovery from depression may be “intimately connected to the search for personal identity within a social context” (p. 488). She locates a turning point in her participants’ recovery which she calls “Clueing In,” a process that translates insight into action.

An important step in grounded theory in assuring a standard of quality is what is called “supplemental validation,” in which the researcher, after she writes the theory, references the literature to give validation for the accuracy of the findings (Creswell, 1998, p. 209). Schreiber refers to literature which supports the importance of relationships for women’s well being. However, one weakness of the study is that it appears to minimize the complex of biochemical, cognitive, affective and personal life events well researched as influencing depression and emphasizes the negative effects of women’s socialization process. In other words, Schreiber and/or the women that participated in her study have a social/relational theory of depression’s cause and cure,

which does contribute to our understanding of depression, but surely is just one facet of it.

Schreiber (1998) deepened her initial research by examining the differences between women who recovered fully from depression and those who did not. Continuing with grounded theory, additional data were collected from seven original participants and six other women. Schreiber claims that in this second study, it became clear that “clueing in is the category that represents the difference between those women who get well and those who simply get better (temporarily free from symptoms)” (p. 274). In this clueing in stage, the woman’s consciousness about her self changes, often suddenly, to include such things as resolving family-of-origin issues, believing herself to be worthy, taking risks, reclaiming disowned parts of self, and taking control. The key to this turning point is that knowledge and insight are transformed into action. Schreiber makes strong claims about this. She says that women who do not experience clueing in will have a “pseudo recovery, in which things may be somewhat improved, but the woman’s understanding of her self and her world remains largely cognitive . . . and she remains somewhat depressed” (p. 276). She goes on to say, “Not everyone clues in, but only those who do so recover completely from depression” (p. 284).

At a time when significant attention in the psychiatric and medical field is being placed on understanding depression recurrence and recovery, Schreiber’s rich analysis of the “clueing in” process, or turning point, in women’s depression recovery is surely generative of more research. However, considering that it is estimated that 60 to 90% of people suffer relapse after their first episode of depression, Schreiber’s claims seem over-enthusiastic, particularly based on such a small sample size ( $n = 13$ ). One troubling issue is that not only does Schreiber not define inclusion criteria for depression, but she also does not define recovery, or detail how exactly she distinguished between “full recovery” and “pseudo recovery.” To substantiate her grounded theory, a longitudinal study involving a larger and more diverse sample size, and an operationalization of depression and recovery, is merited.

Similar stage theories and models have resulted from qualitative interviews with recovered depressed women. Peden (1992) interviewed seven women who had been hospitalized with a diagnosis of depression and now considered themselves to be

recovering. Transcripts were analyzed using content analysis. The analysis revealed three phases: crisis (turning point) in which the women acknowledged something was wrong and asked for help; determination, in which women committed to getting better and using the support available to them; and self esteem, in which the women learned to accept themselves.

Skarsater's (2003) phenomenological study conceptualized recovery from depression as a coping process. Thirteen women, previously hospitalized for major depression, were interviewed about their recovery, using such questions as, "What does being free of depression mean to you?" "What made you recover from depression?" "How do you view your chances of remaining well?" (p. 423). Four descriptive categories were constructed from the data of how women coped with major depression in daily life: self-healing (asking for help); managing (coping strategies of exercise, painting, massage, etc. and taking control); receiving social support; and finding a meaning. When women understood how their behavior contributed to their depression and made the changes necessary for healing, they were on the road to recovery. Skarsater sees the recovery process as one in which the women gained a "cognitive and emotional understanding of how to cope successfully with their lives in order to avoid depression . . . subsequently translated into health-related actions" (p. 436).

Steen (1996) interviewed 22 women who had been clinically depressed about their experiences of recovering from depression, with the orientating question, "Describe for me in as much detail as possible what it was like for you to live through and recover from the experience of being depressed" (p. 78). A phenomenological analysis identified five phases in the recovery process: childhood pain, adult crises, first turning point (asking for help), second turning point (taking charge of their recovery), recovery (cultivating the self). Recovery is construed as a continuing process.

Unsworth (1999) used grounded theory to analyse the interview data of 7 adults over 65 years old who considered themselves recovered from depression. She found a four-phase process to describe recovery: spiraling down, changing direction, working their way out, and staying out. The "changing direction" phase involved the participants' realization that they must change, and taking action by calling for help. She states that her study findings are unique in that the participants indicated that although the health care

professionals described them as recovered, they felt depression recovery was not completed, and they would always remain vulnerable to depression. In other words, the stage theory of recovery which Unsworth presents is not a completion model; if a relapse occurs, the same four phases would be experienced again. It is possible that because Unsworth interviewed seniors, a life-span approach to depression and recovery was possible, which revealed depression's recurrent or chronic nature.

Only one narrative study of depression was located. Kangas (2001) analysed lay theories of depression, focusing on narrative accounts of depression presented in interviews. This narrative inquiry into how depressed people make sense of their depression addressed the research question, "What kind of explanations do people give for their depression?" Eleven Finnish participants were recruited on the basis of self-reported depression, three male and eight female. The sample was diverse in age, occupation and education. Although a diagnosis of depression was not required, the participants were found through two Finnish mental health patient organizations, one of which catered solely to depression.

Since the researchers were interested in identifying lay theories of depression rather than phenomenological experience, narrative inquiry was chosen as a methodology. Participants were asked to tell the story of their depression, with little interference from the interviewer. After this initial question, a semi-structured interview guide was used in eliciting more details about the meaning and the consequences of their depression. The interviews were analysed using narrative and content analysis. The accounts were grouped according to the "storyline" the interviewees used, and then categories of the content themes were formed.

Kangas found that the accounts were usually organized by "a core explanation of the individual etiology of depression, forming a storyline" (p. 80), in other words, an answer to the question presented by the illness, "why me?" There were three storylines, all of them attributing the illness as having causes in the external circumstances of a person's life: deprivations of childhood, excessive demands of work leading to burn-out, and hardships and losses of adult life. Kangas also was able to distinguish four "lay theories" or explanations of depression: psychodynamic, social, biomedical, and holistic.

Kangas notes that the social explanation of depression is more popular in these lay accounts than it is in the psychiatric/psychological discourse, but that depression is depicted as a “multidimensional and holistic illness” (p. 89) by its sufferers. The study is a good preliminary narrative exploration of depression and raises some questions. She points out that, unlike in her study, Karp (1996) found that biological, not social, explanations dominated his interviewee’s perceptions of depression. This difference is an interesting one; it may be due to the different cultural constructions of depression (Finnish vs. American), or different biases of the interviewer him/herself. There is also a significant difference between the two studies in the inclusion criteria for the sampling (self-reports of depression vs. a medical diagnosis of depression) which might explain the difference in the participants’ explanations of depression. Kangas focuses on lay accounts of the etiology of depression, leaving the question of lay understanding of depression recovery aside. This is a gap which is worthy of further investigation. Also of interest in Kangas’ findings is the lack of reference to cognitive factors in depression. This is somewhat surprising considering the major emphasis on the cognitive distortions that underlie depression in the CBT model of depression treatment. Again, more attention might be laid on interviewee’s perception of cognitive factors in their depression and recovery.

There are few qualitative studies of depression and recovery which look in a holistic way at the complete course of depression and recovery from the sufferers’ point of view. David Karp (1994, 1996) stands alone in this regard: his grounded theory exploration of male and female participants who had received a medical diagnosis of depression traces their experience from the beginning to whatever stage of recovery they were currently experiencing.

Karp (1994) interviewed 20 people who had been diagnosed and treated for unipolar depression, to explore how “they perceive, interpret and understand a life condition that often seems incoherent, fragmented, and intractable” (p. 7). He solicited participants who had long histories with depression, and had a variety of age, occupation, religion and gender. Participants were asked to trace the history of their depression from “the first moment you realized that something was wrong with you” (p. 10). A grounded theory analysis of the data resulted in Karp’s theory of depression experience as having a

clear “career sequence,” which is “caught up with assessing self, redefining self, reinterpreting past selves, and attempting to construct a future self that will work better” (p. 8). He draws on Corbin and Strauss’s work on chronic illness trajectories and refers to Strauss’s (1992) conception of identity turning points in illness experience. The five generic stages involved: a) inchoate feelings of distress, b) realization that something is wrong, c) getting help, d) coming to grips with an illness identity, and e) a stage during which they either surrender to an illness identity or define depression as a condition that they can get past (p.13).

Karp expanded his initial study to fifty participants in his 1996 study, published as a book. In this analysis, Karp makes a lot of the notion of surrender in recovery. He says that once people learn to live with depression, they “respond to pain in a more spiritual fashion, trying to find ways if not to embrace it, at least to incorporate depressive illness into their lives” (p. 108). Through the repeated experience of suffering, people move from “the medical language of cure to the spiritual language of transformation” (p. 127). Speaking of his own depression, he says that what helped him recover is changing his response to his suffering: “I now see depression as akin to being tied to a chair with restraints on my wrists. It took me a long time to realize that I only magnify my distress by struggling for freedom” (p. 124).

**Summary:** There are contradictions within the medical discourse on depression. Depression is still to a significant extent presented to the public in medical education brochures and information web sites as a treatable acute illness. Further, doctors themselves feel conflicted between the front line view that depression is primarily biochemical, and their recognition of the myriad of other psychosocial factors contributing to the illness. Interestingly, according to the Srinivasin (2003) report, Canadian patients did not accept a biomedical view of depression, possibly undercutting their compliance with effective medication. In qualitative accounts, somewhat parallel conflicts arise. Most of the qualitative studies reviewed here seemed based on the assumption (by researcher and also interviewee) that depression is an acute, one-episode illness, and that complete recovery is possible with the correct treatment. Another assumption is that depression, while bearing biochemical symptoms, has primarily psychosocial causes and, by extension, psychosocial treatments are most effective. There

is a striking common theme in the interpretations of the data of these qualitative studies - the notion of a turning point in depression recovery which involves agency, or transforming awareness to action. Skarsater sees the “managing” category of her analysis as the turning point, involving taking charge. Schreiber’s “clueing in” phase involves moving from knowledge to action by taking risks. Peden (1993) concludes the key to recovery is the woman’s own commitment. Steen (1995) also described the turning point as the point at which the women begin to take charge of their own recovery process. Unsworth (1999) also describes a “changing direction” phase as involving taking action. Only Steen, Unsworth and Karp present the concept of depression recovery as an incomplete and continuing process. And only Karp posits the turning point in depression recovery as a surrender to the illness rather than greater personal agency.

### **Analysing Illness Narratives**

#### ***Illness narratives and storylines***

Although there has been a rich research interest in physical-illness narratives, mental-illness narratives have received only a smattering of phenomenological and grounded theory study, and little narrative enquiry. Arthur Frank (1993, 1995) looks at the narrative form and content of physical illness in his seminal typology of illness narratives. In Frank’s Restitution narrative, a healthy person becomes sick and then recovers. In the Chaos narrative, life never gets better. The protagonist is a victim of bad luck/destiny, and never recovers from the illness. In the third type, the Quest narrative, the illness initiates a spiritual journey, in which the hero “meets the suffering head on; [he] accepts illness and seeks to use it” (1995, p.115). This typology of illness narratives has not been applied to mental-illness narratives, although Frank is interested in that application (personal communication, March 29, 2005).<sup>1</sup>

Typographies of narratives (Frank, 1995; Frye, 1957; Gergen & Gergen, 1988; Hawkins, 1999; McAdams, 1993) describe the cultural data of narrative and, inevitably, prescribe it. As Murray (2000) points out, “while narratives may be analysed as personal

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<sup>1</sup> In a personal email communication on March 29, 2005, Frank said, “The application of my ideas to depression narratives is fascinating. I wish I had had time and competence to extend the argument of Wounded Storyteller to mental illness narratives, but then the circle just keeps widening to disability and so on. The role of psychopharmacology [in depression] seems crucial: for those who respond well to Rx, a restitution story becomes viable. For others, the failure of Rx can precipitate a deeper chaos story than before diagnosis. Quest stories may be harder to find . . .”



attempts to make sense of disruptions in individual biographies, they can also be analysed as social performances ... The narrator is neither a pawn nor is he or she a sole agent” (p. 344). Kangas (2001) reinforces this concept of the constructed nature of illness when she notes that in her qualitative interviews with sufferers of depression, the interviewees not only have an individual understanding of their condition, but also use shared cultural knowledge and conceptions of the illness (p. 86). Chanfrault-Duchet says these narrative types are “borrowed from literary forms disseminated in social discourse through oral tradition, written literature, and television series” (1991, p. 80). These types might include tragedy, comedy, romance, restitution, chaos, quest, confession, regeneration, or others.

What is the value of identifying genre or story-type/storyline categories?

Postmodern theorists may critique genre studies as reductionist and rather meaningless in our 21<sup>st</sup> century understanding of reality as socially constructed. However, Frank (1993) makes a good case for narrative typing:

Why, then show any boxes at all, as this paper has done? Why suggest types of rhetorics of self-change, rather than leave these narratives to themselves? The first reason is that sociology seeks to provide the Foucauldian and Marxian corollary to Rilke: You must change your life, but understand that you will never be changing it in conditions of your own choosing. There are no boxes only for those who understand what boxes are there. The second reason for displaying some types of self-change in illness narratives is the pure pleasure of honoring the voices of those narratives (49).

In other words, Frank challenges the idea that we have complete freedom in constructing our life stories, but rather, that we construct them within the cultural master narratives or types that are available to us. It may be useful or at least interesting to know within what “box” or storyline we are constructing our experience. And as he points out, displaying these types is a way of honoring the voices of narrators of illness stories.

Hawkins speaks of the usefulness of archetypal theory in accounting for “the fact that recurrent patterns of thought and behavior can be found in vastly different cultures while we can also see differences in those paradigms as mirrors of comparative cultural shifts” (p. 549). She says that archetypes will recur but be “modified, inflected and

transformed with successive cultural changes” (p. 549). She sees illness narratives – “pathographies” as she terms them – as all being basically of a regeneration paradigm:

The paradigm of crisis and recovery is just such an archetype, one that transcends cultural boundaries to be expressed in varied literary forms in different eras and cultures – spiritual autobiography in the seventeenth century, and pathography in the twentieth century (p. 549).

How about the 21<sup>st</sup> century? Interestingly, Frank (1993) sees the “crisis and recovery” or Restitution illness narrative as part of a modernist repertoire, and ponders how this story changes with a postmodern narrator. He describes the “modern hero” of illness narratives as preferring restitution tales (“The illness was conquered” stories) while the postmodern hero, Frank says, is akin to “what Morris says about Nietzsche: his hero discovers alternative ways to experience suffering” (p. 119).

### ***Illness narratives and the construction of self***

“What demarcates the experience of mental health problems from other chronic conditions is the impossibility of disassociating the self from the condition” (Rogers, May & Oliver, 2001). Karp (1994, 1996) sees the depression career as one of continual reinterpretation of self. Frank considers the “rhetoric of self-change” in illness narratives, noting that “the loss of self-recognition, and the need to regain it, may be the impetus that the author claims as the occasion of her or his narrative” (1993, p. 41). He considers the reassessment of identity to be the core theme of illness narratives. Hawkins speaks of the Phoenix metaphor in illness narratives, in which, through suffering and recovery, the self is reborn like a phoenix from the ashes. Hyden (1995) interviewed eight female psychotherapy patients suffering from various issues including depression, to explore their rhetoric of recovery. He was struck by the fact that rather than telling about individual symptoms of their emotional/mental disorder, they all chose to tell about the “Self” and how this “Self” had undergone change during the course of treatment. He notices that the central element in these psychological recovery narratives was a theme of moral development: “By removing the internal obstacles preventing one from leading the “good” life, that is, by changing one’s own “Self,” one can examine one’s innermost being and find the guidelines that will help one to live one’s own life” (p. 88).

### ***Illness Narratives and Turning Points***

An important part of the conventional understanding of “story” is the concept of the turning point. In literary theory, the role of the turning point as a plot device to make a better story is a complex one which involves the character, her essential conflict, her relationship as protagonist to the plot and to the other characters. Frank (1993) declares that “at the core of any illness narrative is an epiphany” (41). He quotes Denzin (1989) in his definition of epiphanies as “interactional moments and experiences which leave marks on people’s lives ... [Epiphanies] alter the fundamental meaning structures in a person’s life” (Frank, 1993, p. 41). Frank theorizes that people change their lives by telling them in narratives, and that writers of illness narratives claim their lives have been changed in four ways: the writer discovers the self as “what I always have been,” a self of “who I might become,” a self as a result of “cumulative epiphanies,” or a self as a “reluctant Phoenix” who claims little self-change following illness.

### ***Common types of written depression narratives***

There are a number of published memoirs of depression and recovery, including Styron’s *Darkness Visible* (1990), Manning’s *Undercurrents* (1994), Wolpert’s *Malignant Sadness* (1999), and Solomon’s *Noonday Demon* (2001). These are carefully crafted stories, with all the elements of fiction: conflict, rising action, climax, and characterization, and can be broadly seen as falling into the Romance genre. Frye describes a Quest Romance (with medieval origins) as one of our culture’s main narrative genres, in which there is a perilous journey and several minor adventures, leading to a crucial struggle which involves a battle, often against a dragon, and finally ends with the exultation of the hero (1957, p. 187). This storyline is manipulated in at least two interesting ways in the written depression narratives. Styron’s memoir is probably the most crafted, with suspenseful rising action, a dramatic turning point in which depression, seen as an external enemy, is finally defeated. The neatly concluded happy ending marks his tale as more of a Comedic trajectory, but it has elements of the Romantic battle against the enemy of depression. The other three we can see as more postmodern in that their core assumption that depression does not have an essential “reality,” but rather, is variously constructed and understood. However, they make meaning of their experience by constructing it solidly within the Romantic genre. There

is a series of heroic battles against the enemy of depression, but these narrators construct the turning point as an intensely internal moment or phase in which the depression is finally accepted and incorporated into the protagonist's lifelong identity, rather than defeated. Smith's (1999) self-ethnography of his experience of depression is perhaps the most striking example of this post-modern adaptation to the Romance genre. He chooses to represent his experience through a discourse that is more of a collage than a linear and coherent "story," and his academic commentary is interspersed with his first person account of depression. He makes no apologies for stepping outside the preferred illness narrative genres:

This story has no final "transcendent epiphany" or happy closed ending . . . Depression still lingers in my history, in my present, and will be part of my future. I am no Phoenix who heroically and cleanly rises out of its own ashes. My life, like stories, has no neat and tidy ending . . . I see, or feel, no conclusions but rather ambiguities, contradictions, and openings (p. 275).

However, his conviction that depression will be part of his future marks him as the resilient Romantic hero, gazing at the inevitable battles lying ahead. Ironically, he misunderstands the Phoenix symbolism (highlighted particularly by Hawkins in her treatment of regeneration illness narratives), wrongly rejecting it as a suitable metaphor for his experience. In fact, the Phoenix serves as a particularly apt symbol of the type of recovery that Smith describes. That is, Smith's depression recovery seems to be a perpetually occurring condition rather than a definitive happy-ever-after rebirth: the phoenix is always degenerating, combusting, resurrecting, then degenerating again.

**Summary:** Physical illness narratives, written and oral, have been categorized by storyline by Arthur Frank in his *Restitution, Chaos and Quest* types that can be compared to Frye's genres of Comedy, Tragedy and Romance. Frank (1993) considers the reassessment of identity by the protagonist to be the core theme of these narratives, through what he calls an epiphany. Karp (1994, 1996) does not refer to genre but similarly sees the depression career as a continual reinterpretation of self through several turning points. It is possible to analyse written accounts of depression recovery using these narrative concepts of storyline, turning point and character. What stands out in written accounts is a tendency towards a Romantic/Quest structure, whereby the heroic

protagonist cycles through a series of challenges, coming to accept depression as a lifelong companion.

### **Concluding Comments**

Major depression is a complex disorder with no single cause or cure, but affected by biological, emotional, cognitive and social factors. Although discrete episodes can be treated effectively in most cases by medication and/or psychotherapy, relapse rates are high. Despite the acknowledgement in recent research of major depression as a largely recurrent or chronic condition, primary care typically involves pharmaceutical treatment for an acute condition rather than prevention of relapse. Four qualitative studies that framed depression and recovery in a feminist context saw depression in a similarly Comedic way – as a curable condition. The question arises, how do people make sense of depression returning, particularly with a dominant discourse which says depression can be beaten? In recent written narratives of depression recovery, this experience is romanticized by the narrator who comes to see depression as a spiritual experience, offering personal growth through suffering. These narrators of written memoirs, unlike most of the interviewees from the qualitative studies reviewed above, describe a surrender to the condition as a lifelong condition.

By analyzing participants' oral stories of their depression and recovery through the narrative devices they choose to construct their experience -- genre, narrative stance, goals, and turning points -- the stories of their experiences will be contrasted. In answering the research question which guides this study, "how do people construct their experience of major recurrent depression," I hoped to illustrate different types of depression recovery narratives and shed light on such fundamental therapeutic concerns as how sufferers of major recurrent depression experience the onset, recurrence, and recovery of the illness within their sociocultural context, and the role of agency or surrender in this recovery.

## METHOD

### Research Design

Narrative analysis has been defined as the study of general social phenomena through a focus on their embodiment in specific life stories (Chase, 1995). Narrative analysis brings together people's particular individual stories along with a focus on the social aspect of these stories. Chase defends narrative analysis as a valuable methodology in social sciences because of this integration of the personal and social. While gaining insight into how people as individuals make sense of their experiences, we also can learn about the social resources that individuals access, resist, and transform as they tell their stories. That is to say, individual stories are shaped not only by their audience, but by the cultural narrative preferences, for example, that a story should have a beginning, middle, end, and a point (Labov, 1972), and a genre ("rags to riches," "redemption," "tragedy"). In this study, a narrative method of interviewing and analyzing the data will highlight how the participants embed their depression into the context of their own life stories – how they impose order on what may be a chaotic and frightening flow of experience, to make sense of it.

Semi-structured interviews were used to obtain narrative accounts of people's experience with recurrent major depression. Using Gergen and Gergen's (1983, 1988) model of narrative macrostructure analysis, a holistic form analysis of oral narratives of depression recovery was done. The holistic form analysis looks at the plots or structures of complete stories, locating turning points, directionality, coherence and valued endpoints. This capacity of narrative to "generate directionality among events, that is, to structure the events in such a way that they move over time in an orderly way toward a given end" (Gergen & Gergen, 1983, p. 257) can reveal at the same time the motivations, conflicts and life stance of the narrator. Through the analysis of form, important content themes are understood. In fact, Gergen (1992) claims that separating form from content is arbitrary: "[The] plots are implicated in [the] structures. A climax is a matter of form as well as content. Though separating form and content may be desirable from an analytic point of view, it is also arbitrary ... The content belongs to the forms, and the forms control the content" (p. 129, 135).

