

# “The Old Me Could Never Have Done That”: How People Give Meaning to Recovery Following Depression

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*Depression is usually a “self-limiting” condition, and recovery is likely, even if people do have subsequent episodes. However, despite considerable research into depression, little is known about how people actually go about understanding and organizing their recovery from depression. In this article, the authors draw on one-to-one interviews with people who have experienced mainly severe depression to explore the approaches and meanings attributed to overcoming depression. They used unstructured and semistructured interview phases to collect data and a modified grounded theory approach to analysis. They interviewed 38 men and women who had previously experienced depression (selected using the principles of maximum variation sampling through general practitioners, support groups, and newsletters) in late 2003 and early 2004. The authors explore the specific components involved in recovery (e.g., authenticity, responsibility, rewriting depression into the self), the stories people tell about their recovery, and the strategies deployed to revitalize life following depression.*

**Keywords:** *depression; recovery; narratives; authenticity; self; identity*

**G**lobally, depression is the leading cause of nonfatal disease burden, accounting for almost 12% of all total years lived with disability worldwide (Üstün, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004). Depression is “self-limiting,” in the sense that it tends to lift over time, even if improvement takes months or years and people have subsequent episodes (Schreiber, 1996). Despite depression’s being limited in this way, very little is known about what people who experience depression understand by “recovering,” nor how they go about recovering. The vast body of research tends to focus on observable and quantifiable measures

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averaged out among many subjects (Foulkes, 1999). A key issue then is the limited research on the personal meanings that people attribute to depression and recovery. From an interpretive perspective, the interior world of people is not directly observable. Here, the focus is on the complexities of thoughts and meanings. In addition, such a qualitative approach allows for an investigation of the process of depression and recovery rather than the usual focus on causes (Smith, 1999).

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

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

## METHOD

In this article, we draw on the data from video- and audiorecorded interviews that provided the foundation for the development of a Web site covering experiences of depression (<http://www.dipex.org>). Between September 2003 and May 2004, 38 people who had had depression were interviewed—usually in their own homes—by the first author, a qualitative researcher with extensive experience in sensitive research topics. People were encouraged to tell their stories in their own words, from their life before depression through to current-day experiences. To be eligible for the study, participants had to be older than 18, identify as having had depression, and be feeling relatively well and symptom free for the interview. The study was approved by the Multi Centre Research Ethics Committee in the United Kingdom, and the interviews were copyrighted for inclusion on the DIPEX (personal experiences of health and illness). Eleven respondents chose to have actors speak their words for the Web site (the issue of stigma frequently played a role in decisions to remain anonymous), and 16 (mainly older participants) agreed to have video extracts from their interviews included on the site. The rest appeared on the Web site as text and/or audio only.

## Sample Selection and Recruitment

To examine the experiences of people who have had (mainly severe) depression, a United Kingdom-wide maximum variation sample was sought. One of the aims of the study was to explore a broad range of different perspectives and experiences. Participants were recruited to include men and women; different age groups, ethnicities, and social classes; people from a wide variety of locations in the United Kingdom; people with different types of depression and treatment experiences; and those who had been diagnosed recently and many years ago. We obtained a maximum variation sample by finding participants through a variety of carefully selected avenues, including psychiatrists, general practitioners (GPs), patient support groups, and newsletters. A relatively diverse sample of participants was obtained. For instance, 16 men were willing to come forward to talk about their feelings about depression, even though other studies describe difficulties in finding men to talk about their mental health (O'Brien, Hunt, & Hart, 2005). Of the 38 participants, at the time of the interviews, 3 were below 30 in age, 14 were aged 30 to 40, 11 were aged 41 to 55, 6 were aged 56 to 65, and 4 were 66 years or older. Most (33) participants were White and of British ethnicity; the other participants were Black, Asian, Southern European, Northern European, and American (1 each). Seven participants lived in London, and the rest lived throughout the United Kingdom.

Eight of the participants were first diagnosed with depression in their teens, 9 were aged 21 to 29 at the time of diagnosis, 15 were aged 30 to 39, 4 were aged 40 to 49, 1 was older than 50, and for 1 the age of diagnosis was unknown. Twenty-two of the participants reported experiencing problems associated with depression since childhood, 6 since their teenage years, 8 in their 20s or 30s, and 2 in their 40s or later. Ten reported bipolar disorder. The "most helpful" treatments reported (not mutually exclusive) were medication (24 participants), talking therapy (31), doctor support (8), and holistic/complementary approaches (9).

