Difference-makers in human affective distress: Perspectives on causation and recovery gained from qualitative inquiry into lived experience.

By

Thomas Lieven Steur

A Thesis Submitted to the Faculty of Graduate Studies of the
University of Manitoba
In partial fulfillment of the requirements of the degree of

Master of Science

Department of Community Health Sciences
Rady Faculty of Health Sciences
University of Manitoba
Winnipeg, Manitoba

Abstract

Background: The biomedical conceptualisation of “depression” as an objective disease entity stems from biological science rooted in a 17th century paradigm, and is an inappropriately positivist idea which discounts individual agency, disregards social context underscored in the descriptive epidemiology, fails to accommodate inter-subjectivity and process, medicalizes suffering, and serves a managed care model of health administration. There are calls both from within psychiatry and other disciplines for more contextual understandings of human affective distress and greater variety of interventions for it.

Purpose: A qualitative study was undertaken with the purpose of eliciting perspectives from individuals who had lived experience of biomedical (pharmacological) treatment for affective distress and who self-reported having attained satisfactory recovery. Three main questions were asked: (1) Conceptualisations of the experience, including their views on their degree of fit or lack of fit with the dominant psychiatric discourse of biomedical individualism and pharmacological treatment; (2) Description of the ‘difference-makers’ or risk factors identified by participants as contributory to the genesis of the emotional distress; and (3) Description of the ‘difference-makers’ or helpful factors participants perceived as helpful to their recovery.

Methods: The study was approved by the University of Manitoba Health Research Ethics Board. Participants were recruited from self-help and social services agencies who (1) were 18 years of age and over; (2) self-identified as having experienced emotional distress, in adulthood, for a period of two weeks or longer; (3) were treated (and possibly still were being treated) with prescription antidepressant medication for this distress; and (4) described themselves as having achieved a satisfactory degree of recovery for at least six months up to the present. Participants were screened for mental health diagnoses other than depression as well as for currently active substance use problems. Demographic comparator data was optional and was collected from most. In-depth interviews were audio-recorded and transcribed verbatim. Interview data were coded and main theme categories identified using thematic analysis methodology in an interpretive description framework.

Findings: Participants' backgrounds, ages, occupations, and income levels showed diversity. The two to one female-to-male sex ratio reflected worldwide epidemiology. Coding of interview data clustered around three main overlapping 'umbrella' theme categories: (1) multifactorial conceptual understandings; (2) context pertinent to the experience of distress and recovery – including gendered experiences, overwhelming stress, and innate strengths and resources – and (3) trajectories of recovery from acute distress to negotiation of ambivalence toward treatment, enlisting of supports, and reclaiming of agency. Participants named a wide variety of factors in both the genesis of and recovery from depression; difference-makers which were felt to be essential for recovery included development of trusting relationships with primary care physicians and/or psychiatrists, counselling, and self-help organisations and community agencies.

Significance: Theoretical orientation appears to be relevant to understanding and recovery in depression. It is suggested that primary care and specialist physicians are practising more than adherence to the dominant decontextualised biomedical discourse surrounding depression would imply, as human factors such as trust, empathy, optimism, acknowledgement of contexts, and acknowledgement of agency and even of resistance were recurring themes. Findings are consistent with a body of literature which finds physicians eschewing diagnostic checklists and algorithms, and respectfully negotiating treatment for depression with individuals while attending to their functioning, social context, treatment preferences, and potential for stigma. The effectiveness of an integrated mental health system with an array of services which respects individual agency and choice is upheld.

Acknowledgements

I have always suspected deep down that if ever I should succeed in such an endeavour, it could only be through teamwork. And what a team I have had! I cannot name you all.

Family. My noisy family. Vedmeed for so much help with the idea, and the love and the inspiration to carry it through. I could not have done this without your constant encouragement and support. Chervona for policing my language and for debating with me. Epic for challenging me always to do – and look – my best. My mother for teaching me the skepticism which coexists with love. My father, who did not live to see this project to completion but who remained a steadfast supporter to the end. I said I'd make ye proud. My extended family for their support and inspiration.

Friends. Yoga North. Winnipeg Insight Meditation Group.

Colleagues. Coworkers and supervisors past and present. Colleagues and supervisors at CTS Inc., at The Grace, and in the broader mental health system and agencies, and managers both past and present for your support and encouragement.

Shawarma Time. Guildy's Eatery. Starbucks. Don for keeping stuff working. Mike the janitor for keeping stuff clean.

Present as well as past mentors, some lost in the mists of time. Dr Jim Nickels. Robert A. "Dr Bob" Altemeyer for being the first to teach me how good science meets human experience. Dr Michael Moffatt for introducing me to Krieger and the mystery of the spider. Dr Jitender Sareen for introducing me to Kendler. Dr Tracie Afifi for elucidating the critical links. Dr Kerstin Roger for expanding on some very important concepts, philosophy, and methodology. Psychiatry Grand Rounds speakers and participants through the years. Dr Murray Enns. Dr Michael Eleff for introducing me to Lipowski.

The Department of Community Health Sciences. Theresa Kennedy. Dr Bob Tate. Fellow students too numerous to mention but I will just say a big thank you to: Dhiwya Attawar, Andrea Blanchard, Dr Andrea Bombak, Nicholas Krueger (and your grandfather!), and Dr Natalie Riediger.

Community agencies who supported my recruiting. Adam Milne at the Mood Disorders Association of Manitoba. The Winnipeg Fibromyalgia Support Group. People at FACES, CMHA Manitoba / Winnipeg and the Grace General Hospital for your willingness to help. Dr Y. Kotecha and Misty. Thank you all. It means a lot to me.

The people who so willingly gave of their time and shared their stories with me. You are an inspiration in many ways which I could never have imagined.

Committee. Dr Leanne Leclair for your wisdom and encouragement over a great many years, for being so tough on me, and for welcoming me to Room P162 so many many years ago. Dr Javier Mignone for your advice and good-natured presence throughout this endeavour. I tried to stay confused as long as I could.

Finally, to Dr Sharon Bruce: This work represents the fulfillment of a lifelong dream I have had, to understand something of the human condition and medicine and science – and yes, culture too! – and my little place in all of it. You not only opened this puzzle box for me as no one ever could before, you welcomed me to play with it, you bore witness to my amazement, and you stuck with me to put it all together in an authentic way.

Dedication

To everyone who's ever suffered.

Table of Contents

Accepting the absurdity of everything around us is one step, a necessary experience: It should not become a dead end. It arouses a revolt that can become fruitful.

ALBERT CAMUS

1. Introduction

OUR UNDERSTANDING of the human condition is a function of history and culture. Mental illness, be it understood as humoural imbalance, gift, madness, genetic inheritance, dæmonic possession, character weakness, social deviance, chance occurrence, chemical imbalance, response to trauma, or all of the above and more, at any point in history represents a complex intersection of biological, social, and personal forces subject to interpretation according to the meanings and constructions imparted by the culture of the time (Foucault, 1989; Good & Kleinman, 1985; Horwitz, 2002; Kleinman, 1988; Lupton, 2003; Shorter, 1997). Depression, defined today by psychiatry as essentially a sad mood and loss of pleasure in activities, accompanied by characteristic cognitive and physiological features, and which causes significant distress and impairment in functioning for a period of at least two weeks (American Psychiatric Association, 2013), has in recent decades grown in prevalence to take first place among worldwide causes of disability (World Health Organization, 2016). Yet this phenomenon which has been observed since the beginning of recorded medical history (Horwitz & Wakefield, 2007; Jackson, 1986) has not always been so delineated and understood conceptually as an objective fact of disease, which exists in nature, and which can be remedied with targeted biomedical treatment (Greenberg, 2010). Rather, our current conceptualisation of human distress can be situated within medical and cultural history as a pragmatic development serving such interests as health care administration, advocacy groups, and pharmaceutical companies (Conrad & Barker, 2010; Deacon, 2013; Greenberg, 2010; Horwitz, 2007; Horwitz, 2002), and, as such, an example of medicalization – “defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it" (Conrad, 2005, p. 3). A historical and critical perspective reveals the medicalization of distress seen in today's psychiatry as a product of unique historical-political happenstance, powerful interests, and values both expressed and unexpressed; one more "era from which we have not yet emerged" (Foucault, 1989, p. x).

Historian Edward Shorter characterised psychiatry as a profession striving for ever greater legitimacy through appeals to medical science (Shorter, 1997). As part of the Western biomedicine tradition, psychiatry rests upon biological reductionism and a realist ontology which stubbornly posits static, knowable biological and psychological processes, discounts context, and discounts subject-object interrelations in favour of a Cartesian dualistic view of mind and body (Horwitz, 2002; Kendler, 2005). Although the scientific paradigm of our times presents itself as a non-culture – cultivating a non-verbal impression of neutrality, rejection of theory, and lack of a philosophy (Foucault, 1989), Western biomedicine is embedded in Western culture as a socially constructed phenomenon, subject – like all social institutions – to power influences and the vagaries of political and social trend (Lupton, 1995; 2003). The "truths" of our paradigm can be understood as the products of interests and networks of power over time, no less socially constructed than economics or civil law (Conrad & Barker, 2010; Foucault, 1965; Good & Kleinman, 1985; Horwitz, 2002; Horwitz, 2007; Lupton, 2003; Shorter, 1997).

It seems curious that a discipline which aims for understanding and healing of human feeling and thinking partakes of a positivist view rather than relational. Profound tensions are seen arising between psychiatric medicine in theory – a theory made murkier for its not being made explicit – and mental health practice as enacted in day-to-day clinical psychiatry and family medicine (Kendler, 2005; 2012a; 2012b; Lipowski, 1989; Macdonald et al., 2009; Maxwell, 2005; Schumann, Schneider, Kantert, et al., 2012; Taussig, 1980). Many critics have, in their various ways, noted the poor fit between the (largely unarticulated) theory of contemporary psychiatry and actual human experience (Duncan, Miller, & Sparks, 2004; France, Lysaker, & Robinson, 2007; Frances, 2013; Good & Kleinman, 1985; Greenberg, 2010; Horwitz & Wakefield, 2007; Kemp, Lickel, & Deacon, 2014; Kendler, 2012a; 2012b; Kleinman, 1988). In clinical terms, psychiatry's gaze (1) places the locus of psychological distress in the individual, (2) requires medical-scientific understanding and categorisation as a condition of helping, (3) takes agency from the individual and shifts it to professionals, (4) privileges the voice of the expert, while regarding as suspect the voice of the client, and (5) fails to recognise the client's intrinsic resources (Duncan, Miller, & Sparks, 2004). Psychiatrist and researcher Kenneth Kendler traces this paradigm's origin to Cartesian dualism – the 17th century French philosopher René Descartes's conceptual separation of the substantial, physical brain from the insubstantial, thinking mind – to which we owe the constructed distinctions we see today between neurology and psychiatry, between the functional and organic (the "software-hardware" diagnostic dichotomy), and even the term 'mental' with its ætiological connotations which seem to reflect a mental-physical discontinuity which does not exist in nature (Kendler, 2012b; 2005).

There are calls from both outside of and within psychiatry to expand models of causation and practice beyond the individual and medical, to include the cultural, economic, and political (Deacon, 2013; Horwitz, 2002; Kendler, 2005; 2012a; 2012b;

Kleinman, 1988; Krieger, 2008; 2001; Link & Phelan, 1995), and accordingly, to advocate for implementation of commensurate multi-factorial, multi-level interventions in both clinical practice (Horwitz & Wakefield, 2007; Kendler, 2012a; 2012b; Macdonald, Morrison, Maxwell, et al., 2009; Sareen, Cox, & Afifi, 2005; Sunderland & Findlay, 2013) and public health (Jacob, 2012). Specific to affective distress or depression, rigorous qualitative inquiry can bear witness to the lived experience of individuals who have come through it, and in the course of analysis, explore the goodness of fit of the reductionist positivist view and perhaps point the way toward alternatives. To that end, the present paper will: (1) briefly review, from a critical-historical perspective, the conception of human affective distress which we have come to know as the biomedical disorder termed “depression;” (2) describe the purpose, methods, and findings of a unique qualitative study into nine adult participants’ lived experience of emotional distress and recovery in Manitoba, Canada, and submit these findings to interpretive analysis; and (3) outline implications for health care policy and clinical practice.

2. Theoretical Framework

Mental health is perhaps the only field in which “changing the story we tell about our suffering can relieve it” (Greenberg, 2010, p. 24). In order to explore the “story” or “stories,” therefore, we must first articulate an alternative philosophical ground upon which our analysis can stand – and anticipate the effects of our position on the individual.

Exploration of psychiatry in its historical context is aided by the postmodern concept of ***discourse***. Discourse is described as “a pattern of words, figures of speech, concepts, values, and symbols... [it is] a coherent way of describing and categorising the social and physical worlds" (Parker, 1992, cited in Lupton, 2003). Discourses "gather around" a phenomenon of interest and provide a means of making sense of it. As a tool of analysis, discourse is a helpful means of grasping the words, figures of speech, concepts, values, and symbols belonging to the abstract and purposeful ways in which meaning is established around objects, persons, groups, and experiences (Parker, 1992, cited in Lupton, 2003). Discourses work in complex ways to engage individuals to make particular choices regarding their everyday activities (Lupton, 1995), drawing them in using what Michel Foucault termed *biopower* – the governance and regulation of individuals and populations through practices associated with the body (Foucault, 1978). Furthermore, discursive language, of which a psychiatric label like depression is an example, has the power to change the way individuals identify and treat themselves – a power wielded not aggressively or even overtly, but subtly, with the appearance of freedom of choice, to choose a preselected ideal (Foucault, 1965; Greenberg, 2010).

As suggested by Greenberg, the perspective one takes in framing one's understanding of a phenomenon can be seen as potentially influencing the very experience – and the outcome – of the phenomenon. This has implications for both clinical practice and for research. Our task in qualitative inquiry is to open up a space in which positivist assumptions are bracketed, inductive analysis can be undertaken in a manner which acknowledges heterogeneity yet permits interpretation, and mainstream biomedical conceptualisations can be set aside – yet still respected as cultural ways of understanding if raised authentically by participants. The specific approach which can afford this kind of openness is articulated in **Methodology,** below; for the moment, let us articulate a position which accommodates such a space.