Gergen and Gergen (1983, 1988) position themselves in the constructivist approach. They ascribe to a post-modern, relativist ontology, which is non-essentialist. In this view, reality is constructed, not inherent, and people construct their individual identities and stories from narrative traditions available in their common culture. Yet the macrostructure form analysis is based on structuralist (post-positivist) assumptions of narrative genre and turning point.

Structuralist literary theory presents a “science of literature”, a story/textual grammar with predictable and systematic rules and codes (Abrams, 1999, p. 301). French structuralist critic Gerard Genette, in *Figures of Literary Discourse* (1982) and *Narrative Discourse* (1980), aims to determine the rules, or codes, of composition of narrative in terms of structure and formula that recur in many stories. These codes are not objective facts identifiable by their inherent properties, but rather these recurring motifs engender their meaning by their relations within the cultural system. What is important is to specify the underlying system of literary conventions and rules that has been unconsciously mastered by author and reader in a particular culture. The use of structuralist (formalist) narrative analysis may be seen as an epistemological contradiction within the Gergens’ model. However, although the form analysis itself can be seen as post-positivist rather than post-modern, the overall purpose is a constructivist one: to see how people render their lived experience as story, and whether or not, and how, they use “cultural master narratives” of comedy, tragedy, or romance as cultural/social building blocks in their individual construction of experience. Although Gergen and Gergen (1983, 1988) refer to Northrop Frye’s essentialist and archetypal model of genre (1957), simplifying his approach to a notion of “progressive” and “regressive” narratives, they do not believe these genres or forms are inherent in human experience, but rather constructed, revised, combined, and subverted in individual constructions of experience. Their macro narrative analysis fits with conventional structuralist literary analysis of plot, conflict (motivation), turning point, theme and genre while at the same time providing a way to question the data from a constructivist viewpoint.

### **Procedures**

**Recruitment:** Advertisements (in the form of a poster, Appendix A) were posted in counselling agencies, community centers, community gyms, libraries, and also in

Departments of Education, and Social Work at two universities. Inclusion criteria were a diagnosis of depression, at least two depressive episodes, and remission or recovery for one year. Remission was defined as the reduction of symptoms to within a normal range (Lam & Kennedy, 2004, p. 17). At least one year of remission/recovery was required to limit the risk of triggering another episode. Excluded was manic-depression (bipolar) and post-partum depression, since these forms of depression have particular manifestations and treatments. I interviewed each participant in a 15-minute screening telephone call, in which I explained the inclusion/exclusion criteria and the project and its risks (Appendix B). If they met the criteria and agreed to continue, a Consent Form was emailed to them (Appendix C) for perusal. This was signed before the first interview began.

### ***Participants***

Two men and five women were interviewed. Each of them responded to advertisements put up within university communities, although only four were students. Occupations included part-time or full-time teacher, student, musician, artist, shop staff, therapist, and human resources manager.

A range of age, gender and ethnicity was obtained. One participant was 23 years old; two were in their forties, and four in their fifties. The participants included five Caucasians, one Asian-Canadian and one African-American. Four were born in Canada and three had emigrated from Asia, South Africa, or the U.S.

Regarding diagnosis, in six cases the diagnosis was done by a physician and in one case, a counsellor identified major depression. In terms of the participants' lifetime experience with depression, the 23 year old had suffered two 4-month episodes within a 3-year period. The other six reported having had a depressive episode in childhood/early teens that was not diagnosed. Including this undiagnosed depression, three of this group suffered three lifetime depressive episodes, two had experienced five, and one reported several "breakdowns" along with a lifelong chronic depressed condition. Only two had not received antidepressant medications. Everyone reported having consulted a counsellor or psychiatrist for cognitive or interpersonal therapy, and two mentioned having had suicidal ideation. The range of time that had passed since the last main depressive episode was between 1 and 6 years.



**Data Collection and Interview Protocol:** Time commitment was a 15-minute telephone screening interview, a 60 – 90 minute interview, and a follow-up telephone call. The member checks (checking the story line graph and the findings section) required a minimum of 30 minutes (by telephone or email), and some participants chose to meet in person to discuss the findings in greater depth, and to make suggestions for greater accuracy. The official site for the interviews was a sound-proof interview room in the Scarfe building at University of British Columbia. However, five of the participants asked if the interviews could be held at their home or at their office, for their greater convenience.

To maintain consistency in the interviews, each interview began with the same orientating statement:

I'm interested in hearing about your experiences of being depressed and recovering from each depression. I imagine your life story has been affected by the experience of depression, and I would like to understand your experience as fully as possible. Please speak as freely as you like. I may ask you sometimes to clarify or expand on something. If you feel uncomfortable at any time, you may pass on a question, or stop the interview. It may be easiest to start at the time before your symptoms began, to give me an idea of what your life was like before your first depression, and then go from there.

As Riessman (1993) points out, most qualitative interviews are not narrative but rather, question and answer exchanges, what Mishler (1986) refers to as the suppression of narrative. As I wanted to elicit and encourage narrative, I tried to let the participants speak as uninterrupted as possible, to give a chance for the story form to emerge. When necessary, facilitating questions were asked, such as: "What changed as the depression started to lift?" or "What happened when the depression came back?" (Appendix D).

**Recording and Transcription:** The interviews were audio-taped and self-transcribed verbatim, with my own transcription key. Non verbal communication was acknowledged (pauses, ums, tears), according to the transcription approach of Lapadat and Lindsay (1999).

### **Data Analysis**

Gergen and Gergen (1983, 1988) describe an approach for assessing the narrative form, or storyline. They are best known for their "progressive/ regressive/ stability" typology but also describe four archetypal storylines (referring to Aristotle and to literary

critic Northrop Frye for the original models) of comedy, tragedy, romance and happy-ever-after (e.g. 1988, p. 29). Since I was interested in not only the plot trajectory but the narrative stance and tone of the story, I chose to attempt to apply the archetypal story typology to the narratives. Lieblich, Tuval-Mashiach and Zilber (1998) provide a "how to" chapter on holistic form analysis which is based on the Gergens' approach. Following this, I plotted each participant's life story on a timeline with x axis representing time and the y axis the subjective "positive" or "negative" quality of the experience, by paying attention to both the thematic content of the story and the actual language (for example, "things took a turn", "it was a happy time", "I plummeted," etc). This resulted in what the Gergens call a "story line graph," or in Lieblich's terms, a "life course graph." The positive area of the graph was first labeled "happy" and the negative, "sad," but these descriptors were changed later to "positive, neutral and negative" after the member checks. Subsequently, I created a prototypical or average graph for the participants, as both Gergen and Lieblich suggest, by estimating an average displacement of each story line from the neutral midpoint at each five-year interval.

The purpose of this holistic form analysis was to identify the form (storyline or genre) used by the interviewee-narrator in her account. I was interested in whether or not, and how, the participants use master cultural narratives, for example, the genres of comedy, etc. in their construction of their experience of recurrent depression. The psychological analysis of narrative structure has adopted strategies from the field of literary criticism. The most famous typology is based on literary critic Northrop Frye's (1957) work. According to him, there are four principal narrative types: romance, comedy, tragedy and satire. In the romance, a hero faces a series of challenges before reaching his goals of social and self-integration, and his journey is characterized by struggle, self-growth, and transformation. In comedy, the hero must overcome the hazards that threaten social order. The tragic hero is defeated by the forces of evil, and ostracized from society. Finally the satire provides a cynical and critical perspective on social conventions that can point toward an ideal or utopia. Gergen and Gergen (1988) applied these genres to their concept of the plot progression of psychological narratives. In a progressive narrative, the story advances steadily (comedy); in a regressive narrative there is a decline (tragedy) and in the stable narrative, the graph does not change. The

story line graphs that depict these plot sequences in terms of high and low points represent a comic plot, for example, as a U-shaped curve and the romantic narrative as an up-and-down curve through time.

Gergen and Gergen (1988) believe that this analysis of form is not simply stylistic but can reveal the thematic content. Lieblich et al. (1998) goes on to address this assumption, by saying that structure is not just a container for content, but a profound carrier of meaning in itself: "The working assumption ... is that the formal aspects of structure, as much as content, express the identity, perceptions, and values of the storyteller. Analyzing the structure of a story will therefore reveal the individual's personal construction of his or her evolving life experience" (p. 88). Therefore, the first step is to identify the story line, and the second step is to look more closely at the structure in terms of the turning points and valued endpoint, in order to explore the effects (we might say, the "meaning") of the form.

Lieblich et al. (1998) outlines the following steps in locating storyline or form of a narrative:

- Identify the dynamics of the plot. This may be indicated by: a) evaluative comments, "It was the worst time of my life" b) genre comments "my life has been a Cinderella story" c) reference to turning points, crossroads, life course, path, or route.
- Compile a life-course graph for each story, based on patterns of ascent, decline, and stability.

After compiling the story line graph, and doing the initial member-check with each participant, I questioned the transcripts specifically for the narrative structure of genre or "story type":

- What is the storyline/story type (genre) of the telling?
- Does it resemble, combine, or subvert cultural master narratives (e.g. tragedy, comedy, romance, happy-ever-after)?

The Gergens refer to this as the macro-narrative analysis. Next, a more "micro" analysis was done, which aims to identify the narrative elements used by the interviewee-narrator to construct her story. Of particular interest in this study and its clinical applications is the role of the narrator as a character/protagonist in her life, her valued endpoint, and the

nature of any turning points in her story of recovery. The methodology of this second step of the analysis is not laid out concretely by either Gergen or Lieblich. By reading examples of their analyses (e.g. Gergen & Gergen, 1988, p.28 - 29; Lieblich et al., 1998, p 99 – 103), and using my own background in structuralist literary analysis (e.g. Genette, 1982; Chatman, 1978), I used the following questions to locate the narrative elements and probe the meaning of these elements:

- What is the narrative stance/point of view? Victim, hero, omniscient? How does this storyteller feel about her story? What is her position to her plot – e.g. how much agency does she describe or demonstrate in the unfolding of the events?
- Tone: ironic, clinical, triumphant, resigned?
- Turning point: turning from what and toward what? Is there a dramatic turning point, or a gradual change, several turning points, or none?
- What is the effect of the turning point on self/identity?
- Is the turning point agency-based or a surrender?
- What is the theme that drives this story? In the Gergens' terms, what is the "valued endpoint" of the narrator that motivates her through the events and also serves to build coherence through the tale?
- How is depression represented in the story? Is it a character? An enemy, an obstacle, a mystery, a punishment? Is it part of the protagonist's Self, or external to her?

I read the story several times to locate these elements, using different coloured markers for each question. I then compiled a summary sheet for each story which facilitated the cross-story comparison (See Appendix E).

### **Member Check**

The first member check involved the storyline graph. I contacted each participant and asked if they would like me to send it to them by mail, or if they would like to receive it in person to discuss it. Only one participant opted to receive hers by mail. I met the others in person and spent approximately 15 - 30 minutes discussing the graph and making corrections. In the second check, I sent each participant the 4-5 page story synopsis and analysis from my Findings chapter which pertained to their interview. They read it and sent it back with comments. Two participants chose to meet me in person to

discuss it. Adjustments were made to make the graphs and the story synopses more accurate. One participant (Ruth) objected to the story line graph, saying that it simply did not represent her experience. She requested that it not be included in the appendices.

### **Researcher's Subjectivity**

I have assumptions about the nature of depression based on personal and professional (clinical) experience. I have a holistic view of the causes for and treatment of depression, tending to be suspicious of solely biological or solely environmental approaches. While my own understanding of depression may have enriched my interpretation of the data, I aimed for researcher reflexivity in staying aware of how my preconceptions influenced my conclusions.

I also have assumptions about narrative, based on my training in literary analysis. From what I understand about written narrative, I assume that a story depends on the presence of conflict, some kind of change between the beginning and the ending, and a turning point. I also expected that the story would conform to certain literary conventions of genre, such as comedy, tragedy, or romance.

### **Issues of Representation**

Since this is a holistic narrative analysis, it was important to represent the data in a way that was not reductive or disjointed, but rather, that gave a qualitative sense of the whole. Even though this made for a lengthy "Findings" chapter, I decided to include a separate story synopsis and analysis for each of the seven interviews. The story-line graphs for six stories were attached as an appendix. In this way I aimed to honour each story in its unique form, before making the cross-story comparisons in order to locate common story-lines/genre and identify common patterns and themes. Information from the member checks informed my final interpretation, but I as the reader/ interpreter had final authorship.

### **Ethical Considerations**

Approval from the Behavioural Research Ethics Board, UBC, was obtained (Appendix F). The two ethical issues that appeared most important were confidentiality (particularly since all the participants volunteered from the same university communities) and limiting the risk of depression relapse. Confidentiality was protected by using pseudonyms and changing identifying markers. In the member check, participants were

asked if they felt their identity was masked adequately in the narratives. The risk of depression relapse was limited by requiring one year of recovery as an inclusion criterion, and also by focusing on positive aspects of depression recovery in the narratives. The co-investigator made an effort to end the interviews in a positive fashion which focused on the interviewees' strengths.

### **Criteria for Evaluating the Worth of My Study**

Narrative inquiry does not refer to the truth-value of a narrative study, but rather to the process of consensual validation -- that is, making sense in the eyes of a community of researchers (Lieblich et al., 1998, p. 173). Of Lieblich et al.'s criteria, I used the following two criteria of worth: coherence and pragmatic usefulness.

Coherence is the way different parts of the interpretation create a complete and meaningful picture. Internal coherence addresses how the parts fit together and if the analysis makes sense to participants. This was assessed through the member checks. External coherence involves how the interpretation fits against existing theories/research. The initial access to data was limited to the supervisor and co-investigator, but BREB approval was later obtained (see Appendix F) to include an expert outside reader, Dr. Lissa Beauchamp, a literature professor from St. Francis Xavier University, Nova Scotia, with expertise in genre theory. She reviewed four of the transcripts and independently categorized them into genre, based on classical (Aristotelian) and medieval notions of genre rather than the adapted social science models used in this study (Frank, 1995; Gergen & Gergen, 1988). There was only one significant discrepancy. She viewed Ngoma's narrative as a Tragedy rather than Romantic Quest, according to the classical Greek tragic forms. The fact that he removed himself from his story, telling a grand tale of suffering in which he remains powerless (in her analysis), yet wedded heroically to his principles, led her to categorize the tale as a tragedy. However, after hearing about Frank's typology of Quest-Manifesto, she agreed it could be cast in this category as well. The general agreement regarding the genre of the stories strengthened the external coherence of the study.

The second criterion of worth is pragmatic usefulness: Are the conclusions useful for therapists and in what ways? This will be addressed in the Discussion chapter.

## FINDINGS

The narrative form of the seven interviews was analysed in order to answer the research question, "How do people construct their experience of recurrent major depression?" The seven narratives can be seen as a resistance to the culturally preferred illness narrative of Restitution/Comedy since all narrators experienced recovery from depression as a continuing and incomplete process. A Romantic plot structure of repeated encounters with the problem of depression was identified. Also typical of the Romance style was the sense of heroic struggle or battle described by the narrators, and the resulting increased wisdom. However, there were differences in the way the narrators describe their change process. These differences are accounted for by Frank's (1995) typology of illness narratives, in which the Romance/Quest genre can be sub-divided into automythology (the narrator feels reborn through her suffering), memoir (the narrator stoically describes a gradual process of change in terms of greater understanding), and manifesto (the narrator locates the need for change within the socio-political sphere). Four of the narratives were cast as quest-automythology, two as quest-memoir and one as quest-manifesto. There were interesting common aspects among the seven narratives in the narrative elements of setting, catalyst to the rising action, motivation and agency of the narrator, and turning point. All stories take place in a physically insecure setting of frequent moves globally or nationally, and the catalyst to the life story of depression is located by six of the seven narrators as a childhood/early adolescent experience of insecurity, fear, abandonment or powerlessness. Five narrators describe a lifelong search for belonging and connection which when resolved in a profound turning point is accompanied by significant depression recovery. Agency is a fundamental theme that runs through each story, as the protagonist searches for his role in the depression; while agency is an important aspect of both the search and the turning point, it is coupled with the greater capacity of the narrator to experience connection with others.

This chapter is divided into three main sections. First of all, a brief summary of the general findings regarding genre and quest illness narratives is given. Second, a synopsis of each story is presented framed by an introduction and an analysis. The introduction refers to the genre and the narrative element of setting (what the Gergens refer to as the social context). This introduction serves to set the scene for the story

synopsis. The subsequent analysis looks at the stance of the narrator (including the narrative voice and the position from which the story is told), the valued endpoint (goal), the agency of the narrator, and the turning point and its role in the structure in terms of achieving the valued endpoint. Finally, a brief third section will compare these narrative elements across the seven stories.

### **Genre and Quest Illness Narratives**

Using Gergen and Gergen's (1983, 1988) narrative methodology of macrostructure form analysis, the stories were categorized into genre. The story line graphs for the seven participants, and a composite graph, can be seen in Appendix G.

The storylines of all of these graphs fall into the Romance form, as described by Gergen and Gergen (1983, 1988). That is, the story line is an up and down wave alternating between good times and bad, as the narrator repeatedly encounters the problem of depression, rather than one steady down and up (comedy), a steady incline (happy ever after) or decline (tragedy). Generally speaking, the content of the stories also fits with Gergens' notion of Romance, as the tale of a heroic character who struggles through a "series of episodes within which [he] is faced with numerous challenges and threats" (1988, p. 98), seeing "life as a continuous array of battles against the powers of darkness" (1986, p. 28). Lieblich (1988) adds that in Romance, "the essence of the journey is the struggle itself" (p. 88).

Indeed the theme of struggle, perseverance and eventual victory (sometimes marked by acceptance of depression) marks these stories' protagonists as Romantic heroes. Life with depression is seen as a battle. Yuki mentions "struggling with the courses I didn't enjoy, which I found awful . . . just absentmindedly going to classes and not doing much," "It was a struggle, but I didn't know that I was depressed." John says, "I just kept going and believing that I could . . . I remember thinking, 'Ok, [this] is pretty bad, but it's not the worst thing, I'll keep going.'" Susan, "By the time I got into high school, I really was struggling, really struggling" and mentions her "keep on going" philosophy, a survival mentality of getting industrious and plowing through difficulties. Brigitte says "Always, always sad. That sadness never went away. Never, never, never, never. Only now, that I'm [recovered], I can say, 'I lived with it.' It was constant." Barbara says that she was "fighting this increasingly difficult atmosphere I was living in"



and speaks of the battle with her negative ruminations, "The reoccurring thing that started happening was thoughts coming into my mind that would upset me. And I would say, 'Oh, get the demons out' . . . I just thought, 'I've got to deal with this and move on,' and so I spent the entire 90s dealing with things and moving on." Ngoma speaks of his feelings of exhaustion which led to depression: "Why do you need to get up in the morning to have to deal with it? It's exhausting if every day is this kind of battle." And Ruth's poignant comment, "Now I associate depression with a certain kind of intensity of just not being able to cope and just going on. It's like these little breakdowns. I see my life as always struggling, always struggling against *that*."

In the composite graph of six stories from interviewees aged 42 – 56 (omitting the life story graph of the 23 year old), there appear three depressive episodes: around age 10, age 35 and age 50 (8 -13; 26 -35; 45 -50). These occur in adolescence, adult, and mid life periods in the lifespan. The story of 23-year old Yuki was not included in the composite since her graph was so different from the others that it flattened the curves. Brigitte's story line is also rather different from the rest, more of a happy-ever-after plot trajectory, with her life before 44 years old largely on the negative side of the y-axis. If her story were omitted, the three depressive episodes of a composite story line would be even more discrete.

Six out of seven narrators describe an event or time period in childhood or early adolescence that was, in retrospect, connected to depression. Accompanying or triggering events include: parents' divorce, abandonment by mother and adoption by grandmother, terror of Cuban Missile Crisis, move away from birthplace, recognition that friend's house was safer and happier than one's own home. None of these depressions were acknowledged by adults or diagnosed, but are labeled as depression in retrospect as the narrators recall their life story. The coping strategies of the child to deal with depressive feelings include: reading, hiding in trees, focusing on school, going to a friend's house, praying, or withdrawing. The depressive episode that occurred around age 35 for four of the seven participants included more self-awareness that "something is wrong" and included counselling and/or antidepressants. Accompanying or triggering events include: abusive marriage, death of family member, moving away from home. The third episode occurring in later midlife seems to be a "last straw" kind of experience. Ngoma describes

it as a “culmination” of negative experiences and feelings which were initiated by work place racism; Susan describes a period of suffering in which she has to address old family-of-origin issues within the crucible of menopause and her son’s addiction; Barbara describes the first time she lets herself really crash, leaves her abusive marriage and gets appropriate counseling. During this most recent episode, there is an accompanying epiphanic shift of understanding that marks their recovery.

One participant’s story was looked at separately since she was only 23. Her story was rather different in that she remembered age 0 – 14 as happy, 14 – 18 as difficult, and then experienced two four-month episodes of depression within a three year period. Thus the time line is not in synch with the others. However, the life story graph still falls roughly into the Romance genre, with its up and down movement, and a heroic protagonist who seeks meaning in her suffering.

Although all stories exhibited the Romantic narrative structure and general content, this classification failed to address the differences between the narratives in the narrator’s perception of their change process. Consequently, Frank’s (1995) typology of illness narratives was applied to address these differences. He first divides illness narratives into three types: restitution (akin to comedy), chaos (akin to tragedy) and quest (akin to romance). In restitution narrative, “the active player is the remedy: either the drug itself . . . or the physician” (p. 115), in chaos, “the suffering is too great . . . to be told,” while in quest, the narrator is the key player:

Illness is the occasion of a journey that becomes a quest. What is quested for may never be wholly clear, but the quest is defined by the ill person’s belief that something is to be gained through the experience. The quest narrative affords the ill person a voice as teller of her own story . . . (p. 115).

Frank’s “quest genre” is very similar to the Gergens’ notion of Romance as a journey of struggle and personal growth. The quest genre, Frank claims, is the most popular form of illness narrative, and this is confirmed in my sample of seven participants recovering from the illness of depression, all of which can be seen as quests. This quest genre Frank subdivides into three subtypes: quest-automythology; quest-memoir; quest-manifesto, depending on the narrative stance and the content. Quest-automythology is a transformation narrative. The narrator speaks of individual change not social change. She is a new person by the end of her tale – a Phoenix reinventing herself from the ashes of

the fire. In quest-memoir, the narrator tells her illness story through other events in her life. Trials are not minimized but are told stoically. There is no dramatic insight, but rather, an incorporation of the illness into her life and a growing wisdom. The quest-manifesto is an illness narrative which carries the demand for socio-political action. The truth that has been learned through the narrator's suffering is expressed in a call for social action. These types proved useful in further classifying the seven depression narratives: five are automythology, two are memoirs, and one is manifesto.