## The Interviews

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

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

## Analysis

The audiorecordings from the interviews were professionally transcribed, corrected by the first author, and returned to the participant for review. The software NUD\*IST V6 was used to aid the coding, organization, and searching of narrative sections from each interview (Richards & Richards, 1994). NUD\*IST enabled sections about themes across a range of interviews to be compared and linked for a systematic analysis. The first author identified emerging themes using a modified grounded theory approach and multiple levels of analysis as described elsewhere in the literature (Glaser & Strauss, 1967; Ridge, Minichiello, & Plummer, 1997). The analysis was a cyclical process: The first author continually moved between reviewing the literature, data collection and coding, linking codes, and revising and reshaping the analysis. The analysis was scrutinized by both authors through regular meetings and electronic exchanges. Any names used in this article are pseudonyms.

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

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

## FINDINGS AND DISCUSSION

### The Recovery Process

Of critical importance, as with grappling to describe the experience of depression itself, participants needed to grasp a language of longer term recovery. This language was not automatically available to them. For one 33-year-old woman (Belinda), the idea of her being able to tell a story of recovery had never occurred to her until, after 9 years of depression, she attended a conference on recovery. Along with supportive counseling, the conference gave her a language and framework to organize her discovery of pleasant feelings and experiences as to do with recovering from depression rather than being perpetually trapped in mental illness:

I feel as if I have been in actually . . . in recovery for a few months now, or perhaps longer since May 2002, June time. June time say, but I hadn't actually realized I'd

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

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

I think I became . . . in 8 weeks, I very quickly became institutionalized myself. I was scared to come out because I was in this enclosed world where I knew what was going to happen. There were routines, mealtimes, getting up times, medication times, OT times. There were routines and I had no responsibilities. I didn't have, because I live, I'm single and I, you know, I pay a mortgage on this house. I have responsibilities, I have to work to pay the bills and things, and the bills need to be paid and the cat needs to be fed and, you know, I don't have children but I have certain responsibilities and suddenly I had no responsibility. I was being cared for, or I was in a place where I didn't have to think about anything, and nobody could touch me.

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

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

### **Meanings Attributed to Recovery**

Getting better meant different things to different people, and people aimed for different levels of recovery. Some just wanted to get back to how life was before depression,

feel “normal” or “human again,” and enjoy life instead of dreading it. Although these people wanted to return to their former lives, another group of participants wanted more than this. Recognizing that depression could return, that their recovery was only partial, and/or that they had not functioned well before depression, these participants grappled with narratives about their longer term recovery prospects. The key themes and tasks uncovered around the recovery process are grouped under headings below, including fixing chemical imbalances, types of insight, authentic self and living, and assuming responsibility for depression and recovery.

### *Fixing Chemical Imbalances*

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

I mean it's chemical, you know I'm quite, you know I'm quite happy to admit there's something screwed up about my brain chemistry, you know. But you know, some people are diabetic, they take drugs, you know. And I know people say, “Oh, it's not the same.” But I'm afraid it bloody well is. It's just, you know, you're trying to undo several hundred years of cultural difference between the brain and every other organ. . . . And when people say to me, “Oh, I'd be worried about the long term effects?” Well all right, let's say Seroxat is more likely to make me, I don't know, let's say . . . or even to take 5 years off the end of my life. I'd say, “Well it's better than feeling fucking awful now.” Which is, you know, I can honestly say antidepressants work, work well.

The chemical imbalance explanation could potentially be used to excuse the person from other efforts to bring about his or her recovery, but there was little evidence of this in the interviews. Although the chemical recovery narrative interwove with participant stories, it did not necessarily exclude nonbiological explanations for depression that could coexist with—or even surpass—the biochemical. Instead, there was a complex relationship between the chemical and the social. Like the participant cited below, those participants who adopted a chemical narrative also reflected on the potential social factors.

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

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

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



### *Types of Insight*

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

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

Furthermore, even though people can feel they are so damaged that they are beyond redemption, it is actually out of the disintegration of the façade of self in depression that a more useful understanding of the self has a chance to emerge. Depression can herald a "heightened reflexive awareness" that allows the creation of a more useful story about the self (Jago, 2002, p. 743).

When you're depressed, because you're very kind of sensitive . . . I think that you try to understand more things that you can't explain or you didn't even question when you're functioning like a machine, that I think most of us are most of the time. . . . I come out (of depression) very strong, and every time I come out I come a bit more, er, how could I say? I think I become more understanding of other people.