Rejecting positivism, qualitative research in mental health can choose an epistemological stance between it (positivism) and pure constructionism: a **critical realism** that invokes a real and knowable world which sits ‘behind’ the subjective and socially-located knowledge a researcher can access (Braun & Clarke, 2013): “Because knowledge is viewed as socially influenced, it is thought to reflect a separate reality that we can only *partially* access. The critical realist position holds that we need to claim that some ‘authentic’ reality exists to produce knowledge that might ‘make a difference’” in terms of policy or practice (Stainton Rogers & Stainton Rogers, 1997, cited in Braun & Clarke, 2013, p. 27; emphasis in original). Moreover, critical realism maintains that we look at life only through a prism or lens – the prism or lens being our culture, history, theory, or other context. Thus the researcher acknowledges his or her subjectivity, viewpoints are not seen as “biases” but are incorporated into the analysis, and findings cannot but reflect our identities and our experiences (Braun & Clarke, 2013; Thorne, 2008). In the case of human affective distress, a phenomenon which has been with us since ancient times (Greenberg, 2010; Jackson, 1986; Shorter, 1997) is understood in terms of the particular meaning and interpretation which our time and culture have layered onto it. Stepping beyond positivism by appreciating this layering, critical realism places individuals in contexts, and begins to acknowledge the less surfaced, more subtle, factors at play in lived experience.

Three further terms used in the title of this paper require explanation:

Human affective distress. Critical-historical analysis such as we are undertaking cannot also be participating in the dominant medical discourse, and so must problematise its terminology. The term ‘human affective distress’ is here offered provisionally, as a placeholder; the key research question in the study was an open-ended inquiry into how participants conceived of their experiences of emotional distress and what language they would use to capture such a meaning.

Recovery. The idea that recovery from mental illness is possible has a strong tradition of over 25 years as being at once an empirical finding, a social movement, and a model of understanding and health care practice. The fact that people diagnosed with mental health conditions can and do recover, once thought groundbreaking, has been documented by writers including Anthony (1993) and Spaniol (Spaniol & Wewiorski, 2012), and the ‘recovery model’ now informs mainstream clinical practice and policy (Manitoba Health, Healthy Living and Seniors, 2011; Winnipeg Regional Health Authority, n.d.) Recovery can be seen as a competing discourse against the medical model, with clinicians caught in between.

Difference-makers. The philosophical term “difference-makers” is used by Kendler in his argument for a multi-layered, multi-factorial conception of mental disorder (Kendler, 2012b). Although similar in concept to a risk factor, a difference-maker holds a purposely looser meaning: “Being exposed to a difference-maker increases the probability of illness but the difference-maker need not be necessary or sufficient” (Kendler, 2012b, p. 379). The present paper further expands the term to also include positive factors and conditions described by participants as having been helpful to them in their process of recovery.

3. Descriptive Epidemiology

According to the World Health Organization, the burden of mental health conditions in general is on the rise globally, and as noted above, depression is now the leading cause of disability worldwide (World Health Organization, 2016). Epidemiological data paint a confusing picture of discrepant prevalence and treatment rates, and differing findings depending on methodology. In general, antidepressant use in developed countries has increased over time (Hemels, Koren, & Einarson, 2002; Kessler, Berglund, Demler et al., 2003; Macdonald et al., 2009), a trend possibly associated with false positive diagnoses (Batstra & Frances, 2011; Dowrick & Frances, 2013; Horwitz & Wakefield, 2007), uses for other indications (Hemels, Koren, & Einarson, 2002), and a disturbing trend of over-prescription to persons not meeting criteria for disorder (Dowrick & Frances, 2013; Frances, 2013; Pagura, Katz, Mojtabai et al., 2011) – particularly among older, female patients with diffuse complaints related to general medical conditions (Mojtabai & Olfson, 2011). American data show an increase in prevalence over time through the 1980s to the early 2000s, and a 76% increase in the proportion of the population in treatment for depression over a two-decade period (Kessler et al., 2003). The rate of antidepressant use in the U.S. general population increased from 2% in the early 1990s to over 10% in the early 21st century, particularly among those with less severe presentations (Mojtabai, 2008). Frances (2013) summarises the situation conceptually as an imperfect match between ‘unmet need’ and ‘met unneed’ – that is, between the set of individuals in need of treatment and the set of persons actually treated (Frances, 2013; WHO World Mental Health Survey Consortium, 2004).

In Canada, the most recent study available found exponential increases in both numbers of prescriptions annually and costs per prescription over two decades from 1980 to 2000 (Hemels, Koren, & Einarson, 2002). The authors note that their data included the use of antidepressants for treatment of depression in children and adolescents – a practice mostly unheard of in 1980, which has become commonplace now.

Yet community surveys seem to find stable baseline rates of human affective distress, at least among adults. The Canadian Community Health Study came into its current form only in 2002, and was not repeated with comparable methodology until 2012. From telephone interviewing of 29,088 households, past-year prevalence (the proportion of the population meeting criteria for major depression at any time in the past 12 months) in 2012 was estimated to be 4.7%, essentially unchanged from the 4.8% found by the same lead author in 2002 (Patten et al., 2012; Patten et al., 2006). In the USA, two national surveys a decade apart found prevalences also largely stable at 6.1% and 6.6%, in 1994 and 2003 respectively (Dowrick & Frances, 2013).

Why is the use of antidepressant medication increasing? The obvious explanation that the world’s population is becoming increasingly depressed can be dismissed out of hand based on these large-scale prevalence studies. Factors put forth as suspected causes for the increase range from the methodological, including inflation of population prevalence estimates owing to discrepancies between findings of lay interviewers in large community surveys and analyses of health system users (Horwitz, 2007; Horwitz & Wakefield, 2007); to the macro-social, including increased acceptability of mental illness, and the cultural dominance of the biomedical model as evidenced in such phenomena as direct-to-consumer pharmaceutical advertising (Conrad and Barker, 2010; Deacon, 2013; Jacob, 2012; Kemp, Lickel, & Deacon, 2014; Macdonald et al., 2009; Mintzes, 2002; Moynihan & Cassels, 2005). The 1980 paradigm change in the *DSM,* from a psychodynamic model to decontextualised symptom criteria, likely also plays a considerable part (Horwitz & Wakefield, 2007). In short, the inexact nature of public mental health epidemiology would appear to be subject to distorting influence from methodological, philosophical, and economic-political interests, further compromising the reliability of population estimates of an already fluidly defined disorder (Batstra & Frances, 2011; Frances, 2013; Horwitz, 2007; 2002; Horwitz & Wakefield, 2007).

Closer examination of epidemiological findings begins to reveal the multi-factorial, pluralist character of depression, which led Kendler to describe its ætiology as having a “dappled” nature (Kendler, 2012b, p. 18). Breakdown of epidemiological findings by demographic categories reflects contextual factors (although causation cannot be inferred from cross-sectional surveys): unemployment and under-employment, presence of chronic health conditions, lower income, and female gender are all associated with higher rates of depression (Caron & Liu, 2010; Hemels, Koren, & Einarson, 2002; Patten et al., 2012; Patten et al., 2006). This greater vulnerability is attributed to greater numbers of risk factors and deficiency of protective factors among lower socioeconomic status groups; adverse life conditions combined with low social support are identified as significant forerunners of depressive symptom onset, especially in economically disadvantaged populations (Caron & Liu, 2010).

That gender is associated with depression is of considerable interest in our critical analysis. In contrast to all other major mental disorders, which strike males and females equally, depression stands out among mental illnesses as consistently affecting more women than men, with a sex ratio approaching two to one worldwide (Nolen-Hoeksema, 1987). In Canada, past-year prevalence among females is almost twice that of males, at 5.0% compared to 2.9% (Public Health Agency of Canada, 2006). Many hypotheses have been advanced over the years to explain this finding – from psychodynamic explanations of penis envy; to biology, in particular hormonal dysregulation (e.g., Goldstein, Holsen, Handa, & Tobet, 2014); to genetics; gender roles in society; and simple reporting bias; yet none of these explanations has emerged as predominant in terms of empirical support and explanatory power (see Nolen-Hoeksema, 1987, for a thoroughgoing review). In the absence of convincing biological individual-level evidence for sex differences in depression, a population health perspective suggests plausible explanations involving social, psychological, and environmental factors (Bassett & Moore, 2013; Horwitz, 2002). Complicating these perspectives, however, is support from genetic studies for sex differences in the risk factors themselves, with personality, low parental warmth, relationships, and lack of social supports playing a greater causal role in women’s depression, and conduct disorder, drug abuse, and adverse financial, legal, and occupational events being more causally significant for men (Kendler & Gardner, 2014). A kind of reporting bias, too, may exist in that women more often tend to seek treatment for problems and also generally enter the health care system at reproductive maturity, while men both tend to seek help less, and to attribute distress to their individual failures in finances, occupation, and achievements (Weissman, 2014); indeed, it has been remarked often that men tend to be more reticent in seeking mental health help (for example, see Seidler, Dawes, Rice, et al., 2016).

For her part, Nolen-Hoeksema offers her own hypothesis that women and men demonstrate different response sets to the experience of depression: specifically, she argues, men's responses tend to be behavioural, whereas women's are more ruminative, which in turn tends to amplify depression (Nolen-Hoeksema, 1987). She cites evidence from multiple studies in which men endorsed responses to dysphoric moods such as ignoring problems, engaging in physical activity, or resorting to substance use, whilst women were more likely to report trying to determine the reason for the low mood, talking with others, and crying. Negative self-evaluations were also more likely found in women's accounts (Nolen-Hoeksema, 1987).

In summary, the neat positivist construct of major depressive disorder is troubled from a great many angles. That a disorder which is not a sex-linked genetic condition seems to differentially affect women over men, un- and under-employed over employed, less affluent over affluent, and persons with chronic health conditions more than those without, speaks to its complex social, political, and cultural associations – all of which the current biomedical discourse fails to account for. We turn next to the history of the development of our cultural narrative regarding human affective distress.

4. Review of Literature

Historical background. Affective distress has been with us since at least the dawn of recorded history. Detailed descriptions are found in the Bible, in Homer, and in

Shakespeare. Hippocrates is the first physician on record to remark on it, using the term ‘melancholia’ – although his extant work stops short of describing this as a discrete disease entity (Greenberg, 2010; Jackson, 1986). Early Western ætiological theories included the humoural model, in which an excess of black bile (meant literally by the term *melan-cholia*) caused affective disturbance; others have postulated impaired circulation of the blood, depletion of vital energy, and religious guilt (Horwitz & Wakefield, 2007).

The concept of depression of our times as an identifiable biomedical disease dates back only about 150 years. Its history can be traced through the intertwined sagas of the relatively young disciplines of 19th century medicine, psychiatry, and pharmacology, the latter being also associated with Industrial Revolution-era efforts to synthesize dyes – products which proved useful not only in the study of biological tissue, but most importantly, yielded the first clues to the interaction between cell biology and man-made chemicals. Inspired by the new germ theory – which was overturning millennia-old beliefs in ‘miasma’ and traditions such as bloodletting and the balancing of the humours – physicians such as Paul Ehrlich and Robert Koch began to conceive of the “magic bullet” that could target germs just as a staining dye targeted certain tissues. In the 1950s, with the discovery of neurotransmitters, this thinking began to be applied to models of mood and affect, ultimately leading to the development of the first antidepressant medications (Greenberg, 2010).

This biological view of mental illness grew up slowly alongside, and in competition with, the psychoanalytic school founded by Viennese neurologist Sigmund Freud, who attributed depression to such unconscious concepts as inner conflicts, "instincts," and "reactions" to things not knowable to the sufferer except through the protracted, and costly, mediation of a trained psychoanalyst. North American psychiatry embraced this approach wholeheartedly for several decades; indeed, the first two editions of the American Psychiatric Association's authoritative practice manual, the *Diagnostic and Statistical Manual of Mental Disorders,* of 1952 and 1968, incorporated presumed psychoanalytic causes into the descriptions and diagnostic criteria of mental disorders, including "depressive reaction." Grouped in with the disorders termed "psychoneurotic," depressive reaction was "defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes the mechanisms listed above [psychoanalytic defence mechanisms] to handle the anxiety created" (APA, 1952, p. 13).

A third approach which never gained traction in mainstream psychiatry was the biopsychosocial model, advocated mainly by Swiss psychiatrist Adolf Meyer early in the 20th century. Working for most of his career in the United States, Meyer sought his patients' stories in their biographical context, and felt that many of their problems could be understood through empathy and treated with psychotherapy. Dismissed as "a second-rate thinker" for "embracing whatever new came along" and for indiscriminate conclusions such as "everything is very complex" (Shorter, 1997, p. 111), Meyer's work was not pursued following his death. However, his strongest mid-career ideas seem to foreshadow humanistic psychology and the recovery movement, and ushered in a new class of psychiatric patient – that of the "walking well" or "worried well" client who presents with distress but is not labeled insane (Greenberg, 2010). His approach may have had an indirect influence on British psychiatric practice too, but mainly through reinterpretation and clarification by acolytes such as Aubrey Lewis (Pilgrim, 2002).

But in North America the continued coexistence of psychodynamic and biological clinical and research agendas divided practitioners into two bitterly opposed camps sardonically dubbed by Lipowski as the “brainless” and the “mindless” for refusing to acknowledge one another’s strengths and common cause (Lipowski, 1989). Eventually, strident critical perspectives from many corners, including the work of sociologists such as Erving Goffman, the French critical theorist Michel Foucault, and “antipsychiatry” activists such as Thomas Szasz and R.D. Laing, combined with a tremendous public backlash against the profession in the 1970s, resulted in a thorough reframing of the psychiatric nosology at the end of that decade, with the publication of the *Diagnostic and Statistical Manual of Mental Disorders, 3rd edition* (*DSM-III;* APA, 1980; Shorter, 1997).

Although overshadowed by “the psychoanalytic hiatus” of the 1950s, 60s, and 70s (Shorter, 1997), the search begun in the 19th century for the neurochemical basis for mental illness never stopped during this time. Curiously, however, the serendipitous discoveries of compounds which relieved psychiatric symptoms – first those of schizophrenia, with chlorpromazine; then depression, with imipramine, were met with oddly disparate receptions. Whilst chlorpromazine is credited with the beginning of deinstitutionalisation of persons living with severe mental illness, imipramine, which claimed a therapeutic effectiveness for depression equal to psychoanalysis but without the years of hard work in therapy, was for the most part ignored. As incredible as it sounds today, the very concept of depression as an insidious common, biomedically treatable illness was missing from the diagnostic landscape. Geigy, the pharmaceutical company responsible for imipramine's discovery in the mid 1950s, stated at the time that depression was too small a market to bother with (Greenberg, 2010). Geigy's major competitor Eli Lilly, too, synthesised an antidepressant in 1972; however, uncertain of its commercial potential, did not name it nor even submit it for approval until 1984. When this compound finally did reach the public pharmacy, in 1988, the newly dubbed Prozac set in motion a revolution of sorts in the marketing of antidepressant medications, becoming the first of a new class of "selective serotonin reuptake inhibitors" (SSRIs) and the second-best selling medication in the world. Prozac inspired much discussion, multiple competitors, and played a significant part in entrenching the biochemical view of mood in the popular discourse (Deacon, 2013; Duncan, Miller, & Sparks, 2004; France, Lysaker, & Robinson, 2007; Greenberg, 2010; Kemp, Lickel, & Deacon, 2014; Shorter, 1997).