### **Seven Stories of Depression Recovery**

#### **Susan – Quest Automythology**

*Introduction:* Susan's story is a good example of Romance/Quest, a tale of physical and emotional sojourning. Moving from city to city, and country to country, Susan seeks a sense of belonging in each new setting. When charted on a story line graph, the story can be seen as quite archetypal, demonstrating a Jungian trajectory. In her thirties, she moved "outwards," delighting in her overseas work, as a solitary adventurer, and then, as high as she flew in that stage, so she sank in her 40s into an inward journey of depression. In her early 50s, she has a pivotal spiritual experience in which her search for belonging is resolved, and her recovery from depression, consolidated. From this secure base, she says that even if depression returns, and she predicts that it probably will, she is not afraid of it. In this automythology, the site of change is the narrator herself, as she transforms through her sufferings.

Susan offered her home for the interview. The first thing on her mind as I busied myself with the equipment set up was whether I'd had breakfast and would I like some toast and coffee? Very nurturing, matter of fact, and calm, Susan sank into the soft arm chair opposite mine, after making sure I was comfortable. She started to tell her story immediately, and it was soon obvious that her level of self-reflection was extremely high. This is a story told from the position of a knowing, wise narrator who has mulled over her own tale with a lot of tenderness and interest.

*Story Synopsis:* Susan's earliest childhood was relatively happy. She enjoyed sports and her friends, but at age 10, life changed. Moving across Canada was a difficult adjustment for the whole family. Although her father had a more successful job, and they enjoyed a larger house in the new place, his alcoholism took a turn for the worse. Susan began to

experience a lot of anxiety and stomach pains around Grade 8, and for the next few years felt unwell and unhappy. Grade 12 was a pleasant surprise, as she became more socially involved, popular, busy at sports again, and happy with her first boyfriend. Nursing school was also pleasant enough, and the next event which seemed to draw her down into a darker mood was her entry to grad school in her mid 20s. Feeling inadequate, anxious and depressed, she struggled with classes and with her new boyfriend, with whom she quickly became entangled. He was controlling, intense, and also suffered from depression, but they seemed to fit together well. Susan had psychodynamic psychotherapy for her depression at this time but found that it made her more distressed. When her boyfriend moved west a few years later, Susan was heartbroken but noticed that her depression lifted considerably as she renewed other friendships and became more involved socially again. But when he appeared on the scene again months later, she dropped everything, took a year off from her program, and moved out west with him. The conclusion of this romantic turn was that he became seriously depressed, and they ended up breaking up for good. This marked an amazing period of freedom and adventure for her. She left Canada and started overseas work. Although stressful and traumatizing at times, the work brought her a lot of joy and she felt free of depression throughout that five year period. Coming home and getting married at the age of 40 was another positive phase. However, in her late 40s, Susan plummeted into her most significant depression. Her stepson had become involved in drug use, and Susan, a nurse with a watchful eye, was aware of the many signs of this, but could not persuade his father and the rest of the family of the urgency of the situation. Plunging into a mire of self-criticism, anxiety, and feeling alienated and unworthy, Susan eventually dealt with depression effectively through counselling and medication. Her recovery from this depression was consolidated in a trip overseas where she was profoundly moved by the universality of suffering, finding hope in human solidarity.

*Analysis:* Although the synopsis and the story line graph (Appendix G) give a picture of the plot of Susan's story, looking more carefully at the narrative elements of voice, valued endpoint, and turning point, give a fuller sense of how the narrative is constructed, and also gives a window into the agency of the protagonist. Susan speaks from the vantage point of a wise 56-year-old, often impatient with the younger protagonist

(herself, of course) who she feels was escapist and in denial. She uses the words “denial” “face” and “not face” several times. Speaking of leaving home for nursing school, she says with a laugh, “I was blindly going off to the big escape route but nonetheless it was an escape route from home that I thought was going to solve everything.” Susan describes one incident in her second depressive episode at age 26, which involves this theme of denial. She describes inviting a friend over for dinner, discovering that the chicken had gone bad, and refusing to open the door when her friend arrived.

When I think of I’m so embarrassed. I actually just threw it away and went to bed. And didn’t answer the door when she came for supper! A really good friend! She was livid with me; she was pounding on the door. She knew I was there, right? I just went into ... totally overwhelm state, and when I think of it now, I have to say, the *denial* ... It was just too much to even *admit* at the time ...

Although she was depressed, holding down a part time nursing job, and passing her graduate classes, she is disappointed as she tells the story with her lack of honesty and competence. However, despite this frustration with herself as the blind and often foolish protagonist, Susan looks at her story at the end of the interview with a degree of tenderness:

I kind of imagine even the points where [the depression] may come again, but I don’t feel afraid of it anymore. I’m not looking forward to it if it happens again, but I don’t have the same fear around it, and maybe it’s because I’ve been able to get so much meaning from the suffering, that I really feel ... in a strange kind of way, blessed, though I would never wish on anybody to go through what I’ve gone through.

The Gergens’ notion of a “valued endpoint” is particularly salient in these stories of quest. We can trace a theme of a search for belonging and connection through several of the events Susan chooses to tell. She starts off by referring to an event of rupture, moving across Canada, and feeling “a tremendous uneasiness ... shy, self-conscious and kind of inadequate ...” Before the move, at the age of 9 or 10, she felt “carefree ... really good at sports ... had lots of friends” but after the move, by Grade 8, she couldn’t depend on the “industrious competence that kept me afloat” and found the “peer pressure to belong” to be problematic. At age 17 she had an “extraordinarily good year” at high school, “I kind of got in contact with a side of myself that I knew was in there but never really could come out. I could be popular. I could be fairly successful... I was really

socially engaged.” She describes her social circle then as “very tight,” “a really strong social container.”

The next period is at grad school, where she experienced her first big depression. She describes herself as feeling unprepared, rather like a fraud, getting into a serious relationship which was isolated and limiting – interestingly, also represented as “tight” but in a dysfunctional way – a “full lock and key type of thing.” Although breaking up was “devastating,” – “like an arm got cut off, like losing a big piece of myself” – this shocked her into acting more for herself, getting re-connected to a larger social circle: “I met more people in the program again, I got more social again, I got involved with study groups, had a lot of fun.” When the boyfriend appears on the scene again, she goes back into a similarly limiting, enmeshed space during which time she gets counselling and realizes that she needs to take care of her own life and get some distance from him. When she finally separates from him, she enters an important five-year phase of her life, when she works overseas – “The work was really good for me, it gave me a lot of confidence, and ... a real sense of purpose being out in the world, feeling much more connected to the broader world and kind of, to humanity in general.” This “high” period was matched by an ensuing, very low period, after she gets married and her adolescent stepson becomes involved in addiction.

The theme of “not belonging” comes to a head here: she recognizes early on that he is involved in drug use, but cannot persuade anyone else in the family system of the severity of the problem. She feels that she is not listened to because she is the “bad stepmother who’s come from the alcoholic family who is suspicious and hyper vigilant.” The combination of distress over her son’s problem, distress over her role in the family system (not belonging), and menopause plunged her into a deep depression:

I get quite emotional thinking about (voice shakes, tears), just how dark and black my thinking was about myself, that there was an essentially black nature in me, and that my son would never have problems if he didn’t have a stepmother like me, because I would look around the family system and think I was the only one that has brought it into the system.

Thus, the valued endpoint for Susan is a sense of belonging, and the feeling of not belonging, not being connected, forms the texture of each of the three depressive episodes she suffers.

The narrator's voice and stance towards her story, and her life goals, indicate her sense of authorship of her life, in other words, agency. Susan is very aware of the role of agency in her story. For example, she describes herself at 12 years old as shy, self-conscious, and depressed, struggling in a new school and only able to get her mother's attention by her stomach pains. An adolescent's lack of agency in this situation is understandable, and Susan looks back at her young self with compassion:

My dad was alcoholic and when I was 10 we moved from across the country and that's when [I experienced] tremendous uneasiness . . . I really became aware of how shy, self-conscious and kind of inadequate I felt . . . By the time I got into high school, I really was struggling.

In her second depression in her mid 20s, Susan describes being overwhelmed by the demands of graduate school and a controlling boyfriend. She took action for herself by seeing a psychotherapist, but this was not helpful. When validated by the interviewer for her resilience in getting through that black period, Susan dismisses the compliment by explaining that her action-taking was part and parcel of the denial of her depression:

I was raised by my mom, one of the super self reliant women, with what my girlfriend I and used to joke about as the KOG philosophy, the "keep on going" philosophy. . . The substrate underneath there is just "get industrious," and it does work to pull you out of depressive stuff . . . But I think that it is also something that I covered up my depression with . . .

What might be perceived as strength and personal agency by outsiders was a cover up, Susan claims, for depression. Through her first two depressions, Susan does not successfully take care of herself or achieve her deep yearning for belonging.

A turning point is a narrative device in which a conflict is resolved, and the narrator comes closer or farther away from her valued endpoint. Susan describes a two-phase turning point in her story. Taking appropriate steps to take care of her son, hormone replacement therapy, cognitive behavioral therapy, and group therapy helped lift her, over a 2 year period, from the third, midlife depression. In therapy, she was able to reframe her concept of agency from a codependent, "industrious," caretaking activity to self-care. It is from this position of depression recovery that she is able to resolve the search for belonging in a profound way. While traveling overseas, Susan placed her own suffering in the context of global suffering, and found more compassion for others and for herself:

Really allowing myself to take in the tragedy, the suffering, and allowing myself to weep about that, weep and rail about the unfairness of that, and it just gave me more compassion for myself, it's the strangest thing.

When asked the rather prosaic question of whether this sense of self-love led to a greater sense of personal agency and self-care, Susan explains it in much more profound terms:

S: I did come out of [the depression] for the first time, in a very real way. I came out of it more connected into my own humanity and more able to really engage socially and be, I think, a better partner and a better person.

I: So there was some growth as result of all the pain. You were better able to take care of yourself.

S: Yup, and feel, kind of, in a funny way, kind of – in the hand of the universe. I think it really solidified for me my own belief in God, and in being seen on the bigger – even though I know I'm very small – being held somehow by life, or existence, or whatever it all is, the big mystery.

In other words, Susan was not only “better able to take care of herself,” one of the main goals of cognitive-behavioral therapy for depression. More than this, she actually experienced cared for by “God ... life, or existence, or whatever it all is, the big mystery.” She feels safe and connected at last.

### **John – Quest Automythology**

*Introduction:* Joseph Campbell speaks of the “monomyth” of the lone male leaving home to seek his fortune and prove himself – the hero's journey. John's narrative is very much this genre, which we can categorize as Romance/Quest. It is a story of travel, adventure and finding love, the story of leaving home and finding it again elsewhere. John tells of a life long struggle with depression and low self-esteem. By the end of his tale, he claims to have been transformed: he has become more spontaneous, more playful, more innocent, more “his real self.”

We had the interview in a private soundproof office. As John sat in the swivel academic office chair, running his fingers through his tousled hair often as he mulled over a question, or tapping his finger slowly against his chin, he appeared the pensive philosopher. There were many pauses as he searched for the perfect word. Language seemed to be important to him, right from the beginning, as he questioned the label of depression itself within the first five minutes of the interview. He leaned forward with excitement when describing one of the key events, when he had his wallet stolen while



overseas, apparently relishing the drama of the anecdote. John loves to tell stories and to philosophize.

*Story Synopsis:* The story opens with the cursory mention of the divorce of John's parents when he was 8. His mother took him and his two sisters and their dog off to Europe for a year, as a break from the sadness at home. This was a wonderful year of adventure and friends, but the return to Canada was hard on ten-year-old John, whose feelings of fatigue and being out of place increased as he turned 12 and 13. Going to a school with an outdoor program at 15 brought a welcome lift to his spirits, as he enjoyed the physical activities and the new friends. However, by the end of his teens he was feeling blue again, feeling inauthentic, and not knowing who he was or what he wanted. The move across Canada to drama school at age 19 held great potential for excitement, and indeed, the first year was good. However, when John moved in with a new roommate, and tried to settle into the second year of school, he started to experience mood swings, between manic elated energy and depression. He eventually sunk into a serious depression which led to his quitting school and moving home to recover. His father, a psychiatrist, was involved in his care. His second major depression came in his late 20s, which medication and counseling helped in part to allay. What John describes as the pivotal period in his life was when he ended a six-year old relationship and moved to a new country in his early 30s. Another very exciting time, but fraught with insecurity, the sojourn overseas was marked with periods of low-level depression, and John experienced his third depression episode. Often lonely, and sometimes without work, John struggled to establish himself in a new place. Counsellors, friends, getting work and meeting his life partner all contributed to John's recovery. He attributes his relatively stable happiness since that difficult time period to his wife.

*Analysis:* John's narrative stance is a heroic, independent one, and also one of resistance in terms of depression discourse. He not only questions the medical use of the term "depression," but he is reluctant to see it as an integral part of his identity. Despite describing much of his life as being driven by low self-esteem, "feeling bad about myself," and receiving two diagnoses of depression, he sees himself as being in charge.

Now I can look back and judge it as a bad time for me. But I tend to think quietness, sadness is good sometimes. Some people might say that's depression. But I think the key thing is, can you move into it and can you move out of it?

He is irritated by his father's stance, a psychiatrist who has a more essentialist view of depression and human nature in general:

My dad is like that. He says, "Oh, I'm just not the kind of person that shows love." But he says it in such a way that it's not like he's grappling with it, it's not like he wishes to be different, basically he's resigned and accepted it. He's very Buddhist about it. I don't want that . . . Where's the room to move? Where's the way to get what you really want? Is that what you really want to be – depressed?

He sees depression more as an external force that he "invites . . . consciously or unconsciously, into my life." It is not himself:

The actual thing? I don't think that is part of myself. The actual full-blown mess of it? No. Well, it's not there now, so am I "myself"?

In this way, John narrates his story as a conscious creator of the tale. He believes that he chooses difficult or potentially depressing situations to "kind of test myself." This solitary hero who says, "I established myself from almost nothing," is also quick to acknowledge the help and influence from others – strangers, his family, and his wife. But there is no victim stance, nothing fatalistic. He believes he is in the driver's seat as the author of his life.

The valued endpoint of John's story is a sense of belonging, and "home," not only in the external environment, but in his inner life. He searches for his "true self" through his various adventures and at the end of the story is proud to say that he feels more "himself." He begins his story by painting an image of himself at the age of 17, camping with his mother and sisters, staring into the fire, asking himself, "What the hell am I doing here? . . . It's just the wrong place." This was the first self-identified depression, although he describes his childhood and early teens as low-grade depression with feelings of low self-worth. The refrain, "it's just the wrong place," frames the rest of the tale, as John speaks of struggling through several physical and emotional dislocations: as a sensitive lonely 8 year old boy numbed by the divorce of his parents, making a new self in Europe at 8 years old, and then coming "home" at 10:

So when I came back, I kind of see myself as this kid that's a little bit wan, a little bit out of place and didn't do well in school . . . I couldn't fit in, didn't feel good about myself.

The depressions he experienced at ages 19 and 33 were also related to feeling alone and uncomfortable in a new environment. He ponders what was going on in his first diagnosed depression in his early 20s: "Feeling lonely, feeling undervalued, disconnected from my dad, and not feeling a good sense of who I am, away from home ... kind of disconnected socially." He drops out of college, feeling unsupported and frightened so far from home, and recovers at his mother's home. It is overseas where his self-descriptions are most poignant: the lone resourceful hero with no money or friends in a strange country:

When I was there, I was again disconnected. That was probably seven years ago. Socially disconnected. New country and not much money, no job.

It seems that John's feelings of being out-of-place and not connected are tied to the depression. Yet he goes on to say something interesting in terms of personal agency:

J: I also think I do those things to kind of test myself. And to come down to ground zero, you know, let's see how this all works out. Instead of this, "I kind of have friends and I kind of don't," let's see what really happens. And there's nothing else kind of like that in a way.

I: I don't know if this is right – As you were speaking, I had this image of a solitary adventurer, kind of just throwing himself out there.

J: Yeah! I have a belief in my resilience and it's connected to that. It's kind of like, I am not really good at handling all of the little things but if anything really hard comes at me, I feel that I can respond really well.

I: The way you spoke about it, it's like you almost enjoy testing that out.

J: Yeah I guess it really makes me feel good about myself. I look back and lots of things I don't feel good about, they were hard but I think, well okay, I just kept going and I believed that I could. And I did get a job, got a place to live, made new friends ... I just kind of established myself from almost nothing.

John implies that he actually chooses isolating situations and harsh environments in order to test and find himself, even though these situations bring depression.

For John, the turning point towards his valued endpoint, finding his true self, was the difficult period of time overseas in his early 30s. During this time, we can see him both surrendering to the interdependent nature of relationship and exercising significant agentic choices. It is through his seeking and self-testing that he finds his wife, and his happiness. Although he often mentions how important it is for him to choose his life, his identity, even his depression ("I invite it, consciously or unconsciously, into my life"), he concludes that belonging and connection are more important than individual success:

I: So it almost sounds like you are rather more accepting of it [depression] now?

J: I'm not as afraid of it and I guess you could say I'm more accepting just because I know that it's going to go away.

I: Ok. So you're more familiar with how it comes and goes?

J: I just have more faith, partly because I've just seen it happen, not because of any great beliefs. I do feel much happier and more secure and more confident. And I think I'm more humble. I think when I said earlier, how long have I been happy? Well since I've known my wife. Well that kind of struck me, sometimes I've told her that, you know, I've said, like, "I'm a lot happier and it's a lot because of you," and sometimes I feel that's a little scary, you know. Am I just relying on someone else to make me happy? But I know that I'm happier if I'm in a relationship. I think the other thing is that I'm more myself with her, you know.

He goes on to say as part of his conclusion that it is relationship that brings him happiness.

I think if I look forward into the future I see this as being probably the direction I would like to go. Probably one which would take me away from depression *per se*. Again, I don't ever want to not feel sad or whatever, but I want to stay away from the sort of thing where I don't feel good about myself. It's so interesting because it's not about feeling *great* about myself. It's not that I have to go out and do wonderful things. I think I used to think that the way I can feel good about myself was to have a lot of successes of sorts, and I think that is really great, that helps, but if I had to sort of put money on my hopes of my plans for being happier, I don't think I'd put it on that. I just somehow, it seems, the human connection, it's more of this earth, more dependable, more meaningful.

Tracing the narrator's sense of agency through his tale is especially interesting considering this turning point. Not a typical macho hero – as Frank describes Hercules “wrestling and slugging his way through opponents” (1995, p. 119) -- John seems even more heroic since he throws himself into unknown and challenging situations despite his wavering self esteem and his depression. He sees his life as a series of choices, including his depressions. That the turning point of his recovery of depression involved surrendering to the importance of another human being somewhat complicates his view of his self-agency: “Sometimes I feel that's a little scary, you know. Am I just relying on someone else to make me happy?” but he is resolute on the point that marriage has been significant in his recovery. He is quick to add, however, that also important were decisions such as ending a long-term relationship that was no longer working, seeking more satisfying work, and generally, making a renewed commitment to authenticity. Thus, the tale of the lone male adventurer ends with his acknowledgment that simple

agency – action, success, and competence -- is not enough for his happiness. Instead, he finds happiness in his sense of “home” and family, and his identity in relation to others. What John stresses is that the home that he finally resides in so happily is the profound feeling of “being at home with myself.” From this place of connection to self and others, he knows that depression will come and that it will go, and he doesn’t fear it.

### **Brigitte – Quest Automythology**

*Introduction:* Brigitte tells a story of resilience in the face of great suffering and chaos. The story is constructed as a fairytale: there is a cast of colourful characters and a plethora of fantastic, almost unbelievable events. Brigitte attributes her adult life of abuse and depression to the early abuse she suffered at the hands of her grandmother. Her silent passive grandfather she refers to as “The Invisible Man” and her mother whom she “adores” but who abandons her is described in magical terms:

She was this beautiful princess. She’s very pretty and she’s just the life and soul of the party, and she’s a singer, and I was so proud of her, and still am, right? As a child, it was like, she was this fairy princess, nothing could touch her, right?

There are men and women along the way that she learns to recognize as “abusers,” and finally, her third husband who rescues her in the end, and gives her the love and the happy home she had sought all her life. Although Brigitte’s story tends more towards the “happy ever after” trajectory than any of the other tales, she still acknowledges that her daily life involves coping with occasional low moods and also struggling with Seasonal Affective Disorder, and she realizes that depression may indeed return in the future. Surviving an horrific series of life events (and Brigitte refers to herself as a “depression survivor”), she is able to say at the age of 53, “I went through life not having a life, like being *dead* and now I’ve been given a new lease, and what’s not to be happy about? . . . I’m creating my own reality! I’m not a child. I don’t deal with abusers anymore.” This feeling of a “new lease” evokes the quality of the born-again experience of the automythology.

Brigitte was one of the most eager participants of the seven to be involved in the study. From the initial phone and email contact, and certainly in the interview, it became clear that she is proud of her life story and derives a lot of pleasure and meaning from telling it and continuing to make sense of it. She greeted me in the lobby of her work

place, looking the part of a professional, confident business woman, and soon we were sitting in a private conference room. From the moment Brigitte started speaking, I was under her spell. Possibly as charismatic and engaging as her mother who had had a professional stage life, Brigitte skipped from anecdote to anecdote, sometimes almost breathless with excitement, building scenes for me, complete with dialogue.

*Story Synopsis:* Born in Africa, Brigitte was four when her parents divorced and her mother went to work full time as a singer and a dancer. Brigitte felt abandoned in the care of a servant, although she enjoyed playing with her older brother. Things got worse when she and her brother were sent to her grandmother's house to live, and shortly afterwards, were legally adopted by her. A strict disciplinarian with a sharp critical tongue, her grandmother told both of them that from that time on she was to be referred to as "mom" and that their birth mother was really their sister. When Brigitte's younger sister was also taken in by the grandmother two years later, life got really hard. For some reason, the little sister was favoured, and Brigitte was abused emotionally and verbally. Although she adored her grandfather, he was a silent and passive man and did not take any action to protect her from the cruel taunting and random punishments from the grandmother. Suicidal thoughts and self-cutting began. When her birth mother remarried and invited Brigitte to live with her again, Brigitte's life turned upwards and she enjoyed her teens, her boyfriend, and living with her beautiful mother. Marrying an alcoholic man at the age of 21 brought more troubles, and divorcing him three years later seemed a happy upswing. However, within the year, Brigitte was married again, to another abusive man. The young couple followed her mother who had immigrated to Canada, had their first child there, and then were forced to return to South Africa for visa reasons. Brigitte enjoyed the year at "home" in South Africa, taking care of the new baby, and visiting with her grandfather. Shortly after their decision to return to Canada, her grandfather died, a sad event that was not properly acknowledged or grieved. Moving back to Canada, still grieving her grandfather, mired in an abusive marriage, and with no support system, Brigitte plummeted in a depression which was to continue for several years, through bringing up three children and trying several different forms of medication and individual and group therapy. When Brigitte's daughter, a teenager, was hospitalized for a suicide attempt, Brigitte decided that it was time to leave her abusive husband. This

decision marks a turning point towards the happy ending. Away from him, Brigitte is able to begin to address some of her deep life long issues. When she realizes that although she has a beautiful home, is safe at last from her ex-husband, and has a job she loves, she still feels hopeless and suicidal, she turns to EMDR therapy as a treatment for trauma. This seems to be the missing key to a more profound depression recovery. Speaking with the counsellor about her difficult and chaotic life story, she is encouraged to make meaning of it by finding repeating patterns in, for example, the types of characters that present themselves. This life review is of significant help to her. She meets a kind, good man and marries for the third time. She is resolved to enjoy her midlife years with more safety, love and wisdom than she could have imagined.