Participants gained insights of various kinds as part of their recovery. Consistent with the literature, one type of insight discussed was about moving from a position of "not knowing" to becoming more aware of themselves and their place in the world. Participants variously gained insight into their destructive thought patterns, distortions in the concept of themselves, and difficulties in their personal circumstances. In relation to depression, this process has been called "cluing in" (Schreiber, 1996, p. 484). In addition, the current study found that gaining insight went hand-in-hand with certain tools to promote insight. Although not the only road to insight, therapy was highly valued by participants. The majority of participants talked about counseling or therapy as among the most helpful approaches they had used to deal with depression. Although short courses of cognitive behavioral therapy were useful, those like Belinda, who identified that they had deep and complex problems, felt they needed longer term therapy.

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

There were also highly valued nontherapy approaches used in gaining insight. Such approaches were varied and included reading self-help books,

praying, attending social support groups, doing personal development courses, yoga, and finding distractions from rumination (see [www.dipex.org](http://www.dipex.org) for a comprehensive discussion). One woman cobbled together many self-development tools (e.g., self-help books and tapes, counseling classes, social support groups, therapy) as part of recovery. A chance viewing of a documentary on dyslexia that led to her dyslexia diagnosis was also described as a crucial part of her recovery.

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

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

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

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



from the self. Rather, it is rewritten into the self in a more helpful way, as Mathew illustrates.

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

Although it was easy to construct depression as the enemy to the self—particularly in the depths of depression—a number of people found a way to rewrite their depression story from personally detrimental to personally beneficial. In these accounts, depression is seen as meaningful: It comes for a reason. Depression is rewritten as the psyche forcing engagement with an essential self at a deeper level, to promote greater self-awareness and a better life, as Elizabeth suggests.

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

Some were able to rewrite depression as a beneficial spiritual journey. Depression could be constructed as an experience that a higher power wanted them to have so that they could eventually lead a better and more useful life. As Elizabeth further illustrates, a key value of the spiritual explanation was that it allowed participants to comprehend (and, at times, endure) very high levels of suffering, all the while helping to promote hope—an important ingredient of recovery.

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

Finally, with another kind of insight, people discussed the potentially different qualities of self that lay beyond depression. People found they not only could move beyond the limits of depression (e.g., negative thinking, low confidence, limited social relations, false self) but could approach themselves and their lives in different, more invigorating ways. This shift in insight was associated in particular with those who had had long-term therapy. One woman (who had had dysthymia and bouts of severe depression all her life) felt she was on the verge of discovering a very new way of being in the world, including a more robust self,

but this also meant moving beyond the familiar confines of a depressed identity into an experiential “void” and self that was constructed as an entity to be discovered. Although the prospect was frightening, she said that she was committed to finding meaning in life beyond the metaphorical prison of her depression.

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

### *Authentic Self and Living*

A repeated narrative about recovery was the quest for more authentic living and self. Reminiscent of the 20th-century language used by gays and lesbians about coming out of the “closet,” many talked about how they had lived a lie to survive life and “pass as normal.” People came to the conclusion that this problematic self needed to be reworked in recovery. Many felt that depression had given them an opportunity to stop and rethink their lives, and identify what was most real and important to them. As part of recovering from depression, people like this woman tried to put their lives into perspective, changed their lifestyles to care more for themselves, and pursued activities that felt right.

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

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

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

"Authenticity" is more than just a narrative turn. Restorying around authenticity was commonly commended for its ability to (re)invigorate lives. Critically, the mood here was more about accepting an essential self—warts and all—than about trying to force change onto the self. Indeed, some were rather militant in their discourses of self-acceptance and authenticity, as was this gay man.

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

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

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

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

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

### *Assuming Responsibility for Recovery*

Some people with long histories of depression in particular believed that they needed to take full responsibility for recovering from depression. This group of participants was convinced that recovery and self-development had to be directed by the person with depression. Like this woman, they relegated medication, talking therapies, self-development approaches, and professionals to the status of "tools" that could be of assistance in the recovery journey, rather than experts.

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

People's ways of taking responsibility for their depression were varied and included researching their condition and treatments on the Internet, attempting to do the things depression had stopped them from doing (e.g., socializing), being

more assertive about their needs, and being more proactive in gaining expertise and adequate care. As this man explained, taking this approach could also help people to challenge the value of the treatment they were offered.