How did such a revolution come about? How did emotional distress, in the views of both psychiatry and the public discourse, transform in the course of two decades from a rare diagnosis with a psychoanalytic remedy to a commonplace cluster of symptoms understood in strictly biomedical terms, and from an insignificant pharmaceutical market segment to part of our everyday vernacular? The answers lie in recent historical developments. Criticism and public ridicule of psychiatry's partiality toward psychoanalysis, the ascendancy of biological psychiatry, and new drug therapies intended to target specific conditions all pointed toward the need to tighten the definitions of diagnostic categories (Horwitz, 2007). The Herculean task of re-codifying psychiatry's diagnostic categories to reflect presumably natural disease entities was taken up by the American Psychiatric Association's *DSM-III* Committee on Nomenclature with a view toward establishing fixed symptom-based criteria as a simple way of determining the presence or absence of any given mental illness. The thoroughly revised *DSM-III* of 1980 officially defined depression as one symptom from column A, four from column B, and with the exclusion criteria in column C ruled out – without any regard whatsoever for purported internal dynamics, personal or family history, phenomenological considerations, or other context (with the exception of an exclusion for two months of uncomplicated bereavement). In one stroke, the ages-old distinction between normal sadness which is proportional to an identifiable cause and true depressive illness, now termed *major depressive disorder,* fell away (Greenberg, 2010; Horwitz, 2007; Horwitz & Wakefield, 2007; Shorter, 1997). The possibility arose that a significant cross-section of the population who present as sad, hopeless, sleepless, and anhedonic – owing to, for example, having recently lost a job, or having been thwarted in romantic pursuits, or experiencing life-threatening illness in a loved one – could now fall under the label of mental illness. This change in diagnostic criteria has been hypothesised as a cause of increasing prevalence of depression (Horwitz, 2007; Horwitz & Wakefield, 2007), with the conceivable unintended consequence of expanding the "social space of pathology" (Horwitz, 2007, p. 217) in our popular discourse and in our discursive language, fundamentally altering the way individuals construe themselves (Foucault, 1965; Horwitz, 2007). In any event, a sea-change in the understanding of affective distress had occurred: Hidden, unknowable, unconscious inner dynamics had been replaced with straightforward symptom criteria ready to lend themselves neatly to a biomedical model, and discussion about context in terms of the causes of the problem or its remedy was off the table.

The advent of symptom-based criteria was but one of the factors which paved the way for the runaway success of the new medications. Several other historical happenings in the late 1970s added to the perfect storm of policy which potentially also contributed to broadening the ranks of the depressed, including a crackdown by the United States Food and Drug Administration on the overprescribing of minor tranquilisers such as Valium and Librium. The potential for addiction and other harm resulting from their use, together with a growing recognition that non-mentally ill “walking well” people, disproportionately women, were being encouraged – in part, through advertising – to use drugs to help cope with normal ups and downs, came to the attention of U.S. lawmakers, who, after years of congressional hearings and partly spurred on by the “War on Drugs” begun by the Nixon administration in 1968, placed the drugs on the FDA’s list of controlled substances in 1975. The climate of opinion amongst the media and the public followed suit soon afterward, causing tranquilisers to quickly fall into disuse (Greenberg, 2010; Horwitz & Wakefield, 2007).

American policy toward the advertising of pharmaceuticals has also played a part in the success of antidepressant medications. The managed care model, which tends to rely on the least costly strategies, favours general physicians over specialists and pharmaceutical treatment over more time-consuming therapy, a preference which has become evident in prescribing and treatment patterns (Horwitz, 2007; Horwitz & Wakefield, 2007). Moreover, managed care has aided in the social construction of illness; with patients being now seen as consumers of services rather than passive recipients of physician-directed care, commercial interests became able to conceive of individual persons as a market (Conrad, 2005).

While the marketing of antidepressants in the 1960s had targeted physicians, marketing in the 21st century targets the public directly (Greenberg, 2010). Direct-to-consumer advertising (DTCA) of prescription drugs, illegal in all developed countries except the United States and New Zealand, has nonetheless flourished in Canada thanks to the Internet, the ubiquitous presence of American cable television in Canadian households, and spotty policy on both sides of the porous border (Mintzes, Morgan, & Wright, 2009). Pharmaceutical DTCA, an industry with annual spending in the billions, has been criticised as harmful to physician-patient relationships (Mansfield, Mintzes, Richards, & Toop, 2005), misleading with regard to likelihood of treatment success and possible side-effects (Mintzes, 2009), and inaccurate regarding information about specific conditions, which it portrays in carefully scripted and subtle ways (Greenberg, 2010; Horwitz & Wakefield, 2007; Moynihan & Cassels, 2005). Mintzes and colleagues have found increases in the frequency of patient requests for prescriptions for advertised products from physicians, resulting in increased prescribing to the requesting patients compared to patients presenting in similar ways but not requesting prescriptions (Mintzes, 2009). Physicians who do prescribe the requested products express ambivalence about the choice of treatment following a patient request, and rate their likelihood of prescribing the same medication for a similar but non-requesting patient as low; in one study, physicians were much more likely to judge the medications they reluctantly prescribed as merely ‘possible’ or even ‘unlikely’ choices than to say they had been ‘very likely’ choices. Another possible outcome is that physicians may refuse to prescribe medications they deem unnecessary, resulting in lost rapport between doctor and patient (Mintzes, 2009). Increased use of brand-name prescription medications – which tend to be the ones promoted in DTCA – has been called a cost-driver in both private and public drug coverage plans (Mintzes, Barer, Lexchin, & Bassett, 2005).

Above all, DTCA appears to further the discourse of depression as a clinical entity treatable with biomedicine and without respect to context. Advertisements such as a 2000 television commercial for Prozac – in this case being marketed for treatment of the controversial condition pre-menstrual dysphoric disorder (PMDD) – which shows a frustrated, angry woman trying to disentangle a shopping cart from a row of them, with the tagline suggesting that her experience is an example of PMDD, provide a ready interpretation of common human experiences as evidence of a medical phenomenon, entirely divorced from social and cultural considerations, let alone such sociopolitical factors as gender inequality (Horwitz & Wakefield, 2007). Instead, the simplicity of a biomedical model for human distress prevails, and "'biochemical imbalance' is now an irrepressible part of the American vernacular" (Duncan, Miller, & Sparks, 2004, p. 165).

A fascinating aspect of the biomedical understanding with singular implications for depression is the suggestion of Kemp, Lickel, and Deacon (2014) that the dominant discourse has a subtle and insidious effect on features of depression itself; that is, on the way in which individuals judge their own experience. Negative representations of the self, the personal world, and the future constitute the classic negative cognitive triad first advanced by cognitive psychologist Aaron Beck in 1967; these constitute the erroneous beliefs targeted by cognitive-behavioural therapy (Beck, 2005). Kemp et al. (2014)

asked the pertinent question of how currently popular biomedical causal explanations affect how individuals view their *own* symptoms. In an experimental study, these researchers found that participants given credible but bogus “chemical imbalance” explanations for their mood reported increased prognostic pessimism, decreased expectancies that they could regulate their moods, and increased acceptance of pharmaceutical therapies while discounting psychotherapy. They suggest that providing individuals with a chemical imbalance causal explanation for depressive symptoms “activates… negative beliefs with the potential to worsen the course of depression and attenuate response to treatment, particularly psychotherapy” (Kemp et al., 2014, p. 50). Interpreting this finding at the societal level, it seems that the description of depression promoted by the biomedical discourse is *itself* contributory to a view of mood distress as chronic, static, and largely beyond one’s control – the very opposite of what cognitive therapy aimed at addressing the negative triad seeks to achieve.

As to the products themselves, much has been written about the weak evidence base for the efficacy of SSRIs; this literature will not be repeated here except to briefly summarise the problems identified regarding the evidence of their efficacy, which include allegations of: (1) publication bias; (2) patient selection bias; (3) misuse of the randomised clinical trial; (4) poor blinding due to side-effects not discernable in placebos; (5) use of clinician-rated outcome measures when client self-rated measures show no improvement (summarised in Duncan, Miller, & Sparks, 2004; Greenberg, 2010; Pagura et al., 2011).

In summary, a historical reading of the development of the contemporary concept of depression shows its fluidity over time, its vulnerability to influence by diverse interests, and the role of policy and market economics in shaping this socially negotiated discourse which engages or “hails” citizens so as to influence individuals’ decision making (Lupton, 1995, pp. 4-5). Good and Kleinman conclude: “Reading through the history of changes in conceptualization [of depression]… is a reminder that we are in the presence of culture. Psychiatric categories and theories are cultural, no less than other aspects of our world view” (Good & Kleinman, 1985, pp. 2-3). Perhaps it was a conscious decision on Hippocrates’ part to write only clinical descriptions of human affective distress, rather than attempt to frame it as a diagnostic entity.

Dissenting perspectives. The cementing of the biological approach to human emotional suffering in our culture has not been without criticism from voices championing more biographical and contextual models; however, these have for the most part found little traction in mainstream North American psychiatry as formally set forth in the literature. The biographical approach advanced by Meyer fell victim to Meyer’s own lack of intellectual rigour and embrace of such incompatible practices as tooth extraction and large bowel removal to cure insanity (Shorter, 1997). Later, more humane advocates for a biopsychosocial model included Meyer exponents Anthony Clare and Aubrey Lewis in the United Kingdom, and George Engel in the United States, all of whom placed emphasis on patients’ personal history and life context in their efforts to understand mental illnesses (Pilgrim, 2002). Admittedly a “whimsically” constructed model (Pilgrim, 2002, p. 588), the biopsychosocial frame of reference promised acceptability and a bridging of the scientific-humanistic divide, and privileged the voice of the patient, yet failed to achieve true integration into either British or American psychiatry following the watershed of 1980. In the face of a de-ætiologised – but tacitly biological – *DSM-III*, the socialisation of medical education, and the “hardy perennial” (Pilgrim, 2002, p. 590) of biomedical psychiatry, the biopsychosocial model went into retreat (Pilgrim, 2002).

In the United States, the writings of internist George Engel presented a dissenting view which espoused neither strict biomedicine nor the abdication of medicine’s place in mental health as demanded by the anti-psychiatry activists of the 1960s and ’70s. Taking a critical position on the distorting influences of dualism and reductionism, Engel sought to integrate, scientifically, the somatic and the psychological, the biological and the behavioural, and clinically, the *observational* and the *relational* modes of inquiry. We shall return to Engel’s broad and synthesising thinking in our conclusion.

Although not challenging the hegemony of American psychiatry and the authority of the *DSM* outright, the work of Kenneth Kendler is critical toward his own profession and is highly relevant to our inquiry. Kendler proposes a multifactorial model of the ætiology of psychiatric disorders which draws upon “explanatory pluralism” – an approach much more rigorous than the biopsychosocial model, and which champions multiple mutually informative perspectives which differ in their tools and level of abstraction. For example, humiliation and loss are subjective first-person biographical experiences to which we can relate through empathy, and no doubt these are also expressed on a biological level in the brain when they occur. It does not follow, however, that the neurobiological level is the most efficient or effective level at which to observe – and remedy – these phenomena. At higher levels of abstraction, psychological and cultural factors act interdependently with biological predispositions, which interact with the simple and complex environmental stimuli that make up unique experience (Kendler, 2005).

Kendler gives several reasons why a multifactorial model should replace biological reductionism. In a sense, all psychiatry is ultimately biological, but what is at issue is the optimal level within the causal pathways of human distress at which clear understanding can be achieved and intervention best focused. He positions evidence from genetic studies on depression within an interdependent framework of cultural processes and psychological factors, and asserts that these processes – which may once have been thought to be independent of one another – are neither simple nor unidirectional. Kendler makes the argument that psychiatric symptoms can only be understood as dysfunctional or not dysfunctional within a psychosocial context, and reducing them to a biological level has failed to account for this important aspect of definition (Kendler, 2005).

In advancing a multi-level, “dappled” causal pluralism which rejects Cartesian dualism, Kendler eschews the ‘hard’ medical model of the sort which was influential in 20th-century science, aimed at reducing phenomena such as gravity to basic laws of physics. While this approach has fit infectious diseases and Mendelian genetic defects quite well, the conceptual problem in trying to make such a model fit psychiatry is the problem of the need to privilege one level of explanation over another (Kendler, 2012a).

Kendler cautions against assuming that in developing causal models for mental disorders, one level of explanation will emerge as obvious or broadly agreed upon. The multifactorial model he proposes acknowledges multiple valid explanatory perspectives without privileging *a priori* any above another. Recognising the possibility of multiple ætiological processes affecting many different levels, often further intertwined by interactions which mediate and moderate between levels, he suggests we focus on "fuzzy, cross-level mechanisms that may do a better job of capturing the true nature of psychiatric illness" (Kendler, 2012a, p. 18). He posits three levels of "difference-makers" – (1) the biological, which includes genetics, neuroanatomy and neurophysiology, and other biological influences; (2) the psychological, comprising neuropsychology, personality, and trauma exposure; and (3) higher-order social, political, and cultural effects. Reviewing the literature to date, he finds different 'causal signatures' for different mental illnesses; for example, a prominent role for genetics in both schizophrenia and alcohol dependence, but no evidence supporting political causal factors in the former, while a prominent social/political/cultural component is identified for the latter (Kendler, 2012b). The causal signature for depression, interestingly, comes across as one of the most "dappled" of all.