*Analysis:* Brigitte's story is epic in its scope, spanning continents, and one gets the feeling that the narrator is not quite in control of such a big story. In fact, in a post-interview email, Brigitte says her story "feels like several lifetimes in one," and this is definitely the sense that the listener gets. There are lots of pauses and "now, where was I?" and moving back and forwards in time. The narrator tells the story from a place of enthusiasm, even joy – she is very intrigued by her own story, and through much self-reflection and psychotherapy, has pieced together the events in a way that she is happy telling it. However, even as a young girl, she was busy constructing it, as she reveals in an anecdote of her best friend begging her at the age of 10, "Tell me the story of your family again!" Brigitte's narrative stands out from the others because it is full of lively anecdotes complete with characterization and dialogue.

As a valued endpoint, Brigitte longs for the security and love of home. She is conscious of having a life goal of a happy family, particularly since she lacked this herself as a child. She understands her depression as being a reaction to two events: abandonment (by her mother at age 4, when because of a divorce, her mother had to work and leave Brigitte in the care of a servant, and again at age 5 when Brigitte was sent to her grandmother) and abuse (by her grandmother who legally adopted Brigitte at the age of five). This goal of a happy family is thwarted again and again as Brigitte recreates her family-of-origin dysfunctions in two abusive marriages and problems at work. She sees the irony in it now – that because she vowed not to divorce, seeing her own mother's four painful marriages, she resolved to stay with abusive men far too long. Brigitte is aware of

always having felt depressed. Her perception is that the depression was covered up for much of her life by survival needs (being in abusive family and marriages) and anger, bubbling up in several suicide attempts. Her life long depression is not significantly touched by antidepressants or counselling until she is able to leave her second husband.

There are many crises in this tale which seems a jumble of various emergencies. A significant turning point which appears to send Brigitte even deeper into depression is the return to Canada from one year back home in South Africa, after the death of her beloved grandfather. This, coupled with the craziness of living in an abusive marriage, sends Brigitte into a long period of depression, where she repeatedly found herself saying, "I don't want to live. I don't want to live." Interestingly, it is only after she, in midlife, divorces her second husband, clears her life of abusive people, gets status and competency in her career, and is financially independent, that the depression rears its head in a dramatic way, when she admits that despite the externally "good" environment, she still doesn't want to live. Therapy really helps at this turning point. Brigitte had undergone medication, individual counselling and various groups (self esteem, parenting) all of which helped ease the symptoms of depression. But when she finally receives trauma counselling (EMDR), followed by a life review in which she is able to piece together the various fragments of a very chaotic and miserable life, a happy ending (complete with a happy wedding) ensues. Although Brigitte does not think depression will come again in the same way, she acknowledges that she probably has some biological predisposition towards depression (e.g. family history and SAD). She knows how to get help if depression hits again and is now learning how to incorporate sadness into her life without panicking that it is depression.

For Brigitte, greater self-agency is the result of greater awareness of previous unconscious patterns. She appears delighted to be able to recognize her family-of-origin members in various life and work situations:

Now this same scenario with my sister, my second husband caused with my two daughters. The same pattern, I've watched it, and now that it's behind me, I let them know that this is a set up. This is abuse that was set up to make [them] enemies and the reason is that he took one child to side with him, and that's what happened with my grandmother, my sister and I, there were triangles going on ... I think back and go, "Oh, this is incredible, this is happening again."



She uses her feelings of depression – “I don’t know how to explain it, almost like something died” -- now as a signal from her wise self that an “abuser” is in the vicinity and that she is unsafe: “Now, if I get that . . . feeling, I’d go, ‘Hang on a second, what’s going on here, what’s the feeling telling me?’” Greater awareness leads to greater possibilities of wiser choices in work and relationship.

### **Barbara – Quest Automythology**

*Introduction:* Barbara is an archetypal Romance/Quest traveler. Her story includes many different settings as she moves from place to place, as a child, against her will, and as an adult, in search of excitement and knowledge. Battling several depressive episodes, and a long period of low-level depression in her 40s, Barbara was able in her most recent depression to get the counselling she needed to make sense of a confusing life story. Looking at her story from the age of 51, a perspective which includes the freedom from a 20 year long abusive marriage, the self-esteem gained through career success, and the wisdom from counselling, Barbara feels like she has been reborn. Rather similar to John, she says that she has reclaimed the innocence of childhood:

The little girl is still there and the excitement, the appreciation of the environment, and the challenge, the excitement, she’s still there. . . In the future I’m going to live very honestly . . . as a little child. The evasive way of living was very unnatural to me . . . All those years, 20 years of marriage, stole myself from myself. Now I know it’s ok to be me. . . I like myself now.

This is a heroine of an automythology – a Phoenix reborn from the ashes.

Barbara insisted on coming to me for the interview, to save me the trouble of travel. She explained that she saw the interview as being actually more for her own sake - as something that may be a somewhat difficult but helpful step in her recovery, which at this point involves speaking out honestly about her life rather than hiding it. She didn’t seem to mind or notice the rather austere setting of the sound proof interviewing room, and started speaking right away in a very articulate, measured, and matter of fact fashion. The interview was more concise than some of the others, and I had the feeling that there was not a word out of place. Barbara takes her depression recovery very seriously and has worked hard at placing it in the context of her life story. A few times, she seemed pleased by interview questions that gave her a new way of looking at things, but generally speaking, this was a story that was already very well-thought through and crafted. When

she finished speaking, it was with a sigh of relief, as if she could check the interview experience off her list of challenges she had set herself in the recovery process. She thanked me very warmly.

*Story Synopsis:* Barbara's story opens in a way that is different from the other six participants. She had a wonderful, idyllic childhood up north, apparently free from trauma, abuse or neglect. She grew up with a love for nature and very content in the small supportive school where she was in an accelerated program, and hence, two years ahead of others her age. At the age of 11, when her family moved down to a big city, this happy era ended and Barbara experienced being teased by her classmates who were not only two years older than she was, but more urban and sophisticated. She withdrew and began to develop obsessive "magical" routines to help her get through the year. By summer, this precocious girl decided that since she was going to a new school in the fall (high school), she would create a new persona. She started piano lessons and band, cheered up, and enjoyed her high school years as a more outgoing and happy student. Entering university at age 16, things went downhill again. Living away from home with a difficult roommate, and going to classes taught by professors she didn't like, triggered another depression, and she quit university after suffering through the first year. Transferring to a college where she could pursue her music, traveling to Europe for the first time, and then completing her undergraduate degree finally at another university, lifted her spirits enormously and so she enjoyed her years from 17 to 20. However, another drop into depression occurred after graduation, when she couldn't find work and at the same time, had a painful relationship break up and moved back to the city. It was in this third depressive episode that she went to a doctor, was diagnosed with depression and received medication. Barbara felt no benefit from the antidepressants, but the depression started to lift eventually over time, as she started and completed the Royal Conservatory in flute, got a job, and traveled to France again to do music training. At 26, she got married and enjoyed the first five years of married life and two babies. However, after the third baby was born, she lapsed into a low-level depression which continued for more than ten years. Very busy with family life and teaching, she did not recognize the depression as such, but just got through the days with little vitality or enjoyment. Increasingly dissatisfied with her marriage, she experienced not only little emotional support, but more and more

emotional and verbal bullying by her husband. When her underachieving, gifted son finally graduated after much support by Barbara, and her husband recuperated from a heart bypass operation, Barbara crashed in her fourth and most serious depression where she experienced enormous fatigue, so much so that it was difficult to get out of bed for weeks at a time. This time, antidepressants worked well enough to bring her out of the depression after several months, and she started graduate studies, which she enjoyed immensely. However, a fifth and important depressive episode occurred at age 49, when she returned from study in England. Amidst the difficulties of an abusive marriage, the illness and death of her mother, and finishing her MA, Barbara crashed again. This time, with antidepressants and effective interpersonal counselling, Barbara was successful in making important changes in her life. She separated from her husband, and started to tell friends and family the truth of her depressions and the abuse. She started more graduate study. She has been free of depression for 15 months and feels a significant change in her attitudes to herself and to life. No longer a victim of her negative thinking or domestic oppression, she is hopeful about the future.

*Analysis:* The position of hard-earned understanding is a salient refrain throughout Barbara's tale. She recalls her lack of awareness of her suffering when she was younger: "It was as a child so I didn't really know what was happening to me." "I think I was in a sort of low-level depression for a while, but I didn't recognize it as such, because I was too busy, however in retrospect I can see that I wasn't having a very vital life." "Well, I didn't even think of it. I didn't think of it as depression."

I didn't think there was anything wrong, I never thought I was sick, I never thought I needed help. . . I was a little confused about it. Trying to figure that out, but never seeking any help, which I never thought about before until recently. Because it was just something that was happening to me so . . . I just didn't know, and I didn't even think to know.

Barbara is very much the problem-solving hero, and as she goes through episodes, she starts to recognize some patterns and realize that she needs help. She repeats phrases like "I didn't understand," "I tried to figure it out," "I figured out ways to get myself out of the situation," and we have the sense of a determined intellectual gradually working out the puzzle of her repeated depressions. Also, as will be discussed below in terms of agency, Barbara's discourse is rich with self-agentic references, like "I decided," "I

chose,” “I did that.” Thus her narrative stance is an active one of piecing things together and finding solutions and explanations for her story’s puzzles.

There are a few ways to see Barbara’s “valued endpoint.” Since young adulthood, she moved around a lot, to and from various colleges and universities, and between Canada and Europe, apparently seeking both an environment and an academic program which suited her. France seemed to be a good fit for a while, and she describes her first foray there with great enthusiasm:

There was never any depression, never any questioning of myself at all. I had the most wonderful time challenging myself in different ways and finding that I could meet any challenge. Any challenge that came up, and having so much fun! I just loved the different culture, I just fell in love with France . . . It’s the combination of excitement . . . but it’s past excitement, it’s thrilling, it’s thrilling and a combination of challenge and thrill and always feeling like I belonged there.

Since the original wounding experience of feeling out of place as a precocious 11 year old in a new urban environment, Barbara seeks environments where she not only fits in comfortably, but where she is challenged. Her depressions and recoveries are marked by physical coming and going. Not only changing places, but finding more appropriate study or work seems to satisfy Barbara, and so part of her “valued endpoint” might be construed as finding her life work, although she does not articulate it as such. Various dead-end stabs at academic programs and a variety of teaching jobs do not quite do the trick. After Barbara defends her master’s thesis so impressively that they invite her into the doctoral program on the spot, she appears to settle into a career focus that fits her. Shedding the non-supportive and abusive context of the marriage frees Barbara to engage fully in her work. A more subtle life goal is implied through her description of her recent recovery: “In the future, I’m going to live very honestly . . . as a little child . . . That sort of evasive way of living [in marriage] was very unnatural to me.” As she stated to me in terms of her giving the interview, speaking honestly about herself and her life experience are daily goals for her now, in her new recovered life.

Looking at Barbara’s lifeline graph (Appendix G), we can see that four of the five depression episodes are in the context of moving to a new place and situation with which Barbara is not comfortable. Likewise, the recovery from the first three of these (ages 11 – 25) involves moving to a more suitable place and engaging in satisfying study. Barbara

becomes aware that she needs help by the third episode, but the pharmaceutical help that she receives is not effective. Her fourth episode in midlife appears triggered, not by a physical move but by utter exhaustion after she successfully gets her son through high school graduation, and her husband through heart surgery recovery. She collapses and for the first time finds an antidepressant which is helpful. The final and pivotal depression seems triggered by leaving Europe (which she loves) and returning to a home that she didn't like, coupled with her mother's death and a disintegrating marriage. It is in this episode that Barbara experiences a significant turning point to recovery – she receives appropriate counselling which supports her in her separation from an abusive relationship and helps her to make sense of a life of recurrent depression.

Tracing Barbara's actions and choices through the turning points of her life story presents an interesting picture of the role of agency in depression and depression recovery. She presents as an extremely self-aware and independent protagonist, right from the age of 11: "I found myself a piano teacher ... I came out and I did that," "I decided that summer that I was going to high school to a new school, new people, and I would be somebody different ... I made that decision," "it was always up to me, so I figured out ways to get myself out of situations," "I could meet any challenge," "I did it all by myself," "I got out of it by myself," "I did all of that" "I [took antidepressants] for a few months and took myself off it." One of the problems seems to be that Barbara was so competent at "surviving" by herself, that she isolated herself from healthy relationships and appropriate help, and her depression and her abusive marriage continued for decades without anyone even knowing about it. This is another refrain in the interview – "I didn't talk to anybody about it, nobody," "I didn't tell anybody what I was going through," "I just kept it to myself," "never seeking any help," "Nobody knew," "Nobody knew about it and still nobody knows about it." There is an enormous bustle of activity in Barbara's story – trying new locations, new academic programs – but this activity does not lead to the happiness she is looking for. When she settles down to "[try] to understand how I got myself into this life of mine right at the moment," gets effective counselling, and takes measures to leave her abusive husband, she becomes freer to make empowering choices for herself. Learning more about her negative and obsessive thinking patterns through cognitive therapy has been helpful. Near the end of the

interview, Barbara says emphatically, "I know that this depression is under my control. I am in control of this." Even if she falls into depression again in the future, she says,

I'll be on top of things as much as I can . . . I have a lot more strategies at hand. If I look at it not as a victim but as somebody in control and appreciate myself for these feelings and thoughts – they're still part of me – but I can appreciate them and deal with it. I don't feel badly anymore that I'm a sensitive human being.

Thus a highly independent and resourceful sufferer from depression finds a new way of living which involves accepting herself and living more honestly.

### **Ruth – Quest Memoir**

*Introduction:* Ruth's story, a Quest-Memoir, has a tragic undertone. The quest is for her "true self" as she moves from being in hiding, to gradually revealing herself to the world through her art and in select friendships:

I think gradually I have become more comfortable being the odd ball that I think I am. I'm feeling I'm getting more comfortable with the things that can be seen, so that I think a lot for me was hiding who I was.

The ending is not what one could call "happy" but the protagonist moves from quite serious lifelong suffering to a place of somewhat greater comfort and agency, and from "hiding" who she was, to sharing herself more honestly and generously with others. For this narrator, life is a struggle. It's a struggle being human, taking physical form, dealing with the body and its weaknesses. Raised in a large, chaotic family where corporeal punishment was the norm, and with a sense of always having felt sad, the protagonist moves through her life experiences battling anxiety and depression. Her story does not offer the dramatic transformation of the automythology. Ruth does not speak as a prophet or a phoenix, but in the quiet tones of surrender to a life which in its very physical nature is one of suffering. Her depression is a double-edged sword, "It was a breakdown, but it was also the beginning to an authentic kind of living." Although she says she would like to feel "better," she hesitates to imagine what "better" would be like:

Now, as for an answer, and not that I believe in truth . . . I think that's what the work is, it's building up a relationship with aspects of my experience, it's not really defining anything, it's just speaking to the questions.

As will be addressed more fully in the Discussion section, this gentle memoir in fact offers a somewhat radical resistance to the dominant master narratives in illness writing by its refusal to offer more of a conclusion than this.

Ruth invited me to her home for the interview. I was greeted at the door by a quiet, friendly woman in her mid 40s. Her intense eyes belied her gentleness of greeting and gracious invitation to step inside. I at once felt at home in a lovely, airy sitting room, filled with paintings and sculptures and three large cats who sat in different corners of the room, gazing at us during the interview. The interview was punctuated by the taking of tea and cake, interacting with the cats, and looking at Ruth's art as she mentioned various pieces.

*Story Synopsis:* Ruth's story begins with her memory at age 10 of not wanting to go home after enjoying the peace and love of a girlfriend's family, and feeling very depressed. Her home was filled with the chaos of seven siblings and two parents who relied on corporal punishment to manage discipline issues. Ruth, second oldest in the lineup, played the role of peacekeeper and emotional caretaker to her siblings. At 20, she started work at a shop and became involved in the union which brought her a lot of satisfaction. At this time, she fell in love with the man with whom she would stay in partnership for 20 years. Despite the positive aspects of work and her relationship, Ruth often was overwhelmed by anxiety and depression. She started experiencing a neurological disorder which would stay with her throughout her life, bringing a lot of physical discomfort. She entered art school in her mid 20s, which was a wonderful new world for her. However, as she became more self-disclosing through her art, she also became more depressed, anxious, and started to experience visual hallucinations. Therapy helped considerably in what she describes as a breakdown. Ruth's thirties were difficult, full of ups and downs. Working in her studio and doing art shows would bring her up, working in the shop part-time would often bring her down, and there were many days when she simply couldn't get out of bed. It was in her early 40s that she and her partner decided to end their relationship in an amicable parting of ways. In anticipation of a rocky transition, Ruth tried antidepressants and found that they helped dramatically to relieve her lifelong anxiety. However, the texture of depression lingers in her daily life and she continues to have good days and bad days. A new physical symptom has come

up, extreme pain in her feet which makes it difficult to walk. Her friends, her cats, her art work, along with yoga and meditation, help Ruth in managing the emotional and physical pain that seems part of her life.

*Analysis:* Ruth's position as recovered wise narrator is much more tentative than the others. The antidepressants help with anxiety but she is still left struggling with daily mood shifts. As she tells her story, she mentions a few times how certain events (for example, art school, counselling, and talking with other depressed friends) have helped her *understand* rather than alleviate the depression. She is what I experienced as a "generous" narrator, not dogmatic in her narrative but often inviting my comments, interpretations, and opinions, and wanting to know about my own experience. Ruth fits Frank's description of the Quest heroine as one whose heroism is "evidenced not by force of arms but by perseverance" (p. 119):

The paradigmatic [quest] hero is not some Hercules wrestling and slugging his way through opponents, but the bodhisattva, the compassionate being who vows to return to earth to share her enlightenment with others. . . . The hero's moral status derives from being initiated through agony to atonement: the realization of oneness of himself with the world, and oneness of the world with its principle of creation. Suffering is integral to this principle, and learning the integrity of suffering is central . . ." (p. 119).

Reading the interview transcript and recalling the interview context, I am struck by how "postmodern" Ruth is as a narrator. She questions the medical diagnosis of depression – "I think some people's brains are configured in certain ways, and in a way, it's the society that doesn't really make a lot of room for different kinds of ways of being." Her narrative was not punctuated by events but by musings, pauses, the taking of tea, attention directed to her three cats, display and discussion of her art pieces, and often a gentle reversal of questioning towards the interviewer. Gergen and Gergen (1986) point to this postmodern narrator as one who feels less bound to "[arrange] events in a temporal order relevant to goal attainment" (p. 26). A rich interruption occurred midway when Ruth asked if I would like to see some of her sculptures:

I: I'm interested in the word you used a few minutes ago, feeling "safe." Because of the yoga practice, you were able to develop more of a sense of safety in your body, which I guess was really missing in your childhood.

R: Yeah. I don't know how to quite describe that. I think I'm working right now – it's a piece that's kind of dealing with navigation but it's navigation of the self.



I've worked a lot with animal bodies and now I'm working with the human body. . . I'll show you some . . . I have a few pieces here . . . [Shows me a doll-sized figure, which she describes laughingly as a crucifix] Like human and animal . . . there's real authority in her stance . . . she's kind of bound up in the legs . . . I'm trying to deal with something of the struggle within my physical body in a different way.

Thus, this interview experience was made up of multiple ways of knowing rather than simple storytelling. Indeed, Ruth suggested later in a post-interview conversation that her art might represent her depression recovery more accurately than the interview, for example, the sculpture that she showed me during the interview. This sculpture depicted a warrior-like woman standing defiantly and proudly despite her bound legs, perhaps expressing Ruth's heroic stance to her lifetime of suffering.

The valued endpoint of Ruth's story is not as clearly defined as in some of the narratives. Relief from physical suffering and a greater comfort with her "real self" are two goals that seem to drive her tale. The physical pain and discomfort in her body started with corporeal punishment in childhood, continued with the neurological disorder and the very physical symptoms of anxiety and depression, and now, a lot of pain in her feet and legs. Ruth describes many of her efforts to ease this pain: counselling, medical treatment, medication, yoga and currently, mindfulness meditation. These have brought only partial relief, and in a post-interview conversation, she said she sees her recovery from depression more in terms of learning how to live with it, how to find happiness within the overall experience of being depressed. Ruth's stance is a good example of what David Karp describes as the surrender to depression. It is not a passive stance. She does not blame her parents for the physical suffering she experienced – "My parents, I don't think they were ill meaning . . . You know, that's what happened to them." She continues to seek help for her pain, but focuses on "understanding" the depression, almost like getting to know it. Expressing her true self, her commitment to art is her avenue to this goal:

"[Art] also really can bring me into [depression]. It's a way of working, it makes me deal with myself. It is a struggle, it's not some fun enjoyable experience that some people might think. It's heavy, it's difficult. If I can express something visually, if I feel that kind of resonance, that's very powerful.

In terms of turning points, Ruth describes a life of many ups and downs in situation and mood. She was one of two in the group who was not satisfied with the lifeline graph which showed the turning points of art school, meeting her partner, having her breakdown, breaking up with her partner and starting antidepressants. These events she concedes were important ones, but part of a texture of daily life which was full of happy and sad, positive and negative, moments. Plotting the events of her life in this linear and categorical way did not represent her experience. "It just doesn't really fit," she said in a post-interview telephone conversation. Firstly, she wondered if it was because of the nature of her depression, which is more chronic than recurrent; she felt that in order to manage or "recover" from depression, she had to learn how to find happy moments within the depression and that there were not discrete periods of "happy" or "sad," "depressed" or "not depressed." Her felt experience of depression changes moment-to-moment, day-to-day, and so the broad macro-narrative structure of the life story graph, she felt, was not appropriate for her. The inappropriateness of the story line graph representation for Ruth may indeed be related to the more chronic rather than episodic depression she experiences, but it may also relate to her constructivist world-view as an artist: "It's like there are no rules, it's like what we perceive is what we choose to perceive and we invent whatever we want to as our reality." Secondly, and related to this, Ruth took issue with the language in the graph, which was first labeled "happy" and "sad" as the y-axis dimensions. As she correctly pointed out, sadness is not necessarily the same as depression, and her experience of more chronic depression means that she has learned to find happy and sad moments within the background of depression.