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

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

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

## Struggling With Recovery

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

I mean, as I say I find living at the moment, um, what I would call living of course . . . Quite tricky at the moment, really as I've already, you know, I said now before because [clears throat], um, I mean, I have to take it, as I say, day to day really now. Day and nighttime too, of course, but mostly in the daytime because of how I'm feeling or . . . or not knowing how I'm going to feel, that's the trouble. Um, you know I often think, oh, what am I doing, and although it sounds rather dark, sort of wh- what am I doing in the world? You know and what is the purpose, what is the point of, say this, what is exactly going on, but, you know, er, in some ways we all have to know that.

Those struggling with telling a recovery story also tended to have few helpful tools that really worked to support their recovery: This was particularly the case if medication failed or was inadequate. Recovery stories and adequate tools seemed to go hand-in-hand. For one man, severe depression was largely considered a chemical imbalance. He relied mostly on his psychiatrist to get the medication right, and even though he once called a telephone help-line when he had tried

to hang himself, he thought, "I don't know what to say. What do you say? . . . So I didn't do anything." The medication was only partially successful for him the last time. His dread of future episodes of depression in his account was a tangible presence in the interview room. He feared that his next episode of depression might well mark his demise.

So the thing that really worries me about the future is about every 6 years I have a major depressive episode, and each one has been worse than the last. This last one very, very nearly killed me. And what worries me more than anything is, what's the next one going to be like, because I know it will come, and you know, I try and prepare for it, try and warn those around me when it happens. You've got to take me to the doctor's, but you know, you never know. . . . Yeah, every one [episode] ends, yeah. That's what worries me. Yeah, what's that end going to be like? [laugh] Is it going to be sort of soft ending of tailing off and being stoked up on drugs, or is it going to be the hard ending of a, at the end of a rope. Um, but it's going to end.

## CONCLUSION

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

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

We were able to interview only people who were willing to talk about their depression, so we are unlikely to have identified some of the most isolated and immobilized. Our participants mainly regarded themselves as being in "recovery"

and were willing to help others by having their story on a Web site (<http://www.dipex.org/depression>), and so were likely to be "role models" for recovery. It is likely that people who were seriously struggling in their recovery would not feel well enough to come forward for an interview. We do not claim numerical representation (this is not the purpose of maximum variation sampling), but we are confident that we have a sample that can reveal a broad range of experience and complexities about the recovery experience in the United Kingdom. We made considerable efforts to include people from ethnic minorities but interviewed few. We might have identified additional perspectives on recovery if we had been able to interview more people from ethnic minorities. In addition, we have not examined how men and women differ in their approaches to depression and recovery here, as this is explored in more detail by us elsewhere (Emslie, Ridge, Ziebland, & Hunt, 2006).

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

The current research goes beyond other narrative research that has identified gaining insight as a major task in recovering from depression. We found that gaining insight of at least four types was important: (a) moving from not knowing to greater awareness of self and other, (b) working out that the self is different from the distorted messages picked up in social life, (c) rewriting the depression into the self in a more useful way, and (d) discovering the different and perhaps unknown qualities of self that potentially lie beyond depression. The paradox is that although depression involves intrusive and distorted thoughts and problems with the self, people with depression might also come to see themselves and the world with greater clarity than before (Solomon, 2002).

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

Authenticity is a notoriously difficult concept to define, because it depends on a person's inner experience, his or her character, and relations to an outside world that contains agendas apart from encouraging absolute authentic citizenship. Nevertheless, the quest for authenticity was a deep yearning in many of the interviews and has been noted elsewhere in the narrative research on depression (Jackson, 1998; Schreiber, 1996). Being true to an authentic self is valued in a postmodern world that is distinguished by multiple ways of identifying and social fragmentation (Holt &



Griffin, 2003). For instance, feeling “different” as children, living a lie to hide behind, passing as “normal,” and the assertion of a more authentic self are all very familiar concepts in stories of depression told to us, and are incidentally prominent in stories of coming out as gay. For participants in our study, the pursuit of an authentic self was about navigating complex (and, at times, dangerous) interior and outer worlds to discover essential truths about the self. There is considerable discomfort in existing and moving within the tensions of thoughts, identities, difference, and yearning (Yngvesson & Mahoney, 2000). Consistent with existentialist writers such as Sartre (1984), participant narratives show there can be payoffs in the unpleasant struggle for authenticity, including reinvigoration of lives and personally radical changes in the way in which people relate to the world.