Although Kendler acknowledges his debt to the biopsychosocial model of Meyer and Engel (Kendler, 2008), his philosophical structure for psychiatry stands as distinct from the biopsychosocial model in some important ways. His empirically based pluralism is posited as a comprehensive, conceptually rigorous model which builds on biological, including genetics, research but seeks to integrate multiple causal perspectives and takes a pragmatic view on where intervention is best directed. Its research agenda is meant to shed light on mechanisms and pathway effects (see, for example, Kendler & Gardner, 2014). The main distinction, however, is its refusal to entertain assumptions about what the various levels of explanation will contribute to our understanding of mental illnesses. In Kendler's words:

> "How does the empirically based pluralism differ from the biopsychosocial model of Engel? The crucial difference is that it is not *a priori* – driven by a theoretical commitment to pluralism – but rather driven directly by what our research reveals. The biopsychosocial model – while making us feel good about our open-mindedness – offers us no critical guidance… In letting all flowers bloom, it provides no focus. By contrast, research has increasingly told us where to look, but it is surely not in one place" (Kendler, 2012b, p. 383).

Lived experience. We have begun to argue that a discontinuity exists between the authoritative view of depression as a disease entity and the myriad causal factors or "difference-makers" with which it is associated in the descriptive epidemiology. This becomes immediately apparent in an attempt at a search for qualitative literature on uncomplicated depression. One finds depression associated with all manner of context – including gender, chronic illnesses, poverty, old age, young age, visible minority status, trauma exposure, and many more. If depression is a disease entity with a locus in the individual, for which pharmacological treatment is indicated, one would perhaps find qualitative research into the experience of such a phenomenon in its own right, yet there is little to no such literature to be found. This in itself seems telling.

Our focus, however, is just that. Of a sample of people who have in common only the experience and the biomedical treatment, we sought to ask the open-ended question as to what were felt to be the causal difference-makers, and to work backward from that point. Of the contextual associations with depression, only gender would be almost certainly guaranteed to figure in the analysis.

There is a body of qualitative literature which addresses the issue, much of it written from a feminist perspective. Stoppard and McMullen's (2003) book *Situating Sadness* is a compendium of qualitative studies into women's experiences of depression, many from a critical perspective which also questions and problematises cultural emphases on the individual as the locus of psychological distress and personal flaws (for example, McMullen, 2003; Scattolon, 2003). These authors point out that gender issues tend to be overlooked by research in this field, and call for broader understandings of women's life contexts and social and cultural influences implicated in emotional distress. Of particular interest is the chapter by Stoppard and Gammell (2003), which describes a study that asked nine Canadian women why they had become depressed; all nine responded in terms of a chemical imbalance, although they also spoke about day-to-day stress as well as trauma such as sexual abuse, and for the most part indicated that counselling was also needed in addition to medications. Participants viewed medications as legitimation and as one resource for coping, leading the authors to ask whether medicalization can co-exist with women's empowerment (Stoppard & Gammell, 2003).

O'Brien's work on what she terms "the biopolitical imperative of recovery" in Australia and other advanced liberal democracies also examines the complex, gendered nature of depression. O'Brien (2012) interviewed 31 Australian women, and found that participants felt burdened with expectations of achieving a vision of "normalised recovery" which places responsibility upon the individual whilst overlooking the possibility that their distress originates in gendered contexts and features of the environment (O'Brien, 2012; see also Fullagar & O'Brien, 2014).

With regard to men's experiences, Seidler and colleagues' (2016) systematic review of qualitative studies found several main themes related to men's reticence to seek help for depressive symptoms. These included difficulty recognising and communicating about inner emotional experience, the contradiction between mood distress and masculine ideals such as stoicism and a sense of control, reluctance to seek help until and unless all internal resources are exhausted, and a preference for action-oriented interventions such as cognitive-behavioural therapy over counselling. Also among the findings were that men valued non-paternalistic, collaborative partnerships with help providers; medication was viewed as least desirable, and linked to loss of control (Seidler et al., 2016).

Not all research in this area privileges participant perspectives and empowerment. To cite an example, Ward, Mengesha, and Issa (2014) interviewed thirteen community-dwelling older African American women, and found that their participants believed their depression to have roots in situations and events, believed depression to be part of life, and found no benefit in seeking medical treatment for it. The authors also found ample evidence of resilience, as well as coping strategies such as religious coping and community participation in the form of volunteering (Ward et al., 2014). Unfortunately, the authors' conclusion that the women were in denial about their "illness" for which they should be "treated" fails to honour the meanings of the participants, including their resourcefulness and the perception of the futility of medical treatment, and rather than critically examining the richness of the data, merely perpetuates the positivist thinking that skips over any considerations of race, gender, poverty, or other social context.

One further thread of qualitative exploration looks into people’s experiences of being prescribed, taking, and altering or ceasing, antidepressant medications (Anderson, Kirkpatrick, Ridge, et al., 2015; Brijnath & Antoniades, 2016; Grime & Pollock, 2003; Karp, 1993; Leydon, Rodgers, & Kendrick, 2007; Malpass, Shaw, Sharp, et al., 2009; Verbeek-Heida & Mathot, 2006). Some studies include physicians’ points of view as well (for example, Maxwell, 2005; Salazar-Fraile, Sempere-Verdú, Mossakowski, & Page; 2010), and others investigate the physician aspect only (Macdonald et al., 2009; Schumann et al., 2012). Although not directly related to our research questions, this line of inquiry may become relevant to our Analysis and Discussion, below.

5. Research Design and Methods

Purpose. The purpose of this study was to explore the views of individuals engaged by the biomedical discourse surrounding human affective distress on three main questions: (1) their conceptualisations of the experience, including their views on their degree of fit or lack of fit with the dominant psychiatric discourse of biomedical individualism and pharmacological treatment; (2) description of the ‘difference-makers’ identified by participants as contributory to the genesis of the emotional distress; and (3) description of the ‘difference-makers’ participants perceived as helpful to their recovery.

Methodology

Interpretive description. Qualitative researchers in the health professions strive for approaches and methods that fit with the complex experiential questions that arise in clinical practice. When early researcher-clinicians found the academic methodological orthodoxies of the social sciences too constraining for the generation of practical clinical evidence, these professionals began to “push at the edges of methodological rulebooks” (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004, p. 2), developing the novel approach termed ***interpretive description*** (Thorne, 2008; Thorne et al., 2004). Interpretive description, as an inductively driven empirical inquiry, aligns philosophically with interpretive naturalistic orientations, acknowledging a constructed and contextual view of human experience that at the same time allows for shared realities. Of most relevance to the present paper is its capacity to help draw conceptual linkages of the sort which emerge when the researcher aims to situate the particular in the general, the state within the process, and “the subjectivity of experience within the commonly understood and objectively recognised conventions that contemporary health care contexts represent as the temporal and symbolic location for health and illness” (Thorne et al., 2004, p.3). Transcending mere surface description of clinical phenomena, interpretive description seeks to explore deeper than the semantic content (Braun & Clarke, 2013), and to look for meanings and explanations which may yield implications for practical application (Thorne et al., 2004).

With regard to epistemology, interpretive description holds to three non-dualist axioms of naturalistic inquiry – namely, (1) the existence of multiple realities which can only be understood holistically; (2) the interaction of inquirer and inquiree which transcends subject-object relations, negating the possibility of ever separating the knower and the known; and (3) the impossibility of any *a priori* theory to ever encompass the multiple realities which one might find in the data (Lincoln and Guba, 1985, cited in Thorne et al., 2004). Thus, theory emerges, grounded in the data, inductively (Thorne et al., 2004).

Methodological rigour is vital in interpretive description, and three key requirements for methodological trustworthiness flow from this epistemological position. First, ***credibility of the findings*** arises from the presence of defensible lines of reasoning on epistemological, representative, analytic, and interpretive grounds, and derives from visible and coherent logic, wrought by skepticism and openness toward what is immediately apparent within the analytic frame (Thorne, 2008). Data collection and analysis inform one another iteratively; “the intellectual task of the analyst, therefore, is to engage in a dialectic between theory and data, avoiding theoretical imposition on the one hand, and atheoretical description on the other, in the quest for a coherent rich interpretation that allows *a priori* theory to be changed by the logic of the data” (Thorne et al., 2004, p. 11). Such iterative analysis serves to situate the emerging findings within the existing body of knowledge, as well as to locate explanatory factors – or in this case, ‘difference-makers’ – within the larger theoretical perspective (Thorne, 2008; Thorne et al., 2004; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997).

The ***research process,*** as it pertains to power relations, the intersubjective construction of knowledge, and the positioning of the researcher must be transparent. This entails adherence to ethics guidelines, and reflexivity as to the position of the researcher (Braun & Clarke, 2013; Lupton, 1995; Thorne et al., 2004) as co-constructor of interview data.

Finally, interpretive description carries a ***pragmatic obligation*** to assume that findings will be applied in practice. Researchers in health care must understand that their ideas are never purely theoretical and that results may find their way into clinical applications regardless of philosophical underpinnings or adherence to methodological orthodoxy. Health care springs from a social and moral mandate to bring benefit to the individual and the collective, and this factor necessarily colours the way in which health research should be evaluated. The credibility of qualitative research in health must extend, then, beyond compliance with rules or method, toward responsible examination of more complex questions of practical application and what meaning can be made of the findings (Thorne, 2008).

Strategies for Ensuring Rigour

In addition to the methodological guidelines of interpretive description, the criteria set out by Sarah Tracy (2010) serve as core values for excellence in qualitative research. Tracy's conceptualisation begins with the worthiness of the research question in terms of novelty, relevance and timeliness, and encompasses such values as sincerity, credibility, resonance, and coherence. Tracy's standard for rigour draws upon Karl Wieck's (2007) concept of "requisite variety," which "refers to the need for a tool or instrument to be *at least as* complex, flexible, and multifaceted as the phenomena being studied" (Tracy, 2010, p. 841; emphasis in original). Taking the researcher as the instrument, she asserts that sensing complex observations requires a complicated sensing device: the human researcher. Complexity comes from working knowledge of a variety of theoretical constructs, as well as from abundant data garnered from an appropriate and adequate sample. Tracy's questions about rigour include: Are there enough data to support the claims? Was enough time spent gathering interesting and significant data? Are the context and sample fitting for the goals of the study? And were appropriate procedures used for data gathering, such as interviewing practices, and analysis? Answering these questions requires transparency in the reporting of the process of sorting, choosing, and transforming and organising the data (Tracy, 2010).

Keeping a reflective journal is recommended as a method for documenting the process of analysis (Thorne, 2008; Thorne et al., 1997). The author maintained a journal throughout the process to document analytic thinking, to note preliminary findings and questions arising, and to reflexively examine his position as the researcher. With regard to this last point, reflection was done on such matters as the advantages and disadvantages inherent in working as an occupational therapist in hospital and community mental health programmes in Winnipeg. While years of experience in various parts of the mental health system confer a more or less comprehensive understanding and an ability to discern relevant findings from material peripheral to the phenomena under investigation (Braun & Clarke, 2013), it must be recognised that such understanding and discernment arise from within the very paradigm one stands in critical relation to; therefore, one must be willing to suspend this training in order to strive toward "honesty and authenticity with one's self, one's research, and one's audience" (Tracy, 2010, p. 842). For example, the very language used in this study is the language of psychiatry, and as this language may connote assumptions and power structures, it is open to critique. Furthermore, the push and pull of the biomedical model and the recovery model against one another, described above, is a theoretical tug-of-war which affects the writer, and possibly all mental health clinicians at this time. The ability to critically and reflexively interrogate one's position as producer and reproducer of certain discourses and practices, values, and interests can help make clear the power relations that otherwise remain opaque (Lupton, 1995). To this end, it is helpful to refer back to the epistemological position detailed earlier – which holds that knowledge is the product of the encounter between researcher and data; thus, findings are "created," not "discovered," as is the case in a positivist paradigm (Braun & Clarke, 2013, p. 29).

Study Design

Participants. In order to identify persons who had been engaged by the discourse of medical treatment for affective distress and who described themselves as having achieved a satisfactory degree of self-defined recovery, five criteria were set out. Participants would be sought who (1) were 18 years of age and over; (2) self-identified as having experienced emotional distress, in adulthood, for a period of two weeks or longer; (3) described themselves as having achieved a satisfactory degree of recovery; lasting at least six months up to the present; (4) were treated (and possibly still were being treated) with prescription antidepressant medication for this distress; and (5) had no currently active substance use problems.

Participant Selection and Data Collection. A recruiting poster titled '**RECOVERY STUDY**' seeking persons who (1) had taken, or were still taking, antidepressant medications, and (2) felt they were now doing well irrespective of medication status (Appendix A) was distributed widely among mental health self-help organisations, community agencies, outpatient clinics, and the author’s professional contacts. Respondents were screened by telephone using the **Screening Interview Guide** (Appendix B).

Exclusion criteria. Participants were to be excluded from consideration for the study if they (1) reported ever having received a diagnosis of a major mental disorder other than depressive disorder; (2) acknowledged current harmful or dependent substance use; (3) were unable to communicate verbally in English; (4) were unable to, or lacked capacity to, provide informed consent; or (5) were under the age of 18 years.

Respondents meeting criteria were asked to provide demographic comparator information according to the **Study Application Form** (also Appendix B) but it was made clear that providing this information was voluntary and was not a condition of participation. Finally, appointments for in-depth semi-structured interviews were scheduled; these took place after obtaining informed consent (Appendix F), in locations which could afford confidentiality, such as participants’ homes or a private meeting room at a University of Manitoba library. Interviews were 1 to 2 hours in duration.

Data Analysis. Interviews were audio-recorded, with the participants’ permission, and transcribed verbatim. Analysis was done according to principles of thematic analysis as described in Braun and Clarke (2013). Immersion in the data was achieved through multiple readings of all transcripts, with constant cross-checking of preliminary findings and themes in an iterative manner, and comparisons and contrasts examined at each opportunity in order to gain a sense of the whole. Transcripts were subjected to initial open coding, and commonalities and points of contrast tentatively identifed. Notes in the reflective journal were made throughout this process, with questions and quotes filed and organised according to the broad themes and categories which began to take shape. The final structure of categories and themes was checked against the data again for coherence and authenticity.

Coding. Codes included both data-derived, or *semantic,* and researcher-derived, or *latent,* codes, a distinction which is not always pure (Braun and Clarke, 2013). For example, material relevant to conceptual understandings of the experience of affective distress was picked out as latent content in the transcripts and coded in order to answer the first research question, whilst participants' accounts of their trajectories through distress and recovery constituted a novel, data-derived code.