Ruth's story, typical of the memoir, does not have a dramatic turning point. However, she uses the term "turning point" to describe how entering art school helped her to understand (not recover from) her depression:

I think art school was real turning point in my understanding of my depression . . .  
When I went to art school, first of all, I felt in some ways I had come home to something in myself, probably other than my family.

Expressing herself through art led to more introspection, a greater awareness of how "disembodied" and rigid she felt, and serious depression:

Well, what started happening first was that I started [experiencing symptoms of the disorder] and it was quite bad because I think it was a kind of push between

expressing myself in a really deep and honest way in a visual way and then hiding myself in a kind of personal way.

Her subsequent “breakdown” was also an interesting turning point – not towards recovery, but “the beginning of an authentic kind of living” which continued to be painful. Counselling helped at this stage but life continued to be a struggle to maintain a grip on reality and self-care. She recalls thinking she was going crazy, telling her therapist,

It’s like I got one arm holding onto some kind of world of reality and the other is just . . . I mean . . . it’s just like there are no rules, it’s like what we perceive is what we choose to perceive and we invent whatever we want to as our reality . . . How do I keep in the world?

Ending her long-term relationship was another turning point which indirectly helped her towards greater recovery. “In anticipation of falling apart” after the breakup, she goes on antidepressants which bring a significant decrease to her lifelong level of anxiety. This lowered anxiety, coupled with the new situation of not having her partner available to take care of household tasks, helped Ruth to be more active and feel somewhat less depressed. In terms of a more spiritual epiphany, her growing understanding of love through yoga and meditation, and greater comfort with being who she “really is” marks her gradual recovery:

Yoga brought me back to my body and a new connection with love. I feel a certain kind of strength and generosity being with people. It’s freeing for me and also I think I’ve always had a certain compassion for people and their emotional lives.

Ruth continues to struggle with feelings of depression from day to day:

My understanding of the depression is that I’ve had it all along. Now I associate depression with a certain kind of intensity of just not being able to cope . . . It’s like these little breakdowns. I see my life as always struggling, always struggling against *that*.

Vipassana meditation, a practice of mindfulness, allows her to practice experiencing the coming and going of depressive feelings without judgment.

### **Yuki – Quest Memoir**

*Introduction:* Yuki, a 23 year old Asian-Canadian, had two episodes of depression during her undergraduate years, and got effective cognitive therapy. Her story was told in a Romantic/Quest genre, with the ups and downs of an unrequited love story. Yuki's quest is, on one level, for love, and at another, broader level, for independence. As a woman making the journey from adolescence to young adulthood, she cycles down twice to month-long periods of time when she has trouble concentrating, feels alienated, unworthy, and rejected, and seeks counselling at the university counselling centre. She understands her story of depression as a story of growing up, of gaining independence. According to Frank's classification, it is a memoir which stoically places the depression in her tale of "growing up" from the standpoint of greater wisdom of age, but with no dramatic epiphany.

We had the interview in a soundproof interview room which quickly faded into the background once Yuki started to speak. Her softly accented English (she was raised in Australia) was precise, slow and melodious. There was little eye contact throughout the interview and Yuki needed few prompts. She sat regally in the classroom chair as if on stage, and it was easy for me to see her as a heroine of a story. During the several long silences, I often wondered if she had understood the questions, or lost her train of thought, but then the pause was ended by a most articulate, considered response that had apparently taken time to form in her mind. This 23 year old seemed mature beyond her years in her poised delivery, but her story was very much one of the rite of passage between adolescence and adulthood.

*Story Synopsis:* Yuki was born in Asia, and remembers her childhood, until the age of 14, as being wonderful. When she was five, they moved to Australia, and at 10, moved back to her home country for 2 years before moving to Canada. By the age of 14, she was experiencing what she called teenage rebellion and spent the next five years in power struggles with her parents. She entered university at 18 with high hopes of a new life of freedom and happiness, but by the end of her first year, was depressed by her lack of success in classes, her feelings of unworthiness, failure, and loneliness. She was also puzzled and hurt by what she experienced as a rejection by her parents, especially her father, who refused to help her with her homework. She felt quite depressed for the

winter and spring term of that year, and found a counsellor at the university student counselling centre who helped her to identify her self-defeating thought patterns. This helped her to feel somewhat better, but it was when she took a summer course taught by a professor who seemed to notice her suffering and take her seriously, that she really started to feel better. Her grades steadily improved and Yuki steadily felt better. However in her third year, he explained to her that she was becoming too dependent on him, and he limited their contact. This shift in their relationship Yuki experienced as a rejection, which plunged her into her second depressive episode. She felt alone again, she started to question her worth and her chances at success, and sank again into depressive feelings and thoughts. However, this time, she was more able to identify the pessimistic thinking and she used what she had learned in counselling to reframe her thoughts. She started to consider her difficulties as a journey to independence, and felt warmer towards her parents and the professor who she realized were trying to help her along the way.

*Analysis:* As a narrator, Yuki is self-admonishing, shaking her head at the immaturity of the protagonist. The story is laced with phrases like, “Now I understand, but not then,” “I realized much later,” “Now I realize,” “Even though I didn’t know it.” This narrative position is used quite skillfully by Yuki as a device to create suspense. When questioned about her understanding of the relevance of, for example, her father suddenly not agreeing to help her with her college math homework, Yuki keeps me wondering:

I: Did you wonder if he was angry with you? Did you understand why he had changed his policy?

Y: (laughs) Well at first I didn’t. That surprised me a bit, and I didn’t understand why he wanted me to be so independent suddenly, until a couple of years later, when I could understand myself better (pause). So with no help from the usual sources I could turn to in high school, and struggling with the courses I didn’t enjoy, especially history, which I found awful, I just absentmindedly was going to classes . . .

This is an effective story-telling device. The listener is put into the same position as Yuki before she understood her father’s motivations, and in this way, empathy for the distressed, apparently abandoned heroine is created. Later in her tale, in keeping with the chronology of the events, Yuki reveals her understanding of “why he wanted [her] to be so independent suddenly.” It is in her second depression which is also an apparent

rejection (this time, by her professor) that Yuki grasps the importance of becoming more self-reliant:

There was a lot better self-control. And I think that's what my parents were asking for. They were hoping that I could develop by myself through the notion of being independent. I think I became comfortable enough with myself, independent enough, from my parents, from whoever, and wasn't so conscious about what other people thought of me, by learning to love myself.

Thus, she narrates her story from this more independent, more mature perspective, with a measure of awareness and compassion for the confused, younger protagonist.

The goal of Yuki's primary narrative is that of the protagonist "growing up" and becoming independent. In the first depression, she felt at a loss because of her perceived abandonment by her parents, particularly her father, and her poor success at school. She was lifted out of this depression not only by the student counsellor but by a professor who took a kindly interest in her sufferings. Unfortunately, the "recovery" from the blues was dashed a year later when the professor told her that he felt she had grown too dependent on him and asked her to limit her requests for help. This plunged her into a second episode, which she describes in terms of despair over a romantic break-up. The cognitive tools she learned in her first episode of challenging negative ruminations and reframing were helpful in dealing with this second episode. At the "end" of her depression recovery tale, Yuki, with an almost mischievous smile, said that "Now my story will turn to one of identity." She is aware of the many conflicts she has to resolve as an Asian-Canadian who feels neither Asian nor Canadian. At the age of 23, Yuki has successfully incorporated her two depression episodes into her understanding of "growing up" and says that since there is depression in her extended family, she wonders if she will have to face it again in the future. She appeared quite accepting of this, knowing that she has cognitive-behavioural strategies to prevent and or deal with an episode, and knowing she can ask for help when she needs it.

The role of agency in Yuki's journey to independence is an interesting one. She gives several examples of her "action-taking" even while she was depressed: visiting the university counselling centre, visiting the professor's office for help with a course she was finding difficult, using the cognitive reframing techniques she had learned in her first episode to cope with the second episode. The young adult protagonist demonstrates

considerable agency in her journey through two depressions. Although she is able to view her story with a lot of awareness, she still fails to acknowledge her own part as the author of this new independence. She uses phrases which imply unconscious or lucky choices: "I don't know how, but I stumbled to the university counselling centre one day," "I don't know how I pulled myself up to take a course I had failed in the first term," "I don't remember why exactly I went to the prof's office before the first class started, to ask, 'How can I study for this course so that I can succeed in it?'" When asked to explain how she recovered from the first depression, she attributes her recovery to external sources: "I had two sources to help me, where I could say whatever was on my mind. Counselling, and this professor." That is, the listener of the story can detect the personal agency in Yuki's choices that led her to her recovery, but Yuki, the 23 year old narrator, prefers to attribute her success to admired adults: counsellors, her professor, and her parents. It is not clear whether this is humility, or genuine unawareness of her role in her journey.

Yuki's memoir also lacks the dramatic internal epiphany of the automythology. By learning to apply the principles of cognitive therapy to her negative thinking, and by gradually completing a developmental piece of growing from adolescence to young adulthood, Yuki successfully recovers from her two depressions.

### **Ngoma – Quest Manifesto**

*Introduction:* Ngoma's tale is an excellent example of Frank's so-called quest-manifesto. Broadly speaking, it is a Romantic/Quest structure in which the narrator faces several obstacles and triumphs in the end. Yet unlike other Romantic/Quest tales, Ngoma's story burns with the fire of activism, marking it as a manifesto. Frank says,

The manifesto asserts that illness is a social issue, not simply a personal affliction. It witnesses how society has added to the physical problems that disease entails, and it calls for change, based on solidarity of the afflicted. (p. 122)

As an African-American, Ngoma's quest is for personal and social equality and freedom. His discourse has an apocalyptic urgency to it. He sees North American society with its racism, sexism, and materialism as a fallen world, in need of redemption. Depression is a healthy response to social injustice, a "wake up call":

I really believe that we were born into this world without depression. . . I mean, there may be diseases, there might be chemical imbalances, I'm not trying to sound like a utopian dreamer about this. But even the fact that there are cocaine

babies and stuff like that means that there is something wrong with the world that produces them. It doesn't mean that there's something wrong with people, it means that there's something wrong that presents itself that those people wind up having to escape reality...

In his view, his depressive episodes helped him to come into contact with the reality of his workplace oppression and take steps towards greater empowerment, by, for example, making public speeches about socio-political issues and engaging in dialogues with friends and professionals about these issues. If "recovering from depression" means falling asleep again to the injustices of society, recovery is dangerous:

I don't think the medication is enough. . . We need materialistic food, we need spiritual food. I think that anybody in their right mind would know that the world that we live in is a world where one can feel helpless, one can feel powerless, one can feel reactive to the condition that they're in. I think there are different levels . . . of threshold in what we're willing to take. So a person that might recover with drugs that believes in the fact that the druggie – the psychiatrist or the person dispensing the drugs – is doing the right thing, and that will be enough, [the drugs] might take him to a threshold where he's willing to accept the condition that he's in. A lot of times they'll go back, though, because they will realize there is something missing in their lives.

These words recall Frank's description of manifesto writers, who "do not want to go back to a former state of health, which is often viewed as a naïve illusion. They want to use suffering to move others forward with them" (1995, p. 121).

We had the interview in Ngoma's living room, surrounded by books of philosophy and musical instruments. He had prepared a small feast for us to nibble on, which was fortunate for both of us since the interview was a long and intense one. Ngoma was delighted by the opportunity for the interview, and repeated several times that he took it very seriously and saw it as part of his commitment to social change. Indeed the 90 minutes began quite seriously and I had the impression that Ngoma had thought carefully about what he wanted to address, but felt overwhelmed by the vastness of the task. As the minutes went on, he relaxed and his warm sense of humour revealed itself with several outbursts of ironic chuckling. My favourite moment was when this gentle, warm man, raised in a fire-and-brimstone home and still a practicing Christian, referred to God not by name but by an upward wiggle of his eyebrows and nod to the



heavens. For all his seriousness, Ngoma had a warmth and an almost childlike enthusiasm that was disarming.

*Story Synopsis:* Ngoma's story starts 500 years ago, with the black experience of oppression and resistance in the United States. He sees himself as very much embedded in this heritage and uses this long history to both explain his life, and to inspire himself by the strength and courage of his people. He was raised strictly in an evangelical home by his mother who believed in the necessity of corporal punishment. The first personal memory he speaks of takes place in the 60s, when he as a 10 year old is terrified for several weeks by the threat of the Cuban Missile Crisis. Studying music at college was a satisfying experience, but the highlight of his young adulthood was participating in the civil rights movement in Chicago. When he is drafted into Vietnam, he recognizes his feelings of helplessness and distress as similar to those he suffered as a child during the missile crisis. Ngoma deserted from the US army and immigrated to Canada hoping that Canada would offer a more democratic and peaceful society, but he soon was disillusioned with the inequities he found there too. Ngoma found purpose and hope by continuing to participate in activist groups and activities, for example, protesting with Clair Culhane against the Vietnam War, in below-zero weather on Parliament Hill. He started working very seriously on musical compositions through which he expressed his feelings and beliefs. His serious depression occurred about three years ago in reaction to workplace racism. This was an intensely painful 2 year period of depression, in which he felt suicidal several times. Counselling and medication helped marginally, but his spirits started to lift when he began working with an African-Canadian psychiatrist who helped him put his sufferings into a sociopolitical context. Ngoma still struggles with feelings of discouragement and fatigue, but feels recovered from depression. He says he feels like he walks with his heroes, Reverend Dr. Martin Luther King Jr., Gandhi, and people like that, who bring him the hope and the courage he needs to live in an unjust world.

*Analysis:* Ngoma tells his story as an African-American man oppressed by racist practices, from a collective point of view. The narrative is de-centered compared to a more typical first-person life story: the narrator rarely uses "I", preferring to use "you" or "we," and does not recount the story chronologically. The narrator is very present as a rather heavy-handed constructor of the tale, but the protagonist ("I") is often not visible.

Ngoma tells his personal story in the context of history, race, and power relations. The result is the depersonalized manifesto.

I'm not going to get into my personal life, my family life, because my family life, you know, was a different time, and there's been changes in how that has holistically healed itself, right? I was raised in a single parent household with a mother who at that time, in the 40s and 50s, the social ramifications of being a single mother were a lot different than they are now. So it took a lot of courageousness. I must take a look at my personal experience with my mother and recognize what a fear she must have had to raise four children and work through that process and have had at that time to emulate the father and mother, show both of those things, knowing at the time patriarchy was a very strong, relevant part of the family makeup, right? That there were beatings -- there were all kinds of things that happened in those times. That wasn't unique but it was a singular experience for me, because I, being young, did not understand why those things had to be at that particular time and place.

We get the sense that his recovery from depression has been through the re-storying of his experience, as he, the narrator, puzzles over the story, trying to make sense of it. Ngoma's narrative stance swings between being a victim imprisoned by racist cultural practices, a warrior intent on fighting back, and a philosophical observer who wishes to understand, deconstruct and rebuild the story. By telling the story as part of the collective black experience rather than a singular story of his own depression, he finds hope for change:

... What one can learn from this kind of conversation and discourse ... is how one can use one's imagination in a positive way to try to understand what's going on, so they can digest it within their consciousness and say, "Well you know, it doesn't have to be this way."

Two goals seem to drive Ngoma's story: understanding ("piecing it all together") and social change:

I'm not trying to be vague but I'm trying to gloss over because I want to get to the larger picture of painting the whole complexity in my life around how depression manifests itself ... Trying to understand with your own judgment of what's right and what's wrong, and how that impacts this feeling about trying to sort out the world we're living in.

The phrases "trying to understand," "trying to sort it out," "trying to piece it together," are repeated over and over. He also repeats the word "build" and "rebuild" as if his life (and his story) were given to him to create and to repair, as an artist:

... I was so down ... crying tears, you know, and the hope that I had was my own determination, as a consistent thing to get energy to be proactive in healing myself, and recognizing that I wasn't going to waste my life ... by just saying, well, that's it. I ... began thinking that, "Wait a minute, that's a bit of a cop out," for instance, in the black experience, to go through ... five hundred years with this kind of experience and just say, "Oh no, I've had enough of this, I'm checking out," without making any type of contribution? ... But I had to go through a long period of time kind of piecing things together ... placing things historically ...

He understands his depression as being a result of feeling powerless in the face of bigger socio-political events or structures, and his second goal or valued endpoint is a redeemed society that would offer equal opportunity and dignity to all regardless of race, culture, and class. He traces his depressions back to his first feelings of helplessness as a 10 year old during the Cuban Missile Crisis, again as a 18 year old drafted to Vietnam, and finally in his third depression episode, as the result of his feelings of futility and oppression in a discriminatory workplace:

... How can you have power? If you try, try in a sense to go beyond that, you have to find the tools to do that, you can't just say, "Well, I'm going to ignore it [discrimination], right?"

If I go through a racism thing ... something says, "Wait, stop, stop, stop, stop, stop, this person has just crossed a barrier that is affecting [me] and I need to deal with it. Sometimes I'll just walk away, or I'll joke, or whatever ... But that voice is down there saying, "Oh there's one, Ngoma ... You'd better stop and listen to that."

I felt I could handle anything. I thought I could handle anything, but I couldn't handle dealing at that particular time with the loss of my own character and personhood. Because if your personhood is taken away from you, there's nothing left to rebuild.

Finding ways to negotiate living in a racist culture, learning when to speak up and when to walk away, choosing empowering activities, and formulating a satisfying philosophical framework to explain his reality, all lead Ngoma closer to his valued endpoint of contributing to a more equitable society. He even finds talking about depression to be a potentially powerful political activity:

I'm amazed at your work here, to take this on. I mean it must be the opposite of the subject; it must be the opposite of depression, to explore the seriousness of the actual event [of depression] that happens within lives. ... People who have gone

through [tragedies] – you can see it in their eyes, those people have gone through something that has made them get in contact with the reality of an experience that says, “Wait a minute, wait a minute, wait a minute.” I think depression really has the same kind of impact in the message for people . . . It’s not a social disaster like Katrina [but if we] give democracy a chance to work by letting the people decide how they want to build . . . that would be the character that would give people hope, that would get them busy in restructuring the kind of lives they want to have . . . I would wager that a lot of the disease and the psychological impact of the anxiety would change.

Thus, Ngoma’s story is driven by his valued endpoints of understanding, and personal and collective agency.

The turning points in Ngoma’s life story graph reflect his belief system. The graph is different from the others since he disclosed so little of his personal life. Ngoma’s brow furrowed in concern when he looked at the graph I had made to represent his interview story. Pointing to it, he said, “But this narrative omits the meaning, the reasoning, behind the collective experience.” After some reflection, Ngoma agreed that he would map the life events that impacted him positively and negatively through his life story of depression. The result is unique in that there are only four “events” marked on it, all of them socio-political in nature. There are three pivotal events that provoked feelings of helplessness and depression: Cuban Missile Crisis, being drafted into Vietnam, and workplace racism. Positive events include the Chicago civil rights movement in the late 60s. It is the workplace racism that brings Ngoma into his most serious depression, and his most significant recovery. Medication and conventional interpersonal counselling did not help him significantly in his management of depression. He speaks of his first experience with counselling, shaking his head:

I remember one counsellor said, “Well you know, Ngoma, I was educated in Eastern US and I had lots of black friends and everything, and I most certainly can empathize with you, but I really can’t do anything for you, except maybe get you out walking . . .” And I said, “Now, wait a minute. Are you willing to sit here and tell me in this session that I’m experiencing all of this racism . . . and all you can do is empathize with me?” I said, “You people created it . . . Come up with some answers!”

It was the conversations (“dialogue” as Ngoma prefers to call it) with an African-Canadian psychiatrist that gave him a way of placing his depression in the context of his struggle as an African-American in a racist society and helped him to “sort it all out.”

But the important thing about Dr. Smith was that socially and culturally speaking, I could relate to him in many different ways. He loves jazz, I love jazz. Some of the conversations were about politics. He would use words that were very holistic for me in analyzing the kind of situation I was in and helping me make a choice of how I would be in relationship to the work environment. For instance, I mentioned an experience there, and he introduced the word "contrary," he said, "Well those are contrary people." Then we explored, well, how can there be contrary people, what does contrary mean? You know, we analyzed it, and put it to task. So in that sense what really happened for me was that I became more active in piecing myself together to understand ... to start rebuilding and become active ... becoming responsible for not only yourself, you know, but for the world that you live in.

Being involved in a larger group with similar goals of consciousness raising and empowerment, is what Ngoma sees as the most effective anti-depressant. His story is laced with references to personal heroes and mentors: Reverend Dr. Martin Luther King Jr. (who, Ngoma hastened to tell me, also suffered from severe depression), Claire Culane, a social activist during the Vietnam War, and Jack O'Dell, a legendary African American activist.

I think that people who go through depression ... are put in a position where they need to rebuild, they have a keen sense of trying to figure things out ... Reverend Dr. Martin Luther King Jr. said, "You lose hope when you're depressed." And what you need to do is build on hope and build on faith, to know that you're on the right course.

During the height of his most recent depressive struggle, he read voraciously. One book helped immensely, "*Looking white people in the eye*" by Sherene H. Razack, whom he met and worked with later at a R.A.C.E. conference. That people are gathering together and discussing issues and planning change gives Ngoma the sense of hope and purpose he needs to achieve the valued endpoint of his manifesto.

The theme of agency, or the lack of it, is an important one in this story. Each of Ngoma's three episodes was triggered by an experience of powerlessness. As a child, he could only deal with these feelings by praying for salvation. As a young man, he decided to take the decision to move to Canada on principle. This choice, and joining with other anti-war activists, lifted him from his depressed state. In his third and most sustained depression, he found himself in the intolerable situation at work, of structural, often "invisible" racism in the form of glass ceilings coupled with more overt racist jokes and

jibes. He first dealt with his feelings of hopelessness and helplessness by working hard and trying to ignore the situation. This led to his depression. With the coaching of his psychiatrist, he re-thought the agentic choices he could make about whether or not to confront racism, and also in what contexts:

I thought that the harder I worked and the better I worked and performed, the more that I could get over and get through the day . . . and get out of there. Without confronting necessarily . . . [But there's] a whole system of integrity to making a choice about how active you want to be . . . the part that you want to change within the society, being a responsible person.