Although Schreiber (1996) noted that women might take more responsibility for the self as part of recovery from depression, the current study found that highly experienced participants talked about needing to take full responsibility for their depression and longer term recovery. This relegated treatments, professionals, and carers to the status of recovery tools. If these participants are right—and recovery requires the individual to find his or her own voice and tools—then ultimately, personal choice and agency must be encouraged and supported by professionals. From a narrative perspective, agency is fundamental to rebuilding a more useful narrative of the self in recovery: Stories cannot usefully be foisted on people. Participants also acknowledged that personal responsibility is a very difficult concept for depressed people to grasp and might become salient only relatively late in life. Responsibility would be an inappropriate narrative to encourage in the depths of depression or early on in recovery, when people are grappling with the basics of getting better. However, some professionals who were highly valued by experienced participants were treating them as experts who could have responsibilities in their own care. The difficult juggling act here is for health professionals to encourage personal responsibility without encouraging clients to feel they are to blame for their depression.

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

Recovery is about seeing people and people seeing themselves as capable of recovery rather than as passive recipients of professional treatments.

It is about working out strategies and taking control of our own lives.

Within the Recovery Approach individuals are encouraged to learn more about their experience and to find ways to deal with their mental health experiences.

People are actively supported to acquire skills, knowledge and strength to reduce the prevalence of harmful experiences in safe, simple and effective ways.

A key element to Recovery is about people taking control and moving away from a negative mental health system. It is about working out ways of helping themselves,

taking responsibility and having hope. Each person's recovery is individual; there are differing views but also common themes. There is a growing movement in the UK and we are learning a lot from people in other countries. (Allott, 2006, paras. 5-8)

## REFERENCES

- Allott, P. (2006). *A brief introduction to the recovery approach*. Retrieved June 22, 2006, from <http://bboard.rethink.org/recovery/index.htm>
- Beck, C. T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research, 12*, 453-472.
- Bochner, A. P. (1997). It's about time: Narrative and the divided self. *Qualitative Inquiry, 3*(4), 418-438.
- Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity? *Social Science & Medicine, 62*, 2246-2257.
- Foulkes, P. (1999). The effectiveness of long-term psychoanalytic therapies. In P. W. Group (Ed.), *She still won't be right mate!: Will managerialism destroy values based medicine? Your health care at risk* (p. 120). Camberwell, UK: Psychiatrists Working Group.
- Frank, A. W. (1997). *The wounded storyteller: Body, illness, and ethics*. West Sussex, UK: University of Chicago Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Holt, M., & Griffin, C. (2003). Being gay, being straight and being yourself: Local and global reflections on identity, authenticity and the lesbian and gay scene. *European Journal of Cultural Studies, 6*(3), 404-425.
- Jackson, P. S. (1998). Bright star—Black sky: A phenomenological study of depression as a window into the psyche of the gifted adolescent. *Roeper Review, 20*(3), 215-221.
- Jago, B. J. (2002). Chronicling an academic depression. *Journal of Contemporary Ethnography, 31*(6), 729-757.
- Karp, D. A. (1994). Living with depression: Illness and identity turning points. *Qualitative Health Research, 4*, 6-30.
- Lewis, S. E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health, 4*, 369-382.
- Mason, O., & Hargreaves, I. (2001). A qualitative study of mindfulness-based cognitive therapy for depression. *British Journal of Medical Psychology, 74*, 197-212.
- O'Brien, R., Hunt, K., & Hart, G. (2005). "It's caveman stuff, but that is to a certain extent how guys still operate": Men's accounts of masculinity and help seeking. *Social Science & Medicine, 61*, 503-516.
- Richards, L., & Richards, T. (1994). From filing cabinet to computer. In A. Bryman & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 146-172). London: Routledge.
- Ridge, D., Minichiello, V., & Plummer, D. (1997). Queer connections: Community, "the Scene," and an epidemic. *Journal of Contemporary Ethnography, 26*(2), 146-181.
- Sartre, J. P. (1984). *Existentialism and human emotions*. New York: Kensington.
- Schreiber, R. (1996). (Re)Defining my self: Women's process of recovery from depression. *Qualitative Health Research, 6*, 469-491.
- Smith, B. (1999). The abyss: Exploring depression through the narrative of the self. *Qualitative Inquiry, 5*(2), 264-279.
- Solomon, A. (2002). *The noonday demon: An anatomy of depression*. London: Chatto and Windus.
- Üstün, T., Ayuso-Mateos, J., Chatterji, S., Mathers, C., & Murray, C. (2004). Global burden of depressive disorders in the year 2000. *British Journal of Psychiatry, 184*, 386-392.
- Yngvesson, B., & Mahoney, M. A. (2000). As one should, ought and wants to be: Belonging and authenticity in identity narratives. *Theory, Culture & Society, 17*(6), 77-110.

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