6. Findings

Descriptive findings

Socio-Demographic Characteristics. The degree of diversity attained was remarkable, for a purposive sample of nine volunteers. True to descriptive epidemiology around the world, the 2:1 sex ratio was preserved in the present study, with six women and three men volunteering to participate. There was representation from the Canadian public service sector, and from several professions including health care and social services. In contrast, two persons indicated that they were precariously employed and financially struggling, and a third reported having experienced low income and intermittent employment while a student, at the time of the affective distress. Two persons indicated that they had been born outside of Canada. One person identified as

LGBT. One identified as Francophone. One identified as a child of Holocaust survivors. One woman was a survivor of domestic violence and stalking. One man felt that he had had undiagnosed ADHD as a child. One woman spoke about her experience with a disability – in her case, fibromyalgia syndrome – and how this affected and interacted with her experience of affective distress.

In terms of age, one person fell within the 18 to 25 years of age category; one in the 36 to 45 category; four in the 46 to 55 category; and two in the 56 to 65 category. One declined to provide his/her current age, but this could be estimated at 46 to 55 years of age.

One participant reported current annual household income under $20,000; two reported $20,000 to $40,000; one $40,000 to $60,000; one $60,000 to $80,000; one $80,000 to $100,000; one $100,000 to $120,000; and one over $120,000. One declined to provide his/her household income. Participants hailed from a variety of neighbourhoods in the capital city of Winnipeg and surrounding areas. With regard to education attainment, however, diversity was lacking, as all had at least some post-secondary education. Socio-demographic characteristics were not used for analysis in the present paper, but are included here for purposes of indicating the heterogeneity of the sample.

Interpretive findings: Theme categories

Interpretive description is about “comprehending data, synthesising meanings, theorising relationships, and recontextualising data into findings” (Morse, 1994, cited in Thorne et al., 2004, p. 11). The critical-historical review of the current knowledge and understanding forms the basis for a “preliminary theoretical scaffolding” (Thorne et al., 2004, p. 9) – but this framework is not expected to accommodate the richness of the data, and must be left behind as the processes of inductive reasoning navigate beyond pre-existing interpretations in order to develop an ordered and coherent new analysis (Thorne et al., 2004).

From a thorough initial reading of the data, three general, and somewhat overlapping, “umbrella” **theme categories** or **clusters** were identified which seemed well positioned to form an overarching structure for analysis. These were:

I. ***Conceptual understanding of human affective distress .*** This theme cluster essentially addresses Research Question no. 1, and includes material related to description, characterisation, and causation of the overall experience, and any metaphors or other devices participants used for conveying their understanding.

II. ***Context.*** Participants gave accounts of existing conditions in their lives, both environmental and intrinsic, and in many cases, each of these in the past and present. Most talked about the context of their experience: often about the immediate life circumstances leading up to the period of distress, but some also about early experiences including childhood and adolescence. This theme cluster forms the umbrella for all forms of stress, perceived predispositions and traits, as well as strengths and inner resources. This is also the appropriate space for the exploration of gendered experiences and social conditions. Where participants identified aspects of context as causal, this material helped flesh out answers to Research Question no. 2.

III. ***Trajectory through distress and recovery.*** Participants, without exception, gave accounts which they framed chronologically in more or less narrative fashion. Themes which emerged through descriptions of the trajectory through distress and recovery seemed to point toward a common pathway, which can be loosely summarised as: (1) noticing, onset, or identification of distress; (2) the emotional response to the onset – including such feelings as shock, bewilderment, and fear; (3) the negotiation of action – including ambivalence about seeking help, varying degrees of trust, and the experience of taking antidepressant medication; (4) the development and engagement of supports – including the finding of new resources and use of existing ones, and the discovery of new coping skills or redeployment of existing ones. These loosely bounded, overlapping, and recycling ‘stages’ – for want of a better term – were noted to roughly map onto long-established models such as the Stages of Recovery in psychiatric disability (Spaniol, Koehler, & Hutchinson, 1994). Many of these accounts then led into sharing of outcomes – which for many included unanticipated benefits such as greater self-awareness and greater ability to empathise – as well as inclinations to “give back” and advice to others who might be facing similar experiences. The idea of “giving back” was strongly linked, for several individuals, to the motivation to volunteer to join the study.

Theme categories

I. Conceptual understanding of human affective distress.

Descriptions of the experience. The descriptions given by participants highlight the multifarious nature of the experience of affective distress. Some were able to provide rich descriptions of the experience of mood distress, in severe terms such as “a heavy, dark, oppressive feeling, like being held under water;” and “the worst feeling in the world, like a cancer of the brain.” A few also described a physical experience. One man referred to a triad of crying, nausea, and inability to sleep, and another to fatigue, forgetfulness, and weeping.

Others depicted mood as pain:

> *It actually hurt. It* [pause] *the emotional pain was a physical pain, like, almost like a heartbreak. You know, when you’re actually emotionally distressed and there’s parts of you that* [pause] *actually goes ‘ouch’ – so it was very, very difficult. Weirdly so.* – Woman, aged 46-55

Still others referenced cognition, and the limits of thinking:

> *I tried to cope with it and to defeat this; said 'Why am I feeling this way?' It's a – it's – doesn’t make sense – and then I tried to will it out, to by will - to go back to what I was before but I couldn’t achieve it. So I spent a few months like that. –* Man, aged 46-55

> *Cognitively, it was different – not just stress, not just a mood, but something different altogether. I asked myself, how is it that other people don’t struggle the way I do?* – Man, aged 36-45

> *… not feeling in control. Um, like I would put an empty case - a six pack of beer in the fridge, and the milk into where I put the six-pack. You know? So I'm like, 'I'm doing things backwards,’ and I knew that's critical, cos I'm also a mechanic* [laughs] – Man, aged 46-55

Some used metaphors to describe what they had been through. One man likened his suddenly finite capacity for coping with stress to a sponge which had become over-saturated:

> *That's a tough question. And um, it was described to me like having a completely saturated sponge, and you just aren't able to deal with – I feel like – the way I see it is, my brain uh, was doin' everything it could, but it was uh, it was just, it was – okay, it just got saturated. It was – wasn't able to – it's like I – I – I exhausted it.* – Man, aged 46-55

A woman, who had also been diagnosed with fibromyalgia syndrome, said:

> *It's like putting too much stress on a table; the more you do, you get the lean in it; and when you take everything off, the lean is still there. You – you've made the damage.* – Woman, aged 46-55

Ætiological conceptualisations. Considerable variety was observed in individuals' conceptualisations of what they had been through, but some commonalities also emerged. Ways of making sense of emotional distress tended toward the multifactorial, and ranged from the genetic, to early experiences, to overwhelming stress, or interactions of the three combined with behavioural tendencies participants noticed in themselves. All spoke with impressive insight, self-awareness, and metacognition, sometimes to the point of self-critique.

The "perfect storm" was a frequently invoked metaphor, occurring in three interviews. All but one person endorsed a multifactorial view of the genesis of affective distress, and the one who did not still speculated on social causes but stopped short of committing to any.

Two speculated on genetic causes:

> *It's not one factor, one illness; I think it's – there's so many – Do I have a precondition to it? Probably. Just like some people have the bad hearts in their family, mental illness runs rampant in my family. Interestingly enough, it impacts*

> *the MEN in our family… the MEN in our family get depression, not the women. If you want to do the pure biological thing. And I don't know if it's because I probably have more testosterone than, like it – did that hit me because I – and again, I – I* [pause] *without sounding anything but sincere, I've LIVED in my masculine energy; I've been, you know, aggressive, I've been competitive… Oh yeah, I'm a total jock – scored the winning goal last night, 2:1! – you know, I'm gay, you know, all of that stuff!* – LGBT woman, aged 46-55
>
> *Oh definitely. definitely. Like my grandmother had it, you know.* – Woman, aged 56-65

Early experiences in life, some of them arguably gendered experiences, played a part in several accounts:

> *I would have to say – although I realise you're talking about a particular, you know, THE depression – it's actually when you really come to understand it, it's not that distinct an event, either – because it is part of a continuum, because part of what you realise is that I probably – I did! – suffer from episodic depression and anxiety, probably most of my life, and right back into teenager years and even possibly childhood… I had also struggled all my life, like I say, from a kid, with kinda self-esteem, self-perception, um, you know, acceptance of myself, confidence; um – I was very, very, very much stuck in trying to please others…* – Woman, aged 46-55
>
> *…my dad was not only the way he was, character wise, but he was also under the influence of alcohol. He mistreated my mother. He showed disrespect to my mother; he showed disrespect to women in general, especially to my grandmother; and you know, I never got no praises, I never got '*[name]*, you look beautiful, or* [name]*, you look nice,' – nothing. I had an incident when my sister got ten dollars... so, see? This is where the favoritism came in ... I took an eight week course on healing... and that's when I dealt with all kinds of issues, where I was molested as a young child, where I been with the wrong kind of company… and now I'm just grabbing the bull by the horns and saying enough is enough, you know?* – Woman, aged 56-65
>
> *I think a lot of the struggles that I had were related to what I learned growing up… probably being – being a guy, you know, being – holding everything in… it's all around us, right? School and whatever, yeah. But then I also – yeah, and my Dad even, if he didn't say it, like even in his modeling, would have definitely been like that, really kind of distant and unemotional; um, yeah – my Mom, with really good intentions, always, always wants people to focus on you know, the bright side, you know: "What's the – what's – Look on the bright side; it's not that bad –" which is not inherently a bad thing, but it's kind of, you know, sometimes you just want someone to say 'oh, that, that sucks, you know, that's hard.'* – Man, aged 36-45

Only two individuals, both male, did not relate their experience of depression in any way to early life experiences.

Tendencies toward introspection, trying to please others, and attention deficit in childhood were among the intra-personal characteristics which participants observed:

> *And you know, being the kind of self-analytic, analytical type, I very much went inwards: 'Well, what did I do?' Like, 'How did I get into this?' And you know, at a certain point you do recognise certain patterns of behaviour and dynamics that you realise: Ooh. I need to change this. I need to move past that kind of - Or I might end up in the same. Because that does happen, too. Very much so. –* Woman, survivor of domestic violence, aged 46-55
>
> *…we were very close to cousins, so we saw them very often – But a lot of the times, like, my sister… she was always very loud, and like Aah! – the centre of attention – but she would always be like, hey, you're so boring, why are you so boring, why are you so quiet, and like – I know she didn't mean it in a harsh way, but like – I was – those are the questions that I was asking myself… It's true, like – why am I so quiet, why don't I never know what to say, why am I like, you know? –* Woman, aged 18-25
>
> *I wonder if depression and ADHD overlap a little. I think I was ADHD. I have a brother who's ADHD, and my father said that he probably had been ADHD too. So it started a long time ago… –* Man, aged 36-45

Most study participants, however, dwelt mainly on the stress of day-to-day life, painting portraits of multiple hassles, worries, and overwhelming strain:

> *Yeah – it was actually several things that came together… [the] relationship with my husband at the time that was – um, uh, getting worse, in particular in the sense that he was becoming increasingly violent, especially when he was intoxicated. And… we had two small children… I had wondered many times if we were going to be able to continue – but it, uh, really came to a series of crises, and it just happened – this is just coincidence, but, life is sometimes like that – um, that I was living in* [town], *and we had… two very difficult winters, and then floods in the spring… The problems in my relations with my husband were becoming more and more severe, and my children were quite young; they were just one and three, and I was a [professional] in a small town; and um, I wasn't telling anybody anything about it. Whatsoever. So I was trying to put on, maintain the facade, cope with him, cope with life, and then cope with the flood. –* Woman, aged 46-55

> *I guess we would call it a bunch of compounding – uh, life issues uh, – that were kinda piling up, and being in* [my job]*, that's high stress, umm, a lot of cutbacks… so, when you have a job, they tend to add more, and more, and more, ... it's probably like that for most corporations… So not only is my job becoming more difficult; I had a parent who was – my father, who was – very sick with brain cancer, and I was married at the time, and uh, that marriage wasn't going very well; and we had started a business, and that was probably the tipping of the scale – was the amount of stress related to trying to run a business within a relationship.* – Man, aged 46-55
>
> *Like, I'm still dealing with issues of depression – like, I'm living in a house – the man's a slum landlord, I got a crack in the ceiling, they did some re-plastering, it'll probably have to be done again - and I'm thinking the water or moisture's going to come from the roof – but I got out of a bad situation to get into this, because I had to get out of it – and it's like: I've had stuff stolen from me, I've had people lie about me, tell stories about me; I gotta go to the [Residential Tenancies] Branch…* – Woman, aged 56-65

These accounts of stressful social conditions would appear to support a multifactorial model of affective distress. Unlike the participants in Stoppard and Gammell's (2003) research, no one in the study advanced explanations like the 'chemical imbalance' to make sense of their experience. Overall, participants' concepts of their experiences fleshed out the "preliminary theoretical scaffolding" (Thorne et al., 2004, p. 9) suggested by our overview of Kendler's multifactorial model.

II. Context.

The discussion of concept touches on many contextual factors, and clearly shows study participants leaning away from any biologically based, reductionist model of depression. On the contrary, people's accounts touched on a complex array of interacting contextual factors. Thus having established, through the endorsement of persons with lived experience, the validity of a multifactorial concept of human affective distress, let us now turn to these contextual factors in greater detail.

Gendered experiences. All of the women spoke of gendered experiences in one form or another. These included the childhood “molestation” mentioned in the quotation above; lack of support with managing the changes of puberty; differential parental control in comparison to a brother; and in adulthood, stress wrought by expectations attached to gender role, and intimate partner violence. Two women felt that their families had habitually compared them unfavourably to a sister, and a third, to a brother. No experiences analogous to these were described by any of the men.

Tendencies toward rumination and self-blame have been extensively described by psychologist researcher Susan Nolen-Hoeksema in her work analysing the response sets, or tendencies, of women to depression as compared to men (Nolen-Hoeksema, 1987). Among the experiences described by female participants were:

> *… you can't get a break from your head! You know, the clinical term is rumination – I call it ‘chasing your tail’ – everything I ever did in my life, I beat myself up; I wasn’t this, I wasn’t smart enough, why didn’t I invest in there, why didn’t I do this, and you* [pause] *just* [pause] *rip a strip off yourself; it's like a big stick, over and over again. You can't get a break.* – Woman, aged 46-55
>
> [chronic illness] *in itself, which is another reason it's very difficult to be ill with this, because then I'll – there's something else I get to blame myself for… So now you get to feel like 'Oh, I've caused this, have I done that too; that's great.’ … So 'Look, I've made myself sick. Look what else I've done. What an idiot I am!'* – Woman, aged 46-55
>
> *I realised I was kind of more black-and-white than I thought I was. Like, 'It's good or it's bad;' 'You're in or you're out.' And I kind of realised a lot of things are – are much less black-and-white than that. But that – that was very hard for me. I felt like I was a BAD person because I had failed. Well, not just ‘I had failed at this marriage,’ but I had got myself and my kids into in the first place. So a lot of guilt, a lot of shame.* – Woman, aged 46-55

This same individual also mentioned parental disbelief and invalidation with regard to her experience of intimate partner violence, which at the time may well have added to the cycle of self-blame and guilt. Finally, one young woman who had indicated that her mood distress began in childhood described ruminating as a child.