The word "choice" is repeated over and over as Ngoma ponders his depression. "I had a choice of saying, 'Well, no, I've got to end this all. I don't have the energy' . . . Lying around trying to figure everything out, I had to make a choice of rebuilding and whether or not I had the energy to do that." Ngoma speaks about taking action for himself through building connections to a community, as pivotal to his emotional well being:

Because when we think about depression . . . being depressed means you're not being expanded . . . What's really happened is I've presented this container for myself [and] actually the world's got bigger . . . because what I've done is I've surrounded myself with a lot of people like Jack and my wife and just having an interview with you, and a lot of people who are really into issues, talking about a bigger picture, changing the world, all that stuff.

Key to Ngoma's depression recovery is his daily commitments to community activism, public speaking, informal and formal dialogues.

### **Comparison of Narrative Elements in the Stories**

#### ***Setting***

There is a common theme of the search for belonging in an insecure environment. These stories are perhaps typical of contemporary global living: only one of seven narrators does not mention moving from place to place (nationally and internationally) as problematic in childhood. These are stories of displacement. With Susan, Brigitte, and Barbara, the beginning of the sad story is a move in childhood to a new and threatening place. John repeats that "it was just the wrong place," a sentiment he has in various situations as he is forced or chooses to roam around. Barbara speaks several times of disliking her environment, and says that it was only in France that she felt she belonged: "I have never felt that sense of belonging anywhere else." Ngoma feels at the age of 10

that the world itself is unsafe – beatings at home and the Cuban missile crisis outside the door, he says:

Well, no you would go to school, you know, and hope, you know, I think it lasted for a week, you know, a week or two weeks, right you know, this crisis. Whether or not you'd be able to walk home, you know, you'd look up at the sky and think, "Oh no the missiles are coming!" You know, it's like terror, right? Like, "Will I make it home? Will I wake up in the morning? If I pray, will God ....?"

Later, Ngoma seeks refuge in Canada, where it was just a matter of time before he is disappointed to find that Canada has its own history of racial and social injustice.

Although Ruth mentioned after the interview that she had moved several times in childhood, this is not part of her interview story. However, there is a poignant anecdote which reflects the yearning for a safe secure home that most of the participants identify:

Probably my first experience of feeling really really depressed was when I was in Grade 5, and going to a girlfriend's place, where they had quite a loving family, a supportive family, and I was so happy that I didn't want to go home. I, um, I remember going home and just, I mean you would come within a block of our place and you would hear the screaming ... It would be everybody, my mom, my dad, my siblings. It was always quite chaotic so I remember that feeling of being really depressed about having to live there.

Yuki cheerfully insists that her childhood was a very happy one, even though she moved from country to country four times before the age of 12. Her depression seems located in a developmental rite of passage from adolescence to young adult. However, at the end of the interview, she remarked that although she feels recovered from depression now, she needs to turn to matters of identity:

Now my attention has turned to more issues of "who I really am," not so much the emotional part but ... I was five when we moved to Australia till I was 10, back to [Asia] for two and a half years to study the language, and then came here at age 12. So I really wasn't, in total, I've only been in Asia for 7 ½ years. I don't think I'm really "Made in Asia" but I'm not really fully Australian or totally Canadian (laughs) so [I'm] kind of like an international citizen."

### *Narrative Voice*

One of the most fruitful ways to question the narrative data was to consider how the interviewees felt about their story – how they saw themselves as the protagonist, and from what position they told the story. This can be termed the narrative "voice" or "stance." All of the participants take enough distance from their story to see it as

somewhat separate from themselves. They narrate from the point of view of recovery, looking back at their history to try to make sense of it all, to find causes, effects, turning points and conclusions. An attitude that is common to all of them is one of having achieved understanding or wisdom through the suffering of depression. This wisdom gives them a privileged perspective now – what we might call an “omniscient” narrative position as they survey their life story: something like, “I didn’t know then, but now I do.” This general movement in their narratives from a place of unaware suffering to a position of greater wisdom is the journey of the Romantic hero. Frank (1995) notes that this echoes Joseph Campbell’s cycle of the hero’s journey, which involves departure, initiation, and return. “The teller returns as one who is no longer ill but remains marked by illness, as Schweitzer wrote of those who ‘bear the mark of the brotherhood of pain.’ This marked person lives in a world she has traveled beyond, a status well described by Campbell’s phrase, ‘master of the two worlds’” (p. 118).

### ***Valued Endpoints***

When examining the narrators’ stance towards their own story, issues of goals and agency arise. What is each narrator’s story goals and how are they achieved or not achieved – through mastery, fate, or luck? Gergen and Gergen (1983, 1988) point out that typically in a story, all events relate to the goal or valued endpoint. If we read a novel or watch a movie, we are frustrated by events which do not seem to relate to the plot. Similarly as someone tells his or her life story, Gergen and Gergen say, he or she is constantly sifting through the myriad of possible events to choose the ones that support a certain coherence to his larger story. By defining the goals of each narrator and how they were achieved, we might have a window into that narrator’s view of agency.

One might think in depression stories, that the obvious valued endpoint or goal will be recovery from depression. Yet, surprisingly, not one of the seven participants constructs her story from this valued endpoint. Instead, they express broader goals in which depression recovery is somehow embedded. The coherence of their tales was built through an overreaching theme like the search for belonging, love, safety, freedom, independence, or justice. When these goals are thwarted, depression ensues. When they are achieved to a significant degree, depression recovery begins.



## *Agency*

How do the narrators understand the achievement of their valued endpoint? Is it fate, luck, or is it the result of their efforts? The theme of agency – in particular, the wrestling with the question of what is and what isn't under the protagonist's control – was salient in the stories. Susan and Barbara view themselves throughout their tales as independent and active protagonists. Their discourse is full of terms like “choose,” “choice,” “decide,” and even, “agency.” However, their style of action-taking is also part of the problem. Susan acknowledges that often her activity was a cover up for her depression; while Barbara's restless movements bring little long-lasting relief or progress. Both of them describe the realization that agency as construed as independent action, is not enough. To acknowledge that they are not separate from others, that interdependent connection and communion is not only possible but also imperative, is a fundamental part of their shift towards attaining their life goals, and recovering from depression. John's story echoes this movement from an emphasis on more typical “agency” – the ability to independently achieve a goal – to an incorporation of relationship and community. Ngoma's story is sprinkled with the words “choose” and “decide” as his story is very much a story of resistance and empowerment. Like Susan, Barbara, and John, he is able to approach his valued endpoint, and also find relief from depression, when he reaches out and connects with others. His experience of personal empowerment is within a like-minded community of social and political activists. Brigitte's story is rather different – much of her earlier life is described as a series of cruel events in which she had little or no power. She survives, rather than masters, these circumstances, but in midlife starts to take agentic steps towards safety and depression recovery: counselling, legal interventions, divorce, etc. She claimed that understanding her life story actually has empowered her to be able to make better choices in work and relationships. Perhaps because of her age and/or her culture, Yuki is reluctant to claim herself as the source of her happiness and depression recovery. Her narrative indeed revealed her to be highly agentic in her help-seeking and also in her commitment to mulling over her young life and making sense of it; however, she tends to ascribe her successes to valued others – parents, therapists, professors. Lastly, Ruth is an example of someone who has tried various avenues of depression treatment and still suffers

considerably; her agency is akin to that described by Victor Frankl, as choosing her attitude to her suffering.

### ***Turning Points***

The Romance story form is a wavy up and down movement. It approximates what Steen (1996) pointed out as the pattern in recurrent depression where each depressive episode is a trough which is repeated across the life span. There are common aspects among the participants in terms of how an episode was typically triggered and what marked coming out of it, in other words, what events or attitudes mark a progressive or regressive turn in the lifeline. Common triggers were abandonment, traumatic moves, abuse, stressful new situations, relationship break ups. Commonly participants attributed recovery from these episodes to time passing, medication, counselling, leaving abusive relationships, friends, or yoga.

Another common pattern is that it is the last episode that is described which is experienced as a real turning point towards sustained recovery. In the earlier episodes, the protagonist appears to have limited or no awareness of their experience as “depression” and through various means (time, external changes) get better. As a narrative device, these ups and downs create suspense and movement in the tale. But in the key recovery “event,” which for these participants is more of an insight than an event, something else happens.

This turning point of insight is a moment or a time period, and as a narrative device is the climax of the story. Six of the seven participants describe such an event: a significant epiphany or insight which marks their sustained recovery and prepares the listener for the conclusion. It is actually from this place, what Hyden (1995) refers to as the narrative “platform,” that each participant looks back on their life, and from which they tell their story. In the pivotal healing epiphany for each of the participants, an experience of “oneness” and belonging was described: Susan as she allowed herself to take in the suffering she witnesses in her travels; John as he recognizes that the human connection is the key to his happiness; even Ngoma, although he doesn’t describe one event, finds increased hope and solace in the idea of empowered community. Barbara learns to soften her independent stance, ask for help, and share her private experience with others. Brigitte, through EMDR therapy, begins to retrain her thinking, murmuring

to herself on and off during the day, "I am safe. I am safe. I am safe" and is assisted by her therapist in restorying her life experience in a more coherent way. Yuki, suffering rejection as she experiences her parents and her professor removing their support from her, eventually realizes that they are doing this out of love, to encourage her independence. The exception is Ruth's memoir, which is told from a place of suffering. Yet even in her tale, she suggests that her recovery, though incomplete, is sustained by a new philosophical-spiritual shift to surrender and witnessing the coming and going of the dark moods, and she says she feels "a new connection with love, a certain kind of . . . generosity being with people."

### ***Musing as a narrative device***

Lastly, one salient aspect of the construction of these narratives was the use of philosophical asides, or "musing" as Barrington (1997) calls it. Barrington, in her manual for life writing, explains that stories are made of three elements: scene, summary, and musing. The scenes are the discrete episodes or events that make up the dramatic plot. They include dialogue and action. The participants in this study varied in their use of scene-making. For example, John and Susan referred to only two specific events in this way, while Brigitte's tale was replete with scenes. The second element is "summary". In summary, the narrator covers large periods of time in a sweep as a way to connect the scenes chronologically. Much of the interviews were taken up in summary. The last element, "musing," is the narrator's chance to comment on his own story, a kind of meta-narrative which involves making meaning of the events. There was a striking use of musing in the depression narratives. Five of the seven narrators spent considerable time explaining their definition of depression, their understanding of how depression generally is caused and how their particular depression began. For example, John, Ruth, and Ngoma challenge conventional definitions of depression. John brings this up within the first five minutes of the interview,

J: Well this whole business about the word "depressed" is interesting. I felt bad. So is depressed when you can't get out of bed? I don't like the idea of depression as something so observable, so measurable, so "you are, or you aren't." That's why I like the word, "melancholy" because melancholy is associated with creativity and so on. A positive casting. But sometimes it's worse than that, it's not just sweet melancholy or nostalgia, it's lousy, really lousy. I understand the clinical meaning of depression, but I don't think it's enough, that's all.

I: It's almost like it's reducing or simplifying it too much?

J: Yeah, and it's kind of making it into a disease, you know.

I: That's not how you think about depression?

J: Not entirely, no. No, well, no! Definitely not. That doesn't make sense to me.

Similarly, Susan begins her interview with thoughts on etiology of her depression:

Well, I think I've probably had low-level depression for on and off, I think it's a background kind of state, maybe characterological . . . I just wonder characterologically about that, you know, you talk about the cerebellum or whatever, that kind of mood strain that is in some of us . . .

Ngoma's narrative is largely made up of musing. It is only at the prompts of the interviewer that he narrates a few personal events. The rest of the narrative contains his theories about the nature and causes of depression, which he sets firmly in the imbalances of an unjust social structure. As Ruth searches over and over for the reasons for her lifelong depression and her incomplete recovery, her musings include the word "physical" 25 times. Knowing that her physical and emotional suffering may have a biological basis seems to bring her some relief, since otherwise, she is left wondering if she has some kind of moral deficiency. At the same time, she ponders the possibility that depression and anxiety may be reactions to a society that doesn't make room for people who are "different." Brigitte has reflected carefully over her depression, and mentions several times her ideas about its multi-causation. When asked at the beginning of the interview to tell the story of how depression has affected her life, she has this to say:

. . . How depression has affected my life? – I think it's the other way around for me. My life affected the depression. It brought up the depression.

That their depression is a reaction to adverse situations in their life rather than a biological "illness" is a shared conclusion, although Susan and Ruth concede that it may be partly biological. That their stories were largely made up of their musing over the causes of their depression, and their roles in both incurring and recovering from it, stands out as a common narrative feature.

## DISCUSSION

Seeking to categorize lay accounts of depression recovery into genre rests on the assumption that these stories are social as much as personal accounts. While the narrators are on a personal quest for the meaning of their individual experience of recurrent depression, they at the same time embody a collective experience of living with depression, and utilize socially available narrative forms. That the seven narratives in this study fell into first, Romance genre, and then, either quest-memoir, manifesto or automythology, suggests a social stock of narrative forms that sufferers from depression may be influenced by, and/or choose from, in order to tell their tale.

The research question that guided this study was how people constructed their narratives of depression recovery. I expected to see Comedic (what Frank (1995) terms Restitution) and Romantic (Quest) genres chosen as the narrative forms since the former is predominant in qualitative research on oral narratives, and the latter, popularly used in written depression narratives. Indeed, these seven rich stories of depression recovery were cast in the Romance genre. Of interest is the lack of Comedic/Restitution tales, and the resonance of the particular stories with Frank's sub-typing of Quest into Automythology, Memoir and Manifesto. There are several patterns and themes which link to previous research on depression narratives and recurrent depression, and raise clinical implications for the treatment of recurrent depression.

### **Links to previous research: Written depression narratives**

Five of the seven oral accounts analysed here closely follow the traditional story line of Romance, with one of these (Brigitte's) tending towards a "happy ever after" trajectory. This is the same genre used in the published depression memoirs of, for example, Manning (1994), Solomon (2001) and Wolpert (1999). However, in the written memoirs, the turning point of the story is an internal moment or phase in which the depression is finally accepted into the protagonist's lifelong identity, rather than defeated. The stories of Susan, John, Brigitte, Yuki and Barbara indeed follow the romance curve of a heroic grappling with repeated obstacles, but the turning point of their tales appear to involve the resolution of larger life "valued endpoints" such as belonging, independence and honesty, which is accompanied by significant recovery from depression.

The other two narratives, Ruth's and Ngoma's, although still falling generally into the Romantic Quest genre, are more postmodern in the telling – less plot driven, more questioning of their own plot, more cognizant of its constructed nature, more doubtful of the ability of words to capture experience. Both of them were uncomfortable with the life story graph, basically not seeing their lives in this linear, plot-driven way. Ruth's story lacked the closure of a modernist story line. She describes her recovery from depression as learning to live with depression, "a way to find happy moments in the depression." Perhaps as time passes and if depression recedes, a neat storyline will emerge, happy ending and all. More significant is the fact that this narrator wants to tell her story this way. Frank says that our social aversion to illness narratives without a happy ending is so extreme that these become unspeakable (in what he terms as chaos narratives). That depression narratives without resolved happy endings such as Solomon's (2001) and Smith's (1999) are published, and like Ruth's, spoken and recorded, implies that the repertoire of available narrative forms has not only widened beyond the Comic/Restitution genre, but can offer the hero of the Romantic Quest tale the alternative of an ending without closure.

#### **Links to previous research: Oral depression narratives**

Oral accounts of depression recovery, recorded and analysed in qualitative research (for example, Peden, 1993; Schreiber, 1998; Skarsater, 2003) tend to be framed in what Frank calls the culturally preferred illness narrative of Restitution (or in the Gergens' (1983, 1988) typology, Comedy/Happy Ever After), in which the sufferer is returned to a position of "as good as new" by the doctor, the medication, or the psychotherapist. The narratives in this study can be seen as a challenge to this master narrative. Some of the participants (for example, Barbara, Brigitte and Ruth) find that antidepressant medication is helpful in their recovery, but not a single participant places it as primary. Even those tales of Susan, Brigitte and Barbara who ascribe a significant debt to "expert" psychotherapists make it clear that the real hero of the recovery is their valiant self. And no one speaks of recovery as returning to a previous state of health, but rather, becoming wiser, more their "real self," stronger, more compassionate, through their sufferings. So in this way, the master medical narrative of "restitution" is subverted or replaced by the quest-automythology. The findings of this study confirm those of

David Karp (1996) who although he was not studying recurrent depression, concludes that depression is much more recurrent or chronic than the mainstream view indicates, and that his participants tended to move from “the medical language of cure to the spiritual language of transformation” (p. 127).

The interviewees’ fondness for “musing” over the reasons for their depression and their role/responsibility in it, echoes the narrative study of Kangas (2001) who found that the accounts of depression were usually an answer to the question presented by the illness, “why me?” Similar to the participants of Kangas’ study, the interviewees in this study depicted their depression as a “multidimensional and holistic illness” (Kangas, 2001, p. 89), favoring social and psychodynamic explanations over biomedical ones.

### **Implications for recurrent depression**

Since this was not a controlled study, implications are offered only as a possible nudge towards future research. One finding that is interesting in this small sample was that the three main life episodes of depression are reported to have occurred at developmental transitions (early adolescence, adulthood and midlife). There are a myriad of ways of accounting for this. One of course is chance sampling. Another constructivist explanation is simply that it makes a good story: three ups and downs build suspense, with the third crisis being the dramatic turn to a happier ending. A third possibility may be that if someone is biologically predisposed to depression, perhaps these stressful transition periods (also times of hormonal/chemical shifts) are predictable contexts for an episode. This could be a positive view in that it normalizes the episodes somewhat within the life span, taking away the “illness” stigma. Another explanation is that trauma suffered in childhood (neglect, abuse, loss, etc) sets an individual up for the possibility of future episodes. Two participants describe a childhood of physical and/or emotional abuse in which they were powerless to effect change. Six participants describe an event around the age of 8 – 12 in which they suffered feelings of abandonment, fear, anxiety and powerlessness. One explanation for recurrent depression is that the first episode of depression produces a cognitive diathesis (“I am powerless,” “The world is unsafe”) or “scar” that increases risk for relapse in later life situations with certain stress triggers (Clark & Beck, 1999; Ingram et al, 1998). Even this small sample of seven stories might be seen to demonstrate one of the most fundamental foundations of our present

understanding of depression, Seligman's (1975) learned helplessness theory, which explains depression in terms of individual lack of control over their environment.

The finding of a pattern in the recurrence of episodes is partially supported by Karp's (1996) work. In his description of the "depression career," he notes that in his sample of 50, many traced their feelings of emotional discomfort to childhood "although they could not associate their feelings with something called depression until years later" (p. 38). As children, they cannot conclude that "something is abnormal because they had no comparative baseline of normalcy" (p. 39). This Karp regards as the stage of "inchoate feelings" following by the stage of realization that something is wrong. In the second stage, he found that people often sought medical treatment and started naming their problem as depression. This was borne out in my sample – six of the seven experienced these two stages as their first two discrete depressive episodes. Karp's participants then tend to experience a stage where they start to locate their depression as somewhere within their bodies and minds rather than their environment. This was not strongly supported in my sample. Ruth and Brigitte both believe that their depression is partly biological and indeed Brigitte seeks out her most successful therapy when she realizes she is still depressed even when her life situation is excellent. However, Brigitte and the other five participants tend to ascribe their depression to difficult external circumstances rather than biochemistry.

There were common themes in the core beliefs of the participants in this sample which seemed related to their depression: not belonging and not being safe. In many of the discrete episodes, these core beliefs came up in dramatic ways. There is a mass of literature, of course, that identifies key dysfunctional cognitions that appear to drive depressive thinking: I am unworthy, life is difficult, this is too hard, there is no point, I am alone, etc. But the experience/belief of one's standing alone in an insecure and unsafe world appeared to be particularly salient in this sample. Since it could be said that indeed life is considerably insecure and unsafe, it stands to reason that depression triggered by a preoccupation with this aspect of reality would be recurrent across the life span. In each of the narratives we can see a relative resolution of the problem of feelings of alienation and lack of safety or belonging, as each narrator describes an experience or unfolding insight that they are not separate from others. Although we cannot draw cause and effect



relationships between the shift to thoughts and feelings of belonging/connection, and the recovery from depression, at least for these participants, this shift appears to be accompanied by less depression.

Schreiber describes a “clueing in” stage which marks her female subjects’ recovery from a depressive episode. There is a similar “clueing in” turning point in these stories of recurrent depression, in the most recently experienced episode, which for six of seven of these participants, was in midlife. Schreiber’s representation of the recovery process as a jigsaw puzzle, with the “clueing in” stage as the final piece of the puzzle being included, seems to describe the experience of recovery in recurrent depression. Schreiber concludes that clueing in involves putting insight into action, and as described in Chapter 2 of this study, other qualitative researchers similarly point to “agency” as the key turning point in depression recovery (Peden, 1993; Skarsater, 2003; Steen, 1995; Unsworth, 1999).

Indeed, the theme of agency was salient in these stories of recurrent depression and recovery. However, in what I have called the turning point of their recovery story, agency is only one of the features. It was in the third (or fourth in John’s case) episode, in midlife, that five of the seven participants turned to a more profound spiritual or existential explanation for their depression, and way of resolving it. They claimed that even if depression returned, they believed they would be able to deal with it. For Susan, John, and Ngoma, their recovery seemed rooted not in agency but in a new feeling of belonging. Susan felt this in a cosmic sense, as if finally she was held in the hand of existence, John through relationship in marriage, and Ngoma through connecting to a like-minded community. Barbara presented as an active, competent protagonist even as a young child, and her recent shift into recovery seems to be tied with being generally more honest and open, allowing others to know the truth about her life, rather than agency. Ruth’s tentative recovery is not so much about agency or communion, but rather more in terms of accepting and witnessing the depression. The only participant whose recovery is clearly dominated by issues of agency is the 21 year old Yuki, who found the developmental individuation process so difficult as to trigger depression.

Schreiber’s research emphasizes the negative effects of women’s socialization process, locating depression’s cause and cure in social/relational theory. As the women in

her study learn to be more assertive and take control, they recover. Certainly, this theme appears in some of the stories of the present study. Susan speaks of deciding to give her personal needs priority over her usual caretaking activities, and both Brigitte and Barbara need to leave abusive, controlling husbands before their depression recovery is significant. It is important to note that this is not simply a matter of changing self-talk to more positive affirmations, or adjusting one's world-view to a more positive one. The significant mention of child abuse, domestic abuse, and racism in four of these stories points to issues of power and abuse in family and the workplace that need attention. In this way, the stories are similar to those in the narrative study of Kangas (2001) who found that all of her eleven participants attributed their depression as having causes in the external circumstances of their life.

Much of these stories is taken up by "musing," – defining depression and positing causes and cures. In their descriptions of their experience of depression, John, Ngoma, Brigitte, Ruth focus more on the disturbance of mood (supporting for example, the definition of Becker, 1977) while Susan, Yuki, and Barbara highlight their negative ruminations (supporting Beck et al., 1979), mentioning such classic depressive cognitive distortions as all or nothing thinking, fortune/future telling, magical thinking, dismissing the positive, and generalizations. Each of the seven stories demonstrated a re-evaluation of the self, which Karp (1994) says is part of the existential process of depression, and certainly all are preoccupied by making meaning of their suffering, a focus that Lewis (1995) finds to be fundamental in depression. As for causes, Ruth is the most certain that her depression has biological/biochemical underpinnings, while Susan, Ngoma, Brigitte, John, and Yuki concede that there may be biochemistry partially at stake, but point to their life events and their habitual cognitive behavioural responses as the primary problem. Only Barbara sees her depression entirely as reactive rather than biological. Their theories of depression echo those of the 102 Canadian patients surveyed by Srinivasan et al. (2003) who dismissed biomedical models of depression, favouring cognitive attributional style and negative life events are the primary causes of depression.

### **Clinical Implications**

One of the truisms of depression treatment is that it should be focused on increasing the client's agency. This is one of the most important objectives of cognitive

behavioural therapy for depression. Research dating back to the 80s by Beck showing that depressed people expressed hopeless and helpless cognitions even in their dreams supports the usefulness of focusing on increasing the client's behavioral and cognitive choices by positive, action-oriented, agentic self-talk and behavior. Issues of agency indeed surfaced as important in these participants' stories of recovery. For the two men, John and Ngoma, the belief that they had choices and power over whether or not they are depressed was fundamental and rang as a refrain through their discourse. Susan thoughtfully reflected on the differences between industrious caretaking action and action taken with the goal of self-care, and how this connected to her depression. Ruth appeared somewhat haunted by the question of how much control over the depression she really had, experiencing it as a powerful and physical limitation.

In narrative therapy, a lot is made of "story repair," the idea that the therapist can help the client rewrite her life story since her suffering may be located in a story that doesn't work for her, for example, that is not aligned with present reality, that doesn't allow for the hopefulness of a happy ending, or that ignores the agency of the protagonist. Omer and Alon (1997) write about identifying the genre of the story a client is living in and refocusing it to a more functional plot. What is implied in the stories of this study is that individuals have a preferred life genre, whether it is comedy, tragedy, quest-automythology, or manifesto, and a valued endpoint that is not depression recovery, but rather, an overreaching life aim. The agency of the protagonist is inherent in any of these forms. The hero of the automythology finds meaning and agency in self-growth, of the memoir, in choosing her stance to suffering, in manifesto, in creating social change. What the therapist's task might be, then, is rather than offering a new genre, helping the client to identify her role in her story, her valued endpoint, and her style of agency (how to achieve her endpoint).

As important as the narrators' individual ability to effect change and achieve goals – the hero's quest – was their capacity to relate and connect in an interdependent context. As has been outlined, this shift from feeling alienated and out of place, to feeling more connected in relationship, was one experienced by the narrators as they recovered from depression. That both client agency and capacity for healthy relationship appear to be important in depression recovery may account for the efficacy of two quite different

psychotherapeutic approaches: cognitive behavioural therapy (which targets agency) and interpersonal therapy (which targets relationship). The importance of relationship (in these stories, family, friends and workmates) suggests that depression should not be treated as a solely individual issue, but in a systemic way as a socially embedded experience. The possibilities for depression treatment within a family-systems therapeutic approach, for example, should be considered.

Another salient finding was the participants' fondness for musing, for asking the question "why," and formulating what might be called lay theories of depression. This rumination is exactly what is associated with maintenance of depression:

Rumination has been defined as passively focusing one's attention on a negative emotional state like depression, its symptoms, and thinking repetitively about the causes, meanings, and consequences of that state. Individual who ruminate report they believe this will increase their understanding of themselves and solve their problems, but studies suggest ruminators are ineffective in active interpersonal problem-solving and show an inflexible, perseverative cognitive style (Ramel, Goldin, Carmona, & McQuaid, 2004).

This raises questions in terms of counselling. If someone is acutely depressed, research supports a structured two-pronged approach: medication may be first necessary to stabilize a higher mood in order for the second step, cognitive therapy, to help. The question "why" is not encouraged in cognitive therapy, but rather, "how:" how can you feel better in this moment, how can you change your self-care, how can you change your self-talk, and so on. "Why" is seen as a petulant victim's kick against an existential wall. However, the question "why" can imply a moral dimension to one's sufferings, and concerns personal responsibility. Indeed, as these participants mused about why they suffer from depression, implicit in their questioning is how much control do they have over it: Is it biological? Emotional? Cognitive? Will it go away if they leave their abusive husband? If the racist perpetuator is removed from the work place? Or is it something in them that needs to change? Ochs (1992) writes of storytelling as a theory-making activity. Perhaps in the case of an experience like depression which is so variously seen as a medical or psychological illness, a matter of cognition, emotions or chemicals, a result of childhood abuse or adult bereavement, theory-making is especially important. An implication for counselling, then, is that some space be given in the

sessions to help clients make sense of their depression's etiology, but that "rumination" be curtailed.

The surprising finding that the "valued endpoints" or narrative goals of these depression recovery stories were not depression recovery, but rather more overreaching life goals of safety, belonging, justice, etc. may have clinical implications. It is somewhat confirming of the findings in Hyden's (1995) discourse analysis of eight female psychotherapy patients suffering from various issues including depression. He was surprised to find that rather than speaking about symptoms of their emotional disorder, their "rhetoric of recovery" involved how their "Self" had undergone change through the experience. This is supported by Karp (1994, 1996) who points to the rhetoric of self-change present in depression recovery. Similarly, these seven stories were as much about the journey of self as about depression recovery. For a clinician helping depressed clients set goals, this need not complicate the current practice of brief time-limited therapy. Addressing immediate self-care and cognitive distortions is an evidence-based clinical approach to depression. However, for recurrent depression, recent research points to the helpfulness of so-called booster sessions (Katon et al., 2001; Paykel et al., 1999). Although typically a review of cognitive-behavioral strategies in preventing or managing depression, these booster sessions could also include continuing "life-review," encouraging clients to see probe the patterns and events of their life through journal writing or support groups.

Recent studies of the effectiveness of Mindfulness-Based Cognitive Therapy in dealing with recurrent depression indicate that while antidepressants and cognitive therapy can certainly ease the symptoms of depression, this does not prove enough for those prone to recurrent depression. A randomized clinical trial found significant reduction in recurrence to major depression in recovered patients with three or more previous episodes following an 8-week course in MBCT (Teasdale et al., 2000). The process of MBCT is not yet clear, but it is postulated that instead of challenging and reframing the cognitive distortions that drive depression, it is helpful for those prone to depression to learn to simply observe these thoughts as "thought events," not reality. Previously depressed patients may have specific cognitive habits, including negative rumination, which mindfulness meditation trains to observe in a nonjudgmental way, and

let go. It is interesting that one participant, Ruth, referred to her recently discovered practice of mindfulness meditation as very helpful in reducing the suffering of what she suspects will be a lifelong condition of depression.

The recent acknowledgement of depression as a commonly recurrent disorder has led to the suggestion that appropriate treatment in the early episodes may be crucial in preventing later episodes (Monroe & Harkness, 2005). If depression were a solely biomedical or cognitive disorder, this may be possible. However, the stories in this sample of seven demonstrate a complex interweaving of biology and environmental stressors – childhood neglect, abuse or trauma, and often similarly harsh events in adulthood. For six of these participants, the ability to make a safe, loving and competent life for themselves seems to come with the wisdom of age, in midlife. Early interventions which include medication and cognitive therapy to address the negative ruminations that underlie depression surely would strengthen people with a vulnerability to depression, but at least from the stories of this sample, also important is to address the home and work life environments, for issues of safety and power. In this regard, feminist therapy, which takes into account the tremendous power of unjust power structures in family, work and society to depress individuals, seems particularly valid.

The narrators also imply that depression itself may be a form of subversion or resistance to master cultural narratives which disempower women, people of colour, and children. This is a creative way of explaining depression which is quite different from the more traditional biomedical or cognitive approaches, and may be used successfully within a feminist, solution-focused, or narrative psychotherapeutic approach with depressed clients. For example, Susan asked me in a post-interview conversation, “What if depression is simply a way of saying that we don’t like the way things are?” Ngoma articulates this idea the most overtly, when he refers to depression as a “wake-up call” to the reality that something is wrong in the external (socio-political) environment. Depression can be a warning voice, telling him he needs to address an issue of power in his work or relationship context. Brigitte similarly has grown to see depression as a “friend,” a way of surviving terrible abuse (when she was depressed, her husband was “nicer” to her), and now an important warning voice for her if there are “abusers” in her environment. Ruth wonders if people like her who are “different” from the mainstream

(e.g. more creative) suffer depression when they are “squished” by family and society. Susan experiences depression as a child in an alcoholic home, somatized as stomach pains, when she needs the attention of her mother, and similarly, becomes depressed in midlife when she feels she is not being heard by her family. For Barbara, depression seems linked to staying in school, work, or marriage situations which are simply not meeting her needs, and silencing herself until she breaks down in an episode. Yuki’s short history of depression may be seen as “growing pains” rather than pathology, a way of saying “I need to be noticed” in a difficult developmental passage. This de-pathologizing of depression, and indeed use of depression to resist a particular situation, is a pronounced aspect of these depression recovery stories and may be used as a creative reframing by therapists keen to validate their client’s role as agent rather than victim.

### **Limitations**

The inclusion criteria were somewhat problematic. Would all seven participants be diagnosed with recurrent major depression according to the DSM-IV? Six out of seven of the participants received physicians’ diagnoses of depression but it is not known how these doctors made the diagnoses. Yuki was treated for depression by a counselor. Only one participant was diagnosed with *recurrent* depression (Ruth), which in the end she questioned since her depression appears more chronic than episodic. It was not clear whether or not recurrent depression was differentiated from chronic and major depression in the seven participants. Since Ruth’s narrative style was quite different from the others, the question arises if the difference is accounted for by the possibility that she suffered a different type of depression (chronic rather than recurrent).

Categorizing the stories into genre brought up many questions. First of all, the area of genre studies is a fascinating but far from scientific field. In Abram’s *Glossary to Literary Terms* (1999), he points out that the four Aristotelian genres of tragedy, comedy, irony and romance are more hypothetical than pragmatic; most stories, he says, combine genres and he goes on to say that genre is a useful but limited tool. The expert external reader used her knowledge of Frye’s (1957) classical genre categories and pointed out that the Gergens’ (1988) typology addressed only structure and not content, whereas Frye’s four types are complex combinations of not only plot but character. She also pointed out that the Gergens and Frank (1995) omit the literary genre of Irony/Satire

which in her opinion would help explain psychological narratives.<sup>2</sup> While we agreed that all seven stories were basically the Romance-Quest form, the expert reader found many elements of comic and tragic subplots and characterization. One story was difficult to firmly pinpoint: Brigitte's story had the flavour of a restitution/comedic tale and the form (particularly as revealed in the story line graph) indeed approximated this genre more than any of the others, yet she was clearly the Romantic quest-heroine made stronger and wiser by her sufferings. In these ways, the lines between genres blurred and the subjectivity of the reader played a large role in categorizing.

Another difficulty was the story line graphs. Ngoma was at first simply not interested in his personal life experiences being charted on a story line since his story involved what he calls "the collective experience" and is socio-politically driven. Although the storyline graph is used by researchers such as the Gergens (1988) and Lieblich (1998) who would situate themselves as constructivist rather than formalist, the limitations of this as a way of representing participant stories seemed connected to the lack of congruence these two participants felt with the modernist plot driven story form. Of course, the richness of socio-political context is missing in individual lifeline graphs. Ruth and John pointed out the inappropriateness of the y-axis original labeling, "sad" and "happy." They correctly protested that sad was not the same as depressed. But even the opposition of "depressed" and "not depressed" didn't seem appropriate either. "Numbness, pain, anxiety, shame" were words John toyed with as a replacement for "sad" or for "depressed." In the end he said rather generously, referring to the graph, "Well I guess it captures something, but there's a lot missing here." Thus, the limitation of language as a one-to-one correspondent with reality is expressed. Furthermore, the graph itself as a one-page summary of a life story was seen as reductive by at least one participant (Ruth) who was not able to use it to represent her story at all. Susan felt it captured the macro sweep of her life, but pointed out that it did not capture the difference

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<sup>2</sup> In a personal email communication on Jan 11, 2006, the expert reader, Dr. Lissa Beauchamp, made this critique of the typologies of Gergen and Gergen (1988) and Frank (1995): "Neither model makes room for the literary genre of Irony/Satire, which is a serious handicap in the sense that neither model is capable of recognizing and dealing with certain key features of the narratives . . . Gergen and Gergen, especially, privilege comedic models at the expense of satirical/ironic ones, misidentifying tragicomedy as comedy and adding "Happy-ever-after" (which is comedy) such that plot structures and their ends are privileged over kinds of narrative (Romance and Irony/Satire) that focus on character and character development, or its failures . . ."



in the *quality* of the up and down swings. For example, her upswing/recovery from her second and third depressions she experienced as qualitatively different, one more in terms of competence, and the other more in terms of communion. Lieblich et al. (1998) address these issues of limitation when they point out that the interview “life story” (and the same can be said about the story line representation) “is just one instance of the life story . . . . Hence the particular life story is one (or more) instance of the polyphonic versions of the possible constructions or presentations of people’s selves and lives” (p. 8). That is, while it may be a useful tool to generate questions and identify patterns, the story line graph is just one form of story representation.

My own subjectivity as a researcher of course also played a part, in some ways limiting, in other ways enriching the data. The stories were inevitably shaped by my orientating statement and my questions. For example, by the orientating statement, I elicited a life story rather than an account of depression recovery, because of my interest in how the two are combined. As a result, sometimes other important aspects of the life stories took center stage and we had to make an effort to get back to the theme of depression. The fact that I asked participants to begin before their first depressive episode, to when they felt happy, may have elicited the framework of family-of-origin causation. Six of the seven narrators located the first experience of depression around 10 with a traumatic event, thus drawing on what might be called the psychoanalytic master narrative of childhood origins of psychological difficulty. I attempted to follow Reissman’s advice about limiting my questions in order to allow a narrative (rather than a Q/A session) emerge. However, some of my responses and questions are particularly leading. Frank (1995) refers to Lawrence Langer’s findings of how interviewers undercut the stories that the surviving witnesses of the holocaust were telling. When these witnesses spoke from a place of tragedy, or chaos, the interviewers “subtly . . . directed witnesses toward another narrative that exhibits the resiliency of the human spirit” (Frank, p.101). Perhaps because of my counselling training, I sometimes found myself doing that, trying to reframe the narrator’s story in terms of her strengths and resilience, rather than allowing her to continue in a self-critical or despairing train of thought. Because I was working with a vulnerable population, I felt it was in a sense my ethical duty to steer the participants away from the negativity that feed a depressive thinking

spiral. A compromise I came to was at the end of each interview, to sum up what I had noticed as the participant's positive or "heroic" actions and beliefs, in this leaving on a positive note but not interfering with the main flow of the interview story.

### **Suggestions for future research**

Longitudinal narrative research and research on recurrent depression in an older cohort might be illuminating. It appeared that these participants located a significant turning point to recovery in their most recent depressive episode. However, with every wish for each participant's full recovery, and at the risk of appearing cynical, I can't help but wonder if this is a narrative device of storytellers who wish for a happy ending. Although they all (except Ruth) felt very much "recovered" from depression, they also all conceded that more depression was a possibility in their future. With one much younger participant whose narrative trajectory was similar to the ones of those much older, the question arises whether this most recent episode will indeed be their last one. Interviewing the same participants in 10, 15, 20 years may (sadly) reveal recurring episodes. One wonders how their significant insights related to their valued endpoints might deepen, or change, through more depressions.

Indeed, this addresses one of the main shortcomings of the qualitative depression research – the tendency to focus on depression as an acute disorder rather than a chronic or recurrent condition. Optimistic findings about recovery such as those of Schreiber (1996) may be qualified if depression is seen from a lifespan perspective. From this point of view, more narrative research into the experience of lifetime recurrent depression in a senior cohort, or even more revealing, in a longitudinal study, might reveal more information about what stays constant and what changes through the episodes, not only in symptomology and remission/recovery, but in the participants' view of themselves as the protagonist of their stories.

Since the theme of agency was so salient in the narrators' "musings" about their depression's causes and cures, a better understanding of the phenomenon of agency and its role in depression and depression recovery may provide fruitful clinical implications. For example, a phenomenological study of agency in depression recovery may differentiate various aspects of goal-seeking alluded to in these narratives, such as industry, over activity, power, independence, and relationship.

Finally, the nature of depression as a socially embedded, rather than solely individual, experience evidenced both by the use of master narratives and also by the participants' reference to belonging and connection as an important aspect of their depression recovery, is something that merits more research. Current theory and treatment of depression is most commonly framed from an individual perspective. Treatment through medication and/or evidence-based psychotherapy attends to the thoughts, feelings, behaviors, and physiology, of the depressed individual. However, in the stories of this study, friends, family and workmates play a large role. Along with an individual's story of her depression, there will also be, for example, a family narrative of the depression, with its own plot, goals, conflicts, and meanings. This family narrative has not been researched and may yield valuable therapeutic implications for family counseling and depression.

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## **Appendix B: Telephone Selection Interview Script**

When I receive calls/email from those interested in participating in my study, I will read the following statement to them:

"This study focuses on your experiences of being depressed and recovering from each depression. I am particularly interested in people who have suffered from depression more than once in their life. I imagine your life story has been affected by this experience. The main question I'm interested in answering is: "How do people construct their story of depression and recovery?" I'm now going to ask you a few questions to confirm that this study is a good fit for you."

1. Have you ever received a diagnosis of depression from a physician, psychologist or counsellor?
2. Was the diagnosis major depression (NOT bipolar or post-partum)
3. Was the last depression within the last 10 years?
4. Have you experienced at least two episodes of depression in your life?
5. Have you been feeling well for at least one year?

If the callers say no to any of these questions, I will thank them for their interest but say that the study's criteria and their experiences don't match.

If the caller does meet the criteria, then I will say:

"Your experience meets the criteria so now I'll explain a little about the study. It is a narrative method, which means that I am interested in your story and how you tell it. If you decide to participate, I will need to interview you for an hour to an hour and a half. The interview will take place at the UBC campus in Point Grey, in a private room in the Education building. Before the interview begins, I will ask you to sign a consent form but you have the right to withdraw from the study at any time. The interview will be audiotaped and transcribed, but to ensure confidentiality, I will not use your real name, but a pseudonym of your choice. Within a few months of the interview, I will send you a summary of the interview so you can check it to make sure it reflects your experience. You do not have to make your decision at this moment. I can guarantee you a space in the study for a week but thereafter, the number of participants needed may be satisfied. If you have any questions, please let me know."

## Appendix C: Consent Form

# THE UNIVERSITY OF BRITISH COLUMBIA



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## Consent Form

### A narrative exploration of the experience of recurrent major depression

#### Principal Investigator:

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#### Co-Investigator:

Brenda (Yaari) Dyer, UBC Department of Educational and Counselling Psychology, and Special Education (Counselling Psychology Program), 604 – 822-4919

The research conducted for this study will be part of a master's thesis eventually made available to the public.

#### Purpose:

The purpose of this study is to explore the experience of people who have suffered from recurrent major depression. The objective is to gain a deeper understanding of recurrent major depression from the sufferer's point of view.

#### Study Procedures:

As a participant in this study, you will be involved in a 1 to 1.5 hour, audio-taped interview with the co-investigator on your experiences of depression. A summary of your interview will be returned to you in order to ensure accuracy. A brief (approximately 30 minute) interview may be requested of you if further clarification is needed. The total amount of time required of you is approximately 2 hours. Any questions you have regarding the procedures of this study may be directed to the co-investigator.

#### Potential Risks

Discussion of your experience with depression may involve recounting painful or emotionally sensitive stories. You may be at increased risk for experiencing sadness or embarrassment while self-disclosing personal experiences of depression. Should I touch

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on areas that make you feel too uncomfortable, you can indicate this and we will move on to other things, or if you would prefer, stop the interview. You can withdraw your participation at any time. The interview is meant to be reflective rather than therapeutic, and if issues come up that need therapeutic attention, you are encouraged to address these with your GP and/or therapist. A list of appropriate and affordable counselling services will be provided to you before the interview begins, in case you decide you would benefit from counselling support.

**Potential Benefits**

The potential benefits of telling your story of depression include possibly gaining an insight into your experience that you did not have before. Sharing your experience may be helpful to others.

**Confidentiality:**

All efforts will be made to ensure your identity remains strictly confidential. You will not be identified by name in any reports of the completed study. Direct quotes from the interview may be reported in the findings of this study, but these quotes will not reveal any identifying information. All printed documents and floppy disks will be kept locked in a filing cabinet.

**Remuneration/Compensation**

As a volunteer, no remuneration or compensation will be made for your participation.

**Contact for information about the study:**

If you have any concerns about your treatment or right as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

**Consent:**

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time.

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

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

---

Subject Signature

---

Date

---

Subject Name (printed)

## **Appendix D: Interview Questions**

### **Orientating interview question:**

"I'm interested in hearing about your experiences of being depressed and recovering from each depression. I imagine your life story has been affected by the experience of depression, and I would like to understand your experience as fully as possible. Please speak as freely as you like. I may ask you sometimes to clarify or expand on something. If you feel uncomfortable at any time, you may pass on a question, or stop the interview. It may be easiest to start at the time before your symptoms began, to give me an idea of what your life was like before your first depression, and then go from there."

### **Main interview question:**

"Please tell me your story of your experience with depression."

### **Possible facilitating questions:**

- What was your life like before your first depression?
- What was your life like before you were diagnosed?
- What was it like to receive the diagnosis?
- Can you talk about how the process of recovery went in your first episode of depression?
- What was going on for you when the depression lifted?
- What changed as the depression started to lift?
- What happened when the depression came back?
- Do you think of depression as an illness that you have recovered from, or as a condition that you live with?
- Have there been particular incidents or insights that you consider turning points in your recovery from depression?
- Can you talk about how your life is going now? Do you feel completely recovered? Do you ever fear the return of depression? What is different about your life now and how it was before your very first depression?

## **Appendix E: Analysis Template**

How does this interview answer my research question: How do people construct the story of their experience of recurrent major depression?