Stress. All participants reported considerable stress from many sources at the time of the onset of mood difficulties. Immediate and recent stressors included: problems in intimate relationships (reported by four women and one man); work stress, including precarious employment (three women, one man); illness or disability (two women); illness, disability, or recent death of a family member (two women, two men); and financial stress (two women, one man). Remote stressors included bullying in childhood as well as the gendered experiences of family dynamics already detailed.

Innate characteristics and skills. Not all reported context was negative. Many people spoke about inner qualities such as resilience, motivation to recover, and humour, and how these helped them along the way. Although the words convey some of the meaning, it should be noted that this message was conveyed even more through the passion with which people spoke in the interviews.

> *I think my, my 'jock' mentality kicked in… I've always been very competitive, and… I used to say a healthy Aries ego.* – Woman, aged 46-55
>
> *…and I opened the page, and there was a phrase from an actor, who said, 'If trying harder doesn't work, try softer.'* [– Lily Tomlin.] *Which made me laugh, so I bought the book, and then I read the book.* [Laughs] *Ha ha! So like, ah, and so I used a lot of humour to – to get past things. Find the funny things just even in the darkest times.* – Man, aged 46-55
>
> *That's one thing my mother said before she died: She said,* '[name], *if you don't speak up for yourself, nobody else will.' …So I mustered through life as best I could.* – Woman, aged 56-65

This woman also stressed the importance of her religious faith to her recovery.

More generally, all participants – without exception – evidenced pride and satisfaction in previous achievements, citing educational or work attainment, or high levels of responsibility. Some individuals also insightfully explored the converse of some of these characteristics, for instance, the double-edged aspects of qualities such as "ego." The woman diagnosed with fibromyalgia syndrome, already quoted above, described herself as a high achiever at work and holding a great degree of responsibility – but referred to her "ego" as both a strength and a point of vulnerability. Similarly, the woman who was a survivor of domestic violence described herself as highly autonomous, which she acknowledged was also a barrier to self-disclosure to supportive others who might have been able to help in the early stages of her difficulties.

Employment and avocation. Notwithstanding the work stress cited above, work and structured activity such as volunteering were described as sources of pride, meaning, and satisfaction. All participants voiced a sense of "contributing" through vocational and avocational activities. Indeed, four women and one man acknowledged great reluctance to stop working when directed to do so by health care professionals, and two people indicated that they had been loath to quit "extra-curricular" commitments such as serving on boards of directors (a woman) and amateur theatre (a man).

Ineffective coping. Reports of ineffective coping were rare. One woman, and one man, mentioned having in the past used alcohol to cope with mood, which they now judged as problematic. Four individuals reported not reaching out earlier for help when in hindsight they wished they had.

III. Trajectory through distress and recovery.

To return briefly to the foundations of our methodology, interpretive description aims to situate the individual's subjective experience within the shared discourses and trajectories which our health care system holds as the temporal and symbolic spaces for health and illness (Thorne et al., 2004). One could conceive of the negotiating of irresolvable distress within health care and social contexts as 'a story within a story:' a unique experience, which is then presented and produced "within the commonly understood and objectively recognised conventions" of health care (Thorne et al., 2004, p. 3), with presumably varying processes and outcomes resulting from the encounter. It is at this point of contact that thoughtful analysis of the individual 'story within the story' has the potential to yield meanings and explanations which have implications for practical application (Thorne, 2008).

All nine participant accounts followed a narrative arc with many common aspects. To reiterate with greater elaboration, these were:

1. The **onset or identification** of affective distress;
2. The emotional **response** to the onset – including such feelings as bewilderment, fear, and other unpleasant emotions;
3. The **negotiation** of action and meaning – including ambivalence about seeking help, varying degrees of trust, and the mixed experience of taking antidepressant medication;
4. The development and engagement of **supports** – including the finding of new resources and use of existing ones, and the discovery of new coping skills or redeployment of existing ones.

1. Onset or identification. As it is on so many aspects of human affective distress, the *DSM* is silent on the timing and rapidity of onset, which in the present study showed considerable variation, and appears to have had some bearing on recovery. Three women and one man reported noticing things such as low mood, lack of enjoyment, and ruminative thoughts as early as childhood:

> *I always had a hard time, like having friends and all that stuff, and I guess in my head I always had like a thousand thoughts running in my head and like, doubting and stuff – but – never had the courage to talk to someone about it, like my Mum or Dad, because I – I figured since my sister … I would always compare myself to her, and she had a lot of friends, so I was like, 'Okay, well, if she has friends and she seems to be having fun, and – she must be normal, so I'm not normal, so I would compare…* – Woman, aged 18-25

Of the five other participants, most bounded their experience distinctly in time, drawing more or less sharp divisions between feeling well and the onset of mood symptoms – even if these came on gradually:

> *I remember I was doing – okay, going about life as usual; you would work, you do your stuff, you – you – you go out, you* [laugh] *eat, you see your friends, stuff like that, like, normal life kind of thing. and then one day I – I woke up one morning and I – I felt – tremendous* [pause] *desire for crying; I was – tremendous sadness, and then I – feel – I felt like crying. At the same time, that same morning, I felt nausea in my stomach…* – Man, age aged 46-55
>
> *I had never been depressed a day in my life – overachiever – you know … like I – I've had a great career … I* [pause] *just didn't feel good, and it started slowly for me… and then from there, I stopped* [pause] *doing everything. I stopped – working; I stopped listening to my beloved CBC, I stopped reading the paper, I stopped eating, I stopped going to sports, I stopped going to work, I stopped everything.* – Woman, aged 46-55

However, the survivor of domestic violence, who had worked through years of insight-oriented therapy, drew a more nuanced distinction:

> *…it kinda had to come to a crisis – but… it kinda – both converged and diverged at the same time with regards to the things. But having said that, I had also struggled all my life, like I say, from a kid, with kinda self-esteem, self-perception,*

> *um, you know, acceptance of myself, confidence; um – I was very, very, very much stuck in trying to please others.* – Woman, aged 46-55

Few participants remarked on the significance of receiving a diagnosis or not. One woman, quoted above on the subject of genetic predisposition, and whose father had years earlier been diagnosed with major depression with psychotic features, was forthright about having received the same diagnosis. No one else took the opportunity to discuss the meaning of formal diagnosis, or lack of it, when asked.

2. The response to the onset or identification. Emotional responses paralleled timing and rapidity of onset or noticing. The five participants who described a more or less acute onset unanimously expressed a sense of bewilderment, feeling “scared” and “panicked” associated with not having a concept of what was happening:

> *I didn’t know that it was depression, cos I’d never experienced it.* – Woman, aged 46-55

Three women spoke of suicidal thoughts coming to them unwanted – “unbidden,” in one woman’s eloquent language – with understandable shock and horror at having arrived at such a state:

> *I remember coming out in the middle of the night, sitting on the couch and deciding – or trying to think of how to – uh, kill myself, and figuring ways out, actually having plans – and realising that's – hah!! – probably not the best thing. That's probably not the best thing to actually – no, ‘So this is how I'll do it. And I'll wait ’til everybody's at work, or at school, and I'll do this, but I'm gonna do it nice and tidy; I don’t want anyone upset.'* [whispering] *Which is ridiculous! I look back now, and I, um, I – it’s so unlike who I know myself to be.* – Woman, aged 46-55

Conversely, the four individuals who reported having struggled since their early years had experiences which may better be termed ‘identification’ – rather than ‘onset’ – and which consisted of a noticing or realisation that something was not right:

> *From early on, I asked myself, 'How is that other people don't struggle the way I do?'* – Man, aged 36-45

Perhaps owing to the greater remoteness of these events in time, participants tended to describe such realisations with less affect than those whose accounts entailed acute onset.

An associated general theme which was reported by all participants was the disconcerting feeling of being, at least for some time, utterly alone in this unsettling and alien experience, with the consequences of "covering up," and not seeking social support. People spoke of struggling through the initial phases of the experience without letting on to others that they were experiencing distress, owing to having no means of making sense of or even speaking about it. A vicious cycle of covering up, and the covering up leading to further isolation, emerged; this observation leads us seamlessly into the accounts of the initial stages of negotiating the ambivalence, detailed in the next subsection.

3. The negotiation of ambivalence. For many participants, bewilderment, and the struggle to make sense of what was happening, appear to have given rise to ambivalence as to course of action. Ambivalence manifested as tensions between trust and skepticism, between shame or stigma and the need for succour, between help seeking and the inclination to 'tough it out' on one's own. Working out this ambivalence, which was played out in health care settings, meant for most participants a stepwise and often incomplete resolution of trust in health care processes presented as nominally biomedical.

The decision to approach medical professionals for care was in several cases precipitated by a crisis:

> *I tried to cope with it and to defeat this; said 'Why am I feeling this way?' It's a – it's – doesn't make sense – and then I tried to will it out, to by will – to go back to what I was before but I couldn't achieve it. So I spent a few months like that, because I wanted to carry on – and I was always not too keen on going to doctors and stuff like that – because especially when you are feeling that type of symptoms – that – you – you are sad, you are crying you're so – I knew it – it had to do with the brain – with mental health, and I didn't want people to – to – you know, find out from me because then you get stigmatised and you know, it's – it's not something that people understand very well. So I wanted to fix it on my own. That's why I spent a few months like that. But the nausea, especially the nausea and the crying* [pause] *became so discomforting that I finally gave up and I – I booked an appointment with – with a – with a doctor.* – Man, age aged 46-55

> *I just wasn't doing well …I couldn't sleep; I would wake up at night crying, and um – I was – I was suicidal. I was contemplating* [speaking softly] *killing myself. So – that's, I started thinking very concretely about: what would be the best drug to get my hands on … And that's when I said, WHOA! Wait a minute. I mean, those thoughts would just come unbidden… And I don't come from a family where we – they were very – parents were very supportive but also very emotionally distant. And um, you know, you're just expected to, you know, stiff upper lip and all. So, when that* [domestic violence] *happened, I told my mom, who was quite disbelieving, ha!* [laughing] *frankly! And I called, um –* [physician] *and I said, 'I'm thinking of – I'm, I'm, really doing badly, I'm thinking of killing myself, I need help.'* – Woman, aged 46-55

> *One morning, just when I was waking up, I – had an anxiety attack. It just came out of nowhere. I was scared. I went to a walk-in clinic – and they recommended I go to the Emergency. I went to* [hospital] *emergency room. I sat there for hours, and was not seen by anyone, any doctor. But I had a chance to sit, and settle, and it slowed my mind down. I realised that maybe I needed to talk to someone about this, maybe see a doctor… I had no GP at the time.* – Man, aged 36-45

The response received from first contacts with health care settings seemed to have a bearing on outcomes, with contacts characterised by trust, validation of context, and optimism leading to earlier positive outcomes, and relationships in which participants perceived a less than optimal sense of human connection having the effect of delays and detours in recovery.

Several people reported feeling heard by their physicians even at the initial visit for this complaint:

> *…and I was feeling the depression, so I think around that time, give or take a year or two after, I might have started taking Celexa … I went through my GP, my regular doctor, who I'd seen for 17, 18 years. And she was familiar a little bit about the negativity and the environment at home… And Dr* [GP] *really – well, she knew the dynamics about my dad and everything, and going through negativity, and not being close with my family; she knew all that. Yeah. –* Woman, aged 56-65

The following excerpt is from a man whose profession does not permit use of equipment while taking any psychotropic medication, which – because of the degree to which he valued this occupation – compounded his ambivalence:

> *And so – with all these little things that were kinda comin' up, I went to the physician and I basically said to him, you know, 'Something's up,' and I told him my story, um, at which point he um ,within the first visit, he had suggested that ah, uh, – and it was a long visit – that uh, we, uh, might have to go on antidepressants. Which was* [laughs] *ha! ha! Depressing at the – at that point! Because I knew that if I subscribed to that treatment, that I would lose my* [profession] *licence. Okay? Which he was, well, he was well clear with; he says, 'If we do this, I have to legally report that to* [authority]*.'*
>
> Interviewer: So you're torn.
>
> *Yeah. But – I couldn't do it anyways. So I was like, okay, uh, knowing – personally not doing it, and knowing it's the right thing to do, but being told 'we're gonna take it from you' was a tougher – was another hit in the – in the – emotional – uh, feelings I was having. But – the one key thing that um, struck well with me, was the fact that, um, this particular physician had said, 'But my goal – and we will get to that goal – is to get you back* [working] *again.' …Right from the start. He just said, These are the things you want to do – we're gonna get you there – but you have to trust me and follow my lead.' So uh, I agreed to the – to the treatment.* – Man, aged 46-55

Others were less fortunate. One man spoke at length about the frustratingly poor outcome of his experience with primary care:

> *Now – that doctor* [usually seen at local walk-in clinic] *– was not working at this time, and uh, so when I decided to go and see the doctor, at the clinic, I had to go with a different one. And uh, that's the one I told about the symptoms – the crying and the no sleep and the nausea – and – and he told me that what I had*

> *was some type of depression. And – he assured me that it was a – not too much of a problem, because he was gonna prescribe me some medicine – that was going to make me happy again! I remember his words* [laughs]: *'It's going to make you happy again; you'll be fine, you'll be fine;' he was very reassuring, very very nice. And I kind of liked that – and then I said, 'Well, then – seems like I did the right thing – I just came here, and then he's gonna help me with that'… Problem was, that from the get-go – despite what he had said… when I started taking this particular medication – I began to feel worse, even worse than I was… I had nausea; now I had even more nausea. And I couldn't sleep. But now, I couldn't sleep even less than before. And then I began to feel strange – like – worse than I was feeling before… Those two factors made this medication not very nice, not very nice. Now …I forced myself to take it… because I wanted to get better; I couldn't do it on my own before – now I had the help of a professional…* – Man, age aged 46-55

This individual went on to describe having similar experiences with a series of three different SSRI medications, each for a 30 day trial, and a norepinephrine-dopamine reuptake inhibitor (NDRI), after which he decided:

> *… after that, I just swore medicine off. I didn't want to know anything about medicine after the experience I had with these.* – Man, aged 46-55

He reported subsequently struggling through several more years without any improvement in his symptoms, unable to work, yet seeing no further options for help.