Storyline (Gergen & Gergen)/genre/ other master narratives

Turning points

Narrative voice; narrative stance; relationship of the narrator to her plot

Manipulation of audience/tension created by sequencing of events

Supporting cast

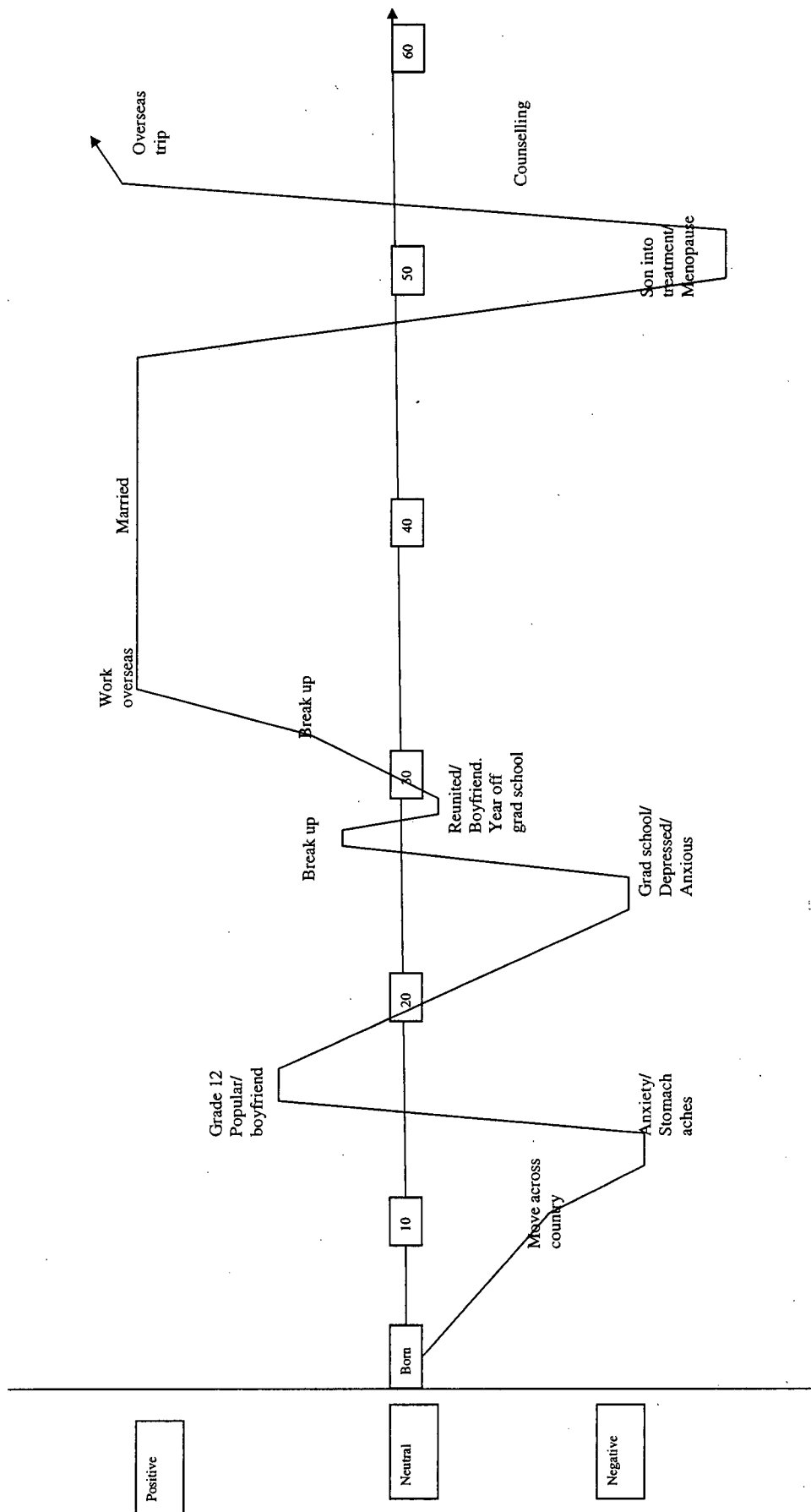
Valued Endpoint

Epiphany

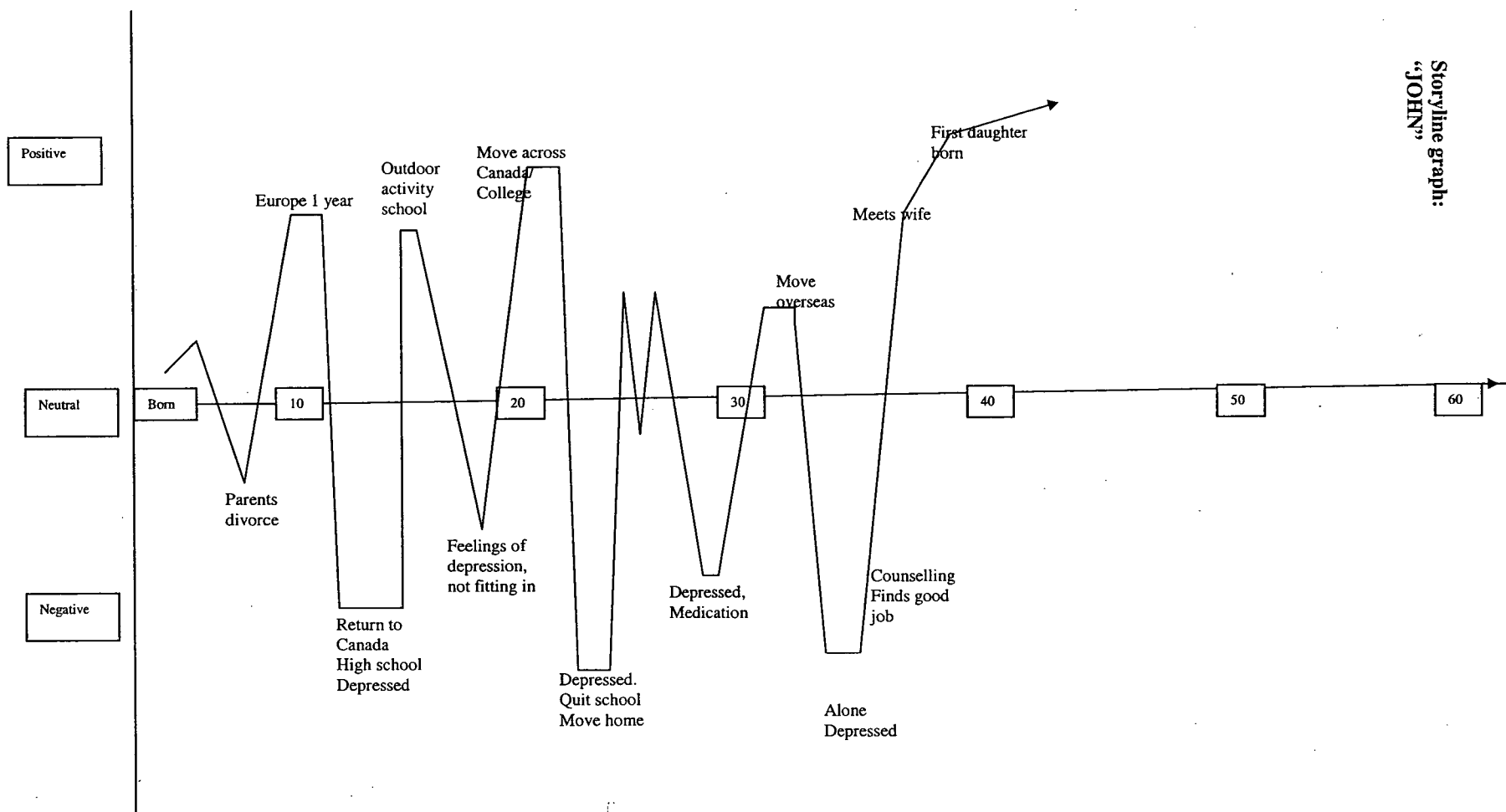
Themes

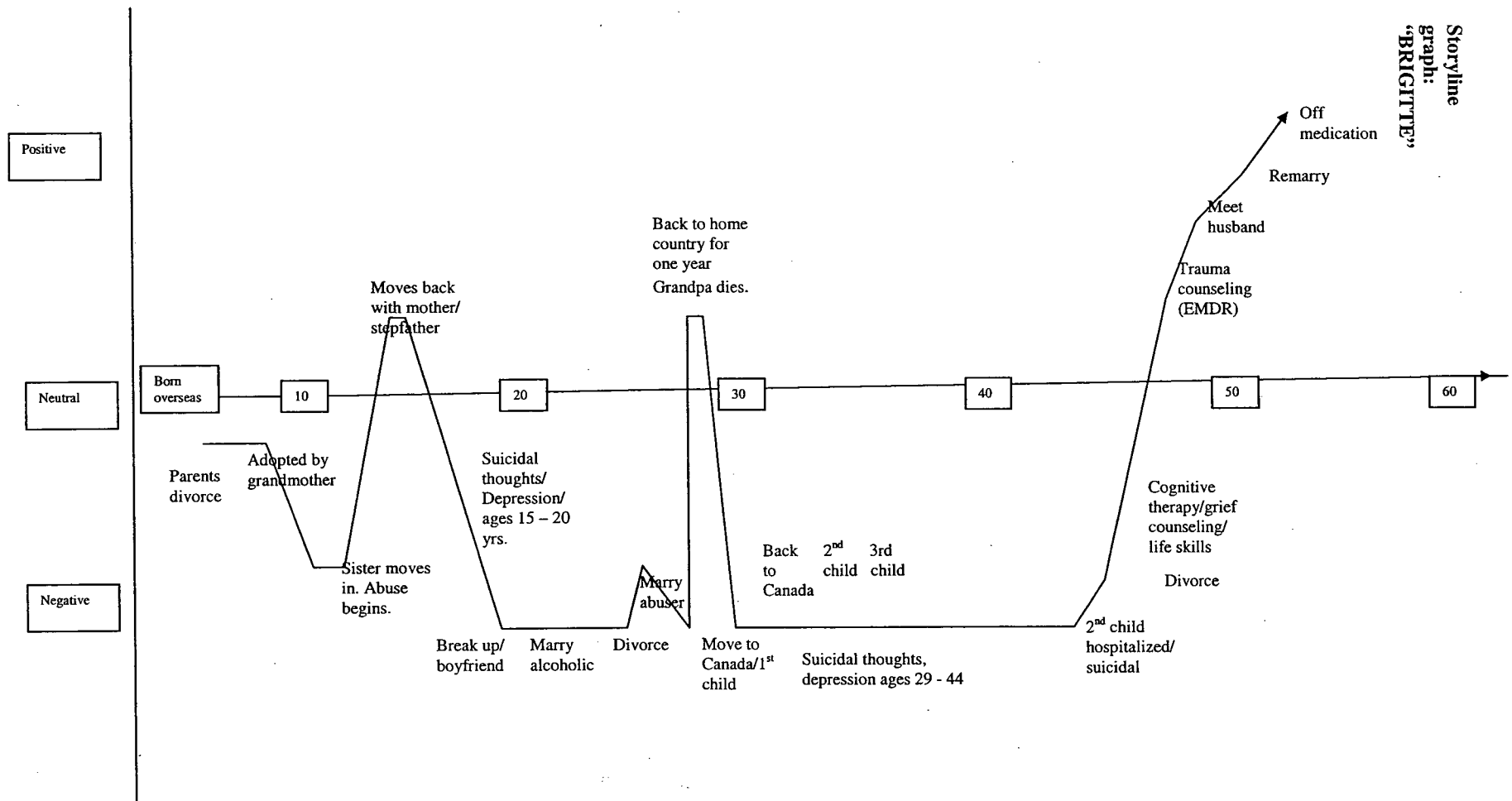
# Appendix G: Story Line Graphs of Participants

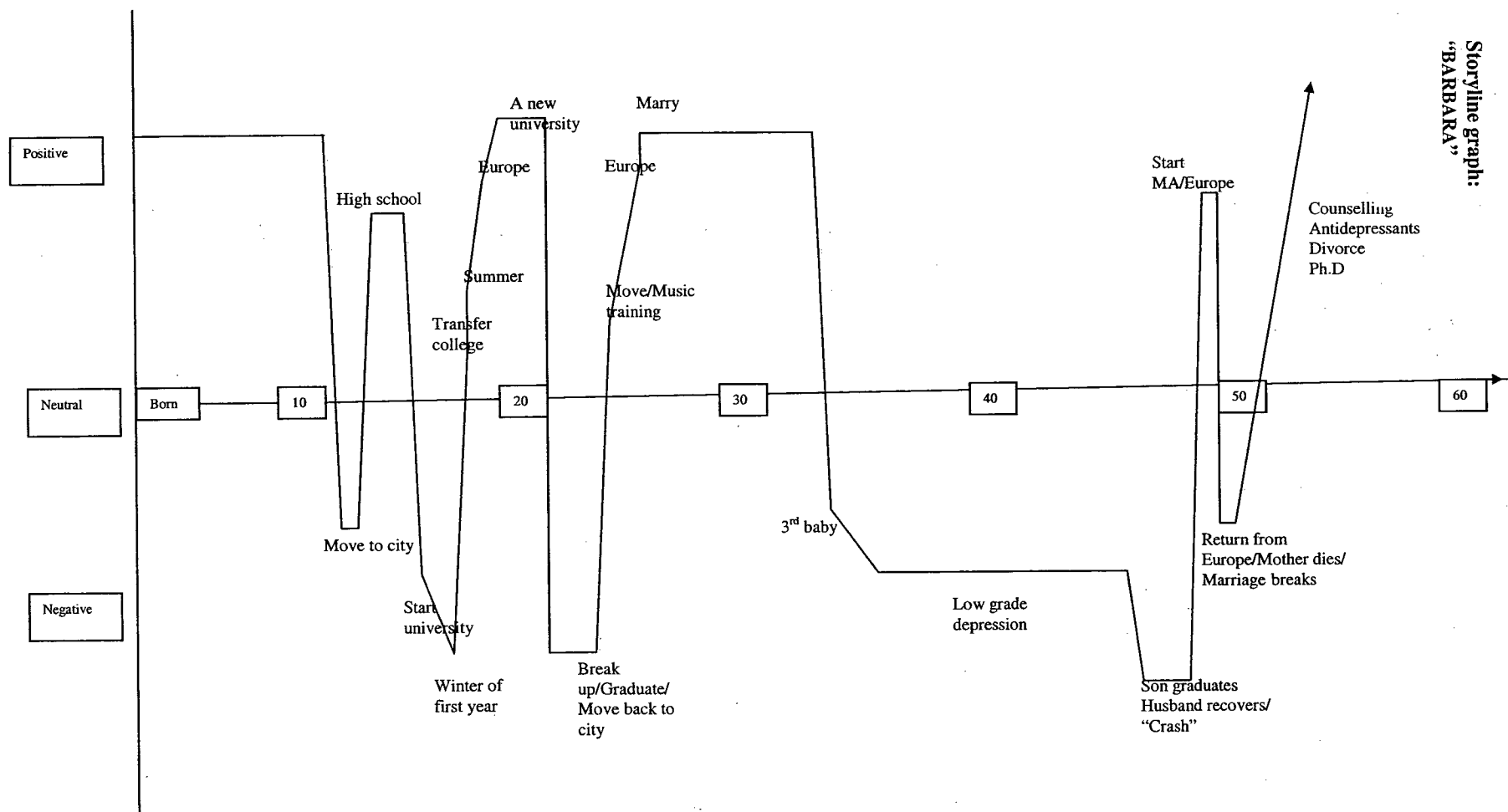
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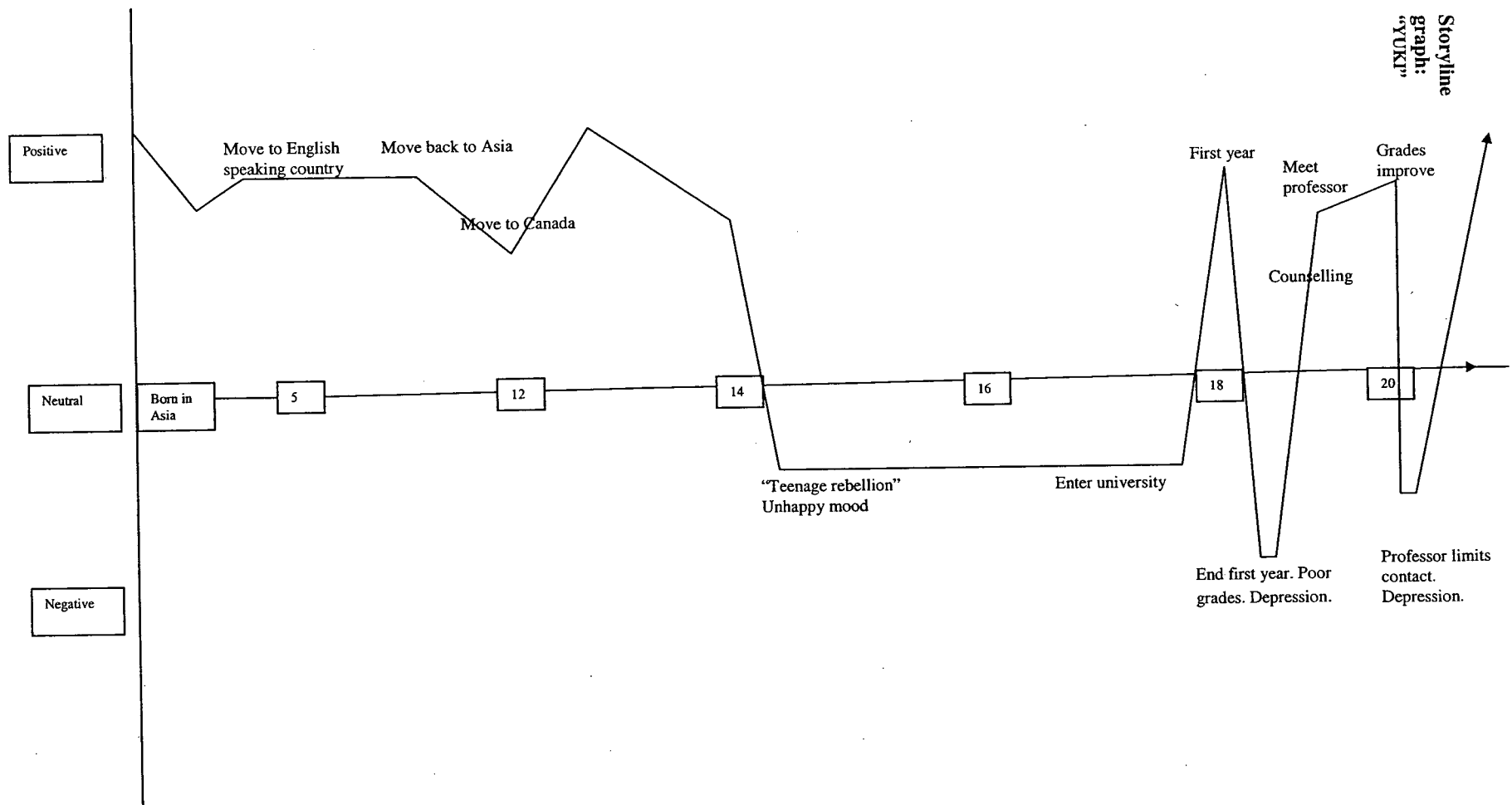


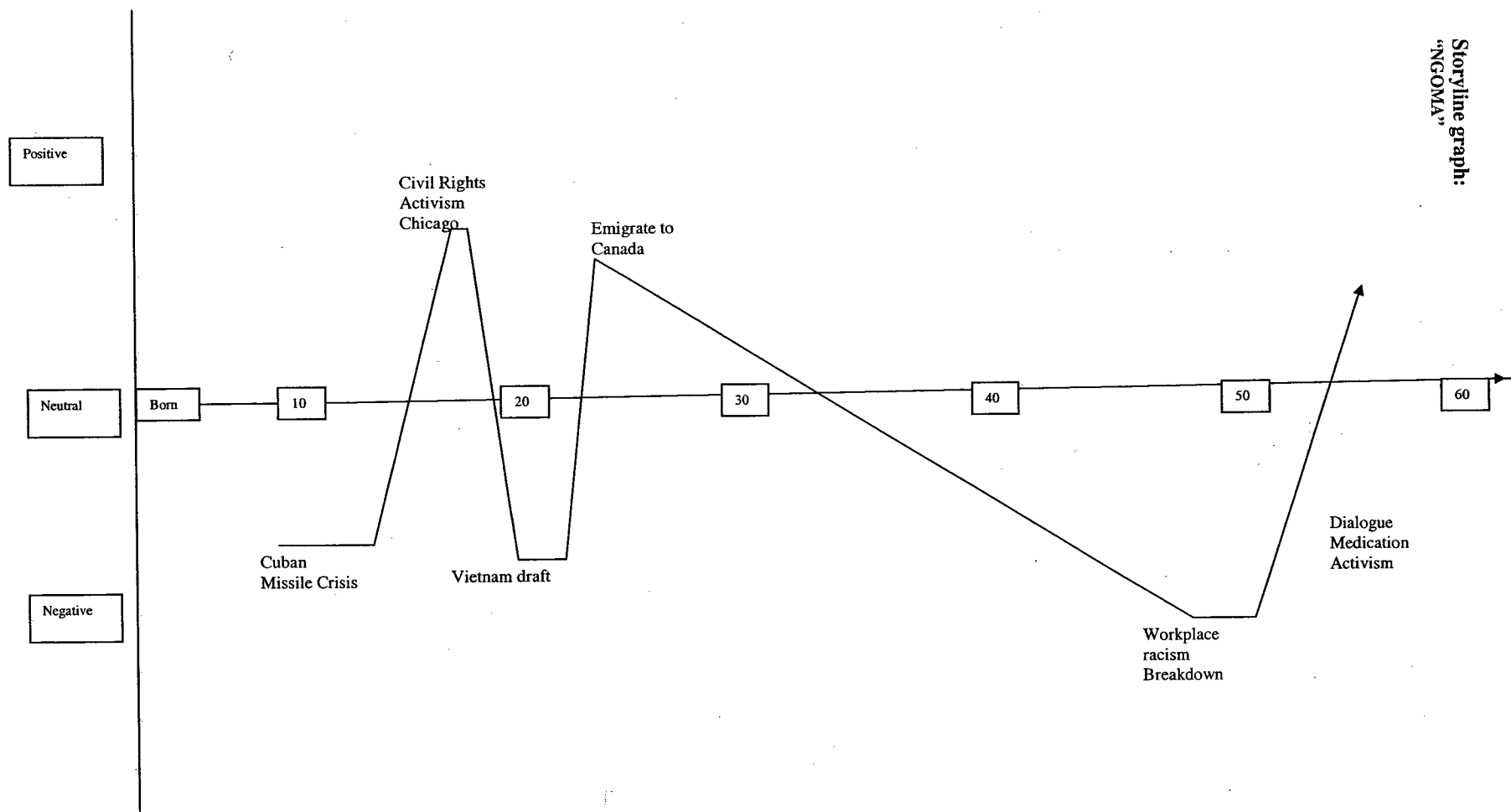












Composite graph of six participants