Several participants, conversely, insightfully recognised their own part in putting up barriers in the negotiation of trust:

> *No, I'm backing up my story, um – I – for those first 13 months, I was, I went to the, the first time I went to the doctor, – I didn't have a doctor back then… I went to my mother's doctor, who diagnosed, uh, who gave me Celexa, a little teeny teeny amount, maybe 5 or 10 mg, I took that pill, uh! I had a complete body stone. It was the weirdest.* [Another physician] *gave me Trazodone, and that didn't knock me out either; it didn't work… and then from there, uh, I was in…* [other hospital] *for two weeks, what they promised…*
>
> Interviewer: Did they try you on medications?
>
> *Yeah. But I wasn't, I wasn't very cooperative, trust me.*
>
> Interviewer: You weren't very good at taking it while you were an inpatient.

> *No, no, no I wasn’t. I wasn't cooperative, because how could I be depressed? I was* [name]*! Big ego too!* – Woman, aged 46-55

It is perhaps noteworthy that both this unsuccessful health care encounter, and that of the man immediately above, began with family physicians who happened not to be these participants’ usual doctors. Another woman showed ambivalence in accepting, but at first not filling, prescriptions for antidepressants:

> *My doctor had encouraged medication three years ago – I got a prescription, but you can get a prescription without filling it. … My doctor kept pushing me to quit work, and I was 'no, no, – I'm – no, not ready yet.' And I – I remember the day that I finally went to him, and I said, ah, 'I'm ready.' And he was giving me the note for that day, and I said, 'No no! Two more weeks, so I can clean out my desk! I need two more!' And he just – ‘Ugh! Really?’… So he had had me on the pills shortly after that because I, um – You can get prescriptions but you don’t need to fill them!* – Woman, aged 46-55
>
> *I had been seeing a therapist but um, a private practice therapist; to be honest, I don’t think he really appreciated – and I don’t think I was really telling him – I don’t think he knew how directive you have to be with* [laughing] *people like me! Ha ha. So – uh, it was uh… I know that kind of wanting to protect others from my feelings, not really liking to disclose, not liking to appear like I had um, – like, anything that interfered with my autonomy; those all interfered with me asking for and seeking for help until it came to – a – pretty major crisis.* – Woman, aged 46-55

From these accounts, two things are apparent. First, it appears that the quality of the patient-professional relationship bears strongly on the outcome, and second, that the responsibility for this quality of relationship is shared between patient and therapist or physician. Even where the treatment offered is limited to the biomedical, careful interpretive reading finds a considerable difference in flavour between the one man describing *“the one key thing that um, struck well with me, was the fact that, um, this particular physician had said, 'But my goal – and we will get to that goal – is to get you back* [working] *again'”* and the other man’s skeptically sketched account of *“he was gonna prescribe me some medicine – that was going to make me happy again.”* The first shows appreciation for the patient's life context and values; the second, albeit equally optimistic, is a generic response, made without digging for background. The first participant went on to describe recovery within two years; the second languished in distress for many more years.

On the second point, ambivalence is noted to hinge on trust and self-disclosure as these ebb and flow in successive iterations of contact with entry points into the health care system – each iteration being the result of the inner processes of resolving the polarities of trust versus doubt, shame versus pride – for example, *"… because how could I be depressed? I was* [name]*! Big ego, too!"* – and autonomy versus facing one's powerlessness to solve the problem alone.

4. Development and engagement of supports. The "dappled nature" of depression (Kendler, 2012b) was once again evident in the study participants' chronicles of which "difference-makers" were found most helpful in the journey of recovery. The unique feature of this study was taking the biomedical discourse as the starting point, but then throwing the window wide open in order to survey all manner of restorative factors on multiple levels. Given the opportunity to explore this multiplicity, participants did not disappoint in providing rich accounts. Apart from the experiences of taking medication and other biomedical treatments, and working with physicians and other health care professionals, non-medical themes which emerged included: support from friends and family; work and volunteer work; self-help organisations; spiritual community and practice; and general approaches such as finding a new work-life-leisure balance.

Health care "difference-makers." We shall begin with a deeper inquiry into the relational work of health care. As was hinted at in the exploration of ambivalence, above, many participants' accounts strongly suggested the presence of complex human dimensions to the relationship between patient and professional – including factors such as gender, acknowledgement of life contexts and willingness to use these therapeutically, mutually viewed goals, and the durability of the relationship.

Three women commented on how helpful it was to have a female family physician. In each case, there seemed to be an effort on the part of the physician to hear the context of the patient's presentation, over the long term, with the result that participants felt that trust had developed. Each of these three women reported receiving non-medical recommendations from her family physician, sometimes before trying antidepressant medication:

> *So we waited, like, – she gave me some tips you know, see, to make it better, you know, like exercise, and like eat better, and…* – Woman, aged 18-25
>
> *… and she goes, 'I'm going to give you assignments,' and one was to go to the house … 'and then you write about it, and let me know next time we meet;' and I like 'yea, I'm really gonna do that like a hole in the head;' … but you know what? I thought I couldn't write – I wrote pages of stuff – most of it was positive! And my husband said, 'What are you writing, a novel?' – I said, I didn't tell him until I read it out in front of him and my doctor… And then I realised, I'm seeing a lot of positive things about the situation… and so that actually was helpful… And my husband was surprised too… It just came oozing out of me.* – Woman, aged 56-65

These women all commented on the amount of time which their physician would take with them in order to do this work.

Besides the listening to context, the continuity of the therapeutic relationship seemed critical to recovery. All participants linked their recovery to having an ongoing relationship with their family physician or with a psychiatrist, and those who did not have such a relationship at earlier stages did not report attaining any relief until such a long-term empathic relationship materialised:

> *So I finally booked an appointment with this psychiatrist, and he saw me; he saw me for a few days. He was not – you see, before, it was just a one time thing…. He was impartial… He just wanted to fix the problem, not to be guided, to fix the problem in a certain way, like a lot of pharmaceutical companies do. So, the doctors they just prescribe what they say is good. So he wasn't like that. So he took his time. Said, 'let me do some research;' and I – So I saw him maybe for three times before he even prescribed anything…* – Man, age aged 46-55

This man drew a sharp distinction between this experience and his previous experiences of psychiatrists he had seen previously, who had all made it clear that their role was one-time consultation only. It is, again, noteworthy that it was upon starting to work with this specialist that this man finally experienced relief of his extremely distressing symptoms, once given a prescription for a medication of a different class from anything he had tried before.

Prescriptions for antidepressant medications, however, were generally greeted with a complex mix of trust and skepticism:

> *Well, I told her* [family physician] *I didn't want medication – for that… like ugh, I don't want to be on medication and stuff, like, for – but I have an amazing relationship with her, and… so we tried the medication…* – Woman, aged 18-25

Examples already cited above further illustrate this finding as well.

In all cases the skepticism – albeit reported in hindsight – seems justified, as all nine individuals recounted thoroughly mixed experiences of taking antidepressants. Complaints ranged from intolerable side-effects, to distressing withdrawal symptoms upon missing doses or weaning off, to feelings of shame and weakness and loss of autonomy.

Reported side-effects commonly reported were dry mouth, nausea, a fainting spell, palpitations and sweating, digestive tract upset, weight gain, sleep disturbance, disturbing dreams, and sexual dysfunction – the latter reported by a woman. One woman and one man – who had also been an amateur actor – complained about constriction of their range of emotion; the loss of life's "highs and lows" which each valued for life, let alone for acting. One man and one woman described fleeting suicidal ideation, recognised these "microthoughts" as an SSRI side-effect which has been reported in the media, and promptly brought this to the attention of the physician.

Four participants related working with family physicians in a trial-and-error fashion to find the best medication fit. This process seemed quite frustrating, given the protracted way in which antidepressants in most cases are given a trial period to work – and to wreak the side-effects described – and are then tapered gradually before a new agent can be introduced. This struck one man as quite different from the medicine he knew:

> *Say you have a headache. I don't have headaches very often, but maybe once a year I might get one – I take an Advil, and I lie down for half an hour, and I wake up, and – it's gone. Yeah. And ah, in other cases, I probably have taken other medicines before, when I was younger and stuff, and they kind of relieve you of the symptoms. You know? So – I had faith in medicines, so – at first, I began to take this like, like, with a lot of faith in them – but…* – Man, age aged 46-55

One man characterised the compromise between mood relief and side-effects as a "tradeoff" he could accept – temporarily.

Shame and weakness associated with taking medication were mentioned by several participants, even while recognising this as problematic:

> *I guess like, I think a lot of this experience too, for me, is probably kind of, kind of shameful – you know, even in my – even though I don't – I don't agree that it SHOULD feel that way…* – Man, aged 36-45

> *But taking the antidepressant meant I was weak, right, cos I can't control myself. So I was very negative about it.* – Woman, aged 46-55

Most participants ultimately wanted off the medication. Physician responses to this were described as accepting of patient choice, with the caveat in three cases that longer tapering-off periods were indicated for certain medications known to have more severe withdrawal symptoms.

The one exception was the man who had at last found a helpful medication in a different class of medication from the SSRIs and NDRI, whose course was stopped abruptly because of a miscommunication between psychiatrist and pharmacy. It is again noteworthy that his recovery appears to have been sustained even after this sudden termination of biomedical intervention, but with continuation of the therapeutic relationship.

In summary, many people said, in different ways, that antidepressant medication helped them to achieve a certain basic level of mood stability, but that the real work of recovery took place on other levels:

> *I think it's – I think – there's no 'one size fits all,' but the medications… they're going to get you to a place where you can do that kind of difficult work, so that hopefully you don't need the medications. I mean, that's been my path.* – Woman, aged 46-55

> *And – you know, at the time, when I told my doctor, 'This isn't doing anything, you know, I want off,' and… um – and it's funny, because – what if this was the thing that helped you? All of it? You know, the perfect storm – you started telling your close friends how you're feeling, this medication is helping you maybe over that hump, to get to a better place, so… I did not feel it was helping me, because I did not suddenly feel happy. Or… totally in control again. But perhaps it helped – like, open the door from the darkness. And then everything around me was the stairs back up. Okay! So now, in hindsight, I can look back and think, you know,*

> *you don't know, I was all, 'No, it's not working, we need off of this!' and – maybe it worked enough. Just to get that foothold.* – Woman, aged 46-55

> *I think medication sometimes is – can be, can be good, um – especially if you're really you know, in that dark place, and you kind of need that almost like respite or something… And I don't know, I wouldn't want to judge someone else's experience, but I think for me – like, I took medication for a long time and it didn't – it relieved things, but it certainly – it was kind of less making me happy, and more just taking away some of the pain, and I think what I needed was to really – you know, take that next step, right? Like, medication's not going to help you find meaning in life or something, right? Or hope, really. I guess you hear about these – these studies that say, you know, CBT or meditation or things are just as equal as medication, and I – I kind of believe that, but um, maybe – I don't know, when you're in that dark spot, maybe it's a lot easier to get a pill into your mouth than it is to you know, join an eight-week group!* – Man, aged 36-45

Other biomedical treatments. It should be noted that three participants had mixed experiences involving other biomedical interventions. One man tried repetitive transcranial magnetic stimulation (rTMS) delivered on an outpatient basis over several sessions; he reported no improvement in his condition. Another participant, a woman, was evaluated as a candidate for rTMS but, according to her account, was deemed not sufficiently severe. Finally, one of the women in the study was hospitalised after trying suicide, and was treated with a course of electroconvulsive therapy (ECT):

> *… thanks to a team of doctors and nurses, I got the help I needed, including uh, they kept me safe, they fed me, and I got* [pause] *ECT… Let me tell you, did it ever work for me. Within one treatment I was – it was like a miracle… it's… like you were in surgery – all you see is eyes, and they're putting the electrodes on my head, and, they're holding my feet, and this was going on, and the nurse, just looking over me and going,* '[name]! *You're gonna make it! You're gonna make it!' … and then she bagged me, but just nothing but beautiful eyes, and… And then I woke up, it was like, did a quick scan of my body, and you know what – I felt better. So I called the nurse over… I wanted to see the doctor immediately. I went back to my room and… saw myself in the mirror… I needed to shower, I needed to brush my teeth, my hair, and I needed about ten cheeseburgers.*

> *And jokingly, – I can say this, you can't* – [if depression recurs] *I will hook my own booster cables up and get ECT, because, I know that that's effective for me.*
> – Woman, aged 46-55

This participant underwent a course of such treatments, with no ill effects, and was subsequently discharged with psychiatric follow-up including antidepressant medication.

In perhaps a category in between the medical and the non-medical, all participants spoke highly of counselling accessed in addition to primary care, whether by psychologists or other professionals. Many could not define their helpers exactly by profession; this did not seem to matter as much as did the continuity and quality of these relationships, and once again, the attention to such nuances as social context, values, and goals. A barrier to utilisation of this help identified by several individuals was the restriction placed by health benefits and insurance plans on numbers of sessions.

The woman who had endured domestic violence attributed much of her recovery to insight-oriented therapy programming specifically for survivors of such violence. These group and individual programmes were provided free of charge at a community health centre.

Non-medical "difference-makers." Participants spoke passionately about a diverse range of other ingredients in their recovery recipes. Some of the many advantages of work and volunteer work have already been depicted above; to these we can add reports of supportive organisations, and professional associations, and supervisors who afforded understanding in times of distress and a warm welcome upon return to work. Two women, however, criticised their workplaces as at times "toxic" and perpetuating stigma against mental illness – the latter in a general sense, though, and not toward the participant herself.

The mental health self-help organisations in Manitoba merited frequent mention as sources of peer support, including validation, sharing of strategies and resources, and social connectedness. Faith, spiritual community, and spiritual practices such as prayer and mindfulness figured strongly in the stories of two women, although several other women also embraced journalling as a secular reflective practice.

Other insights offered by participants into non-professional factors that facilitated recovery were the therapeutic value of pets, the relevance of good nutrition to mood, and rigorous application of cognitive-behavioural therapy technique as a self-help method.

For two women, however, the greatest difference-maker was the skillful ear, and timely intervention, of friends and family. Key features of such intimate social support seemed to be empathy balanced with action, and a non-judgemental stance, even toward suicidal ideation:

> *And she was very gentle and supportive of me, understanding that the things that I did, I did want to do them, while letting me know that 'this is a bit much.' She never actually said, 'You need to stop, we need to do an intervention.'… So – by the time the depression fully hit, I could talk to her – She's remarkable. About the suicide. And she wasn't panicking, going 'Oh my God, we'd better get to the hospital;' she would just say 'All right, well, what's happening? I understand you're overwhelmed, and I'm not upset with you for feeling this way, and just – and I don't BLAME you.' Yeah! Oh my God! So her validation – she never flipped out when I was in the darkest part; you know, some people will get just very – afraid of mental illness, and either want to fix you, which is horrific, cos I'm not broken; I'm hurting, that's different. Or they don't want to deal with it. 'Oh, you're havin' a rough day? That's OK, let's go shopping! I'm gonna come over with some coffee; you'll be fine!'*

She continues:

> *Whereas she would just go, 'I'm gonna sit down in this dark hole with you and we'll – I brought sandwiches; let's talk.' It was the most amazing thing – that could, I think, could ever happen to somebody who's depressed. It's not – don't try, don't try and talk me out of it, cos people – tend to do that too: 'Well, you've got so much to be grateful for.' I'm not saying I don't! I'm just saying,* [pause] *'I'm done.' Doesn't mean I'm not grateful; just means this isn't working anymore. You know, the connect? So she was – just a soft – but forceful support. It's very hard to describe. It's very hard to describe. It's making me feel a little* verklempt, *just* [both laugh] – *ha ha ha! She's awesome! Oh my God, she's awesome!* – Woman, aged 46-55

Another woman was appreciative of her sister:

> *I was sooo, I was – First of all, I was so grateful to not be depressed anymore, that I was doing everything I could not to be depressed anymore. Like, I was not going back there! So I would say to my sister – really – well, my sister's my hero… And she really saved my life, cos when you're as sick as I am, somebody has to advocate for you, and she got me to the hospital to get the help, and everything after that.* – Woman, aged 46-55

Less tangible restorative factors frequently identified were hope, whether instilled by physicians, friends, family, or counselling programmes; newly gained coping skills and resources; and life changes such as finding a new work-life-leisure balance. Hope looms largest as the difference-maker here, and seems to constitute an essential element of the complexity of helping relationships. A striking example is found in the speculation of the man whose physician had said "*my goal – and we will get to that goal – is to get you back* [working] *again."* This participant wondered aloud about the hypothetical situation of receiving the same medical treatment, but without a doctor who took the time to listen and reassure:

> *I don't know what would have happened to me if he would have walked away; uh, I know that if I would have had a doctor that basically said, uh, 'Here you go, deal with it, and know by the way, you're gonna lose your [work] licence,' um, I don't know what …* – Man, aged 46-55

This participant's exercise in imagination, seeing a radically different outcome in an alternate scenario, speaks to the critical importance of the non-medical in medical care.

Unanticipated benefits. Inadvertent positive outcomes of the trajectory included greater self-awareness and becoming better "attuned to what's going on inside;" reevaluation of earlier life choices such as overwork, destructive relationships, and alcohol use; new perspective on family dynamics and early environments; greater "sensitivity" and understanding toward others who experience mental health issues of any kind; and increased use – reported only amongst women – of self-reflective practices such as prayer, mindfulness, gratitude practice, journalling, and art. Many participants emphasised their need to "give back" in the form of sharing their story so that others may benefit from their learning.

On the more intrapersonal psychological level, some participants reported an increased sense of agency, "grounded"-ness, and confidence:

> *Oh yeah. Yeah. I'm definitely, I'm a different person for it. I was a better parent for it, um, I'm a better* [professional] *for it… I'm more secure and sure of who I am…* – Woman, aged 46-55

> *I think I know what brings me joy now. And I know – it's not what brought me joy before. And I think my insides and outsides match up much better now. Because when I'm alone I'm not lonely. It's – it's – ha! You don't learn that. I couldna learnt that earlier but it's all part of the path. I don't recommend my path to anybody, but I'm ah, a much more grounded person. Cos I was always 'A type' personality, I was – you know, energy now, it's like my energy is much more grounded. You know, I still have my enthusiasm and zest for life, but I'm much more grounded.* – Woman, aged 46-55

7. Discussion

True to the methodology of interpretive description, unanticipated findings emerged from this study which pointed the way toward new considerations beyond either the multifactorial model of Kendler or the biopsychosocial model. Participants, each in their own way, spelled out life-course and process aspects to recovery which warrant further consideration. Of particular significance to our approach are the intertwined – and again, somewhat overlapping – threads of: (1) gendered experiences; (2) the negotiation of ambivalence toward help seeking; (3) the importance of helping relationships and certain qualities of these; and (4) how these all ultimately relate to conceptual understandings of the phenomenon – the keystone of our discussion, which will bring us back to epistemological considerations as well as to practical implications for health policy and clinical practice.

We had described the experience of help seeking for affective distress as a ‘story within a story’ – a subjective problem which is presented and negotiated “within the commonly understood and objectively recognised conventions that contemporary health care contexts represent as the temporal and symbolic location for health and illness” (Thorne et al., 2004, p. 3). In other words, individual subjectivity takes place within a culturally determined context. Because this was a study of people who had taken antidepressant medications available only with a physician’s prescription, our study participants all had the health care system as a locale which figured prominently in their experiences. The health care system at this time in Manitoba, Canada, in turn, reflects in its own way and to its own degree the larger discourse of affective distress within mental health, psychiatry, and medicine. Thus our participants’ stories nested within the larger story can be analysed in terms of the relationship of the individual to health care service providers, and of health care to larger conceptual and policy issues.

We outlined in the Introduction the problem of Western medicine's denial of any theoretical basis or culture, and that despite the impression of neutrality, it can indeed be viewed as having both a culture (Foucault, 1989; Lupton, 1995; 2003) and theoretical underpinnings in realism and positivism, as well as in a dualist biomedical reductionism. A critical perspective on the Cartesian subject-object dualism that still informs psychiatry helps to elucidate how concealed theory makes itself felt in clinical practice – and also, surprisingly, how it fails to assert itself when individuals seem to step outside of this discourse. This tension between views will form the crux of our analysis and discussion.

Gendered experiences. We had noted the remarkable consistency in the descriptive epidemiology worldwide of a sex ratio of women to men approaching two to one, a finding not explainable in strictly biological terms but likely amenable to partial explanation by social, psychological, and environmental hypotheses (Bassett & Moore, 2013; Horwitz, 2002; O'Brien, 2012). All of the female participants in this study mentioned having in some way experienced differential treatment based on gender – some in childhood, others in adulthood, and some in both. In all cases these experiences were negative, and indicative of power imbalances which manifested themselves in circumstances such as sexual abuse, unequal parental support, stress associated with expectations attached to gender role, and domestic violence. Adding to the complexity were the insightful remarks by several women on the inner experience of self-blaming, rumination, and guilt, and the part these seemed to play in bringing about and perpetuating the depression. We might draw from this some support for the disturbing double conclusion described in the literature that not only do women seem more vulnerable to societal factors associated with depression, but that women's responses, in some instances, may tend to perpetuate emotional distress (Nolen-Hoeksema, 1987).

For their part, the three men reported seeking help at times of particularly heightened awareness that something was felt to be wrong. In keeping with the findings of the literature review by Seidler et al. (2016), all three male participants seemed to focus therapeutic discussions on function, especially on work and difficulties related to working. None related their adult mood distress to early experiences in any way. Not surprisingly, the men voiced appreciation for clinicians who approached in collaborative and non-paternalistic ways (Seidler et al., 2016).

The negotiation of ambivalence. That treatment would be something that gets negotiated between care recipient and carer, and that such negotiation would form such an integral part of the narrative arc of the genesis of affective distress and recovery from it, was an unanticipated finding. Participants spoke at length about inner struggles between needing to seek professional help for something distressing which lay beyond their coping capacity, and needing to preserve a sense of autonomy. Perceived stigma surrounding "mental illness" further complicated this deliberation. Some remarked about the irony of relinquishing power in the course of seeking help for a phenomenon which is itself partially rooted in powerlessness. In all cases, trust and the reciprocation of trust appeared to be critical to outcomes, with health care encounters characterised by empathy, hope, and the validation of the individual in context being associated with earlier improvement in mood. Participants were also quite clear about the two-way nature of this trust, namely the dual responsibility of patient and physician in successfully and gingerly negotiating the therapeutic relationship; those who felt that they had been genuinely helped for the most part reported having had to take a risk, but that ceding autonomy had been met with an understanding and trustworthy response from at least one carer, whereas others who acknowledged having held back from self-disclosure and even from seeking care at all regretted this in retrospect. To our knowledge, the finding of participants' sense of 'patient responsibility' for the therapeutic relationship is not observed in the literature.

General support for our negotiation theme comes from studies into the experience of taking antidepressants, one in the form of a novel research paper by Brijnath and Antoniades (2016). Applying play theory to the taking of antidepressants, these authors interpreted the negotiating of medication-taking as following a course of learning the rules of the "game," then breaking the rules and formulating a new game. Themes identified included experimentation under medical supervision followed by realisation of the unpleasant aspects of the medications and the urge to reduce or stop, and then the exercise of self-determination by finding a balance between treatment imperatives and privileging one's own experiential knowledge. Individual agency was central to the resolution of the "game," in that participants made decisions regarding medications, and also self-evaluated based on experience and functioning rather than clinical definitions of improvement. Echoing the suggestion (Deacon, 2013; Greenberg, 2010; Kemp, Lickel, & Deacon, 2014), that the story we tell about suffering can change the experience of it, participants' newfound agency in the context of their very treatment can be viewed as a sign of greater self-efficacy, control, and capability (Anderson et al., 2015; Brijnath & Antoniades, 2016; Grime & Pollock, 2003; Karp, 1993; Leydon, Rodgers, & Kendrick, 2007; Taussig, 1980).

Malpass et al.'s (2009) comprehensive meta-ethnographic analysis of people's experiences of taking antidepressants found multiple themes which in many respects echo our participants' accounts. Among the studies reviewed, many identified aspects similar to those seen in our trajectory, including: recognition that something is seriously wrong and that one's own coping resources are not working; feelings of loss of control; avoiding pharmaceutical treatment owing to fears of stigma; trial and error in prescribing; taking back control through experimentation with dosages or stopping antidepressants; and the great significance of the tone of the first consultation with a physician in terms of acceptance of help. Furthermore, Malpass et al. characterise patients' ambivalence – and agency – as springing from a constant process of "lay evaluation" which privileges experiential knowledge and judges outcomes according to individual definitions of function rather than clinical improvement (Malpass et al. 2009, p. 161).

Themes of trust and rapport with physicians are also frequently referenced in the qualitative literature as helpful in mitigating the uncertainty and ambivalence involved in help seeking. Anderson et al. (2015) identified shared decision-making and respect for the beliefs, opinions, and expertise of patients as critical to successful medical treatment of depression, again especially at the first consultation with the physician. As had been remarked by Stoppard and Gammell (2003), receipt of a doctor's prescription is seen as legitimating suffering but again, stigma as well as questions of losing one's authentic self, complicates acceptance (Anderson et al., 2015).

Study participants' reactions to biological treatment likewise varied from mixed at best, to skeptical and even avoidant. Participation in treatment was a process marked by ambivalence and verbal and non-verbal negotiation with physicians; resistance, in the form of non-cooperation, was openly acknowledged by two persons and may also have been on the minds of other participants who described wrestling with decision making regarding medication. Pharmacological treatment itself was described all around as being plagued by multiple unpleasantries, including intolerable side-effects both physiological and psychological – for example, suicidal ideation; distressing withdrawal symptoms upon even one missed dose, and frustration with the arguably imperfect trial-and-error process of matching product to consumer. Ultimately, many concluded in hindsight that antidepressant medications had functioned essentially as an adjunct to the work of recovery done on other levels, and that the difference-makers identified as most conducive to meaningful recovery were for the most part interpersonal, on social and psychological levels. In the words of some study participants, medication was at best a "tradeoff" of mood improvement for side-effects, capable of relieving emotional pain and "helping you over that hump" – but unable in and of itself to build any aspect of a foundation of hope, value, meaning, or social support. Grime and Pollock also report views of antidepressants as a cushion or safety net which serves to restore energy for recovery (Grime & Pollock, 2003). Both Leydon, Rodgers, and Kendrick (2007) and Verbeek-Heida and Mathot (2006) found that participants expressed confusion as to whether medications were truly helping them, or other factors were, or whether they were experiencing a placebo effect (Verbeek-Heida & Mathot, 2006). In all of the above studies, the multiple unpleasant side-effects of antidepressants came up as significant barriers to medical care.

Consistent with our findings regarding therapeutic relationships, however, physicians for the most part seemed accepting toward people's ultimate rejection of medications, were not reported to balk or become defensive at such striving for self-determination and choice, and in some cases were observed to work in concert with their patients to safely taper them off. It can be speculated that physicians' responses hint at a complex understanding of medical therapeutics which is not commonly articulated in authoritative psychiatry literature nor in the popular discourse. We shall analyse this question further in our Discussion, which returns to the critical notion of conceptual understandings and their philosophical underpinnings.

Professional helping relationships. Strongly related to the negotiation of ambivalence, for many, was the interpersonal aspect of health care in all its complexity. In different ways, all participants emphasised how critically important the human dimensions of the therapeutic relationship had been for them – namely empathy, validation, the instillation of hope, and appreciation of life contexts and goals and values and the subsequent integration of these into the professional response. The continuity of the relationship was also felt by many to bear positively on the outcome.

Gender, again, is relevant here as well. The value ascribed by three female study participants to having worked with female family physicians, and these physicians' apparent willingness to listen, to consider context, and to use non-medical interventions, sounds a somewhat positive clinical note in the unresolved debate surrounding the enormous gender disparity in the epidemiology of depression. On the other side of the same coin, two of the men expressed appreciation for male doctors whom they saw as hopeful and empathic.

The qualitative aspects of the therapeutic alliance between patient and physician, and the tremendous effect of these on outcomes, arose entirely unforeseen from the data; this was a surprise given that the common characteristic used to screen participants for this study had been simply the experience of having taken prescription antidepressant medication.

Some qualitative research exists into family physicians' experiences of patients presenting with depressive symptoms, the majority of it from the United Kingdom (Macdonald et al., 2009; Maxwell, 2005; see also the systematic review by Schumann et al., 2012). A study by Maxwell (2005) sought perspectives from both family physicians and female patients, and also problematised and left undefined the concept of depression. The findings outlined two dilemmas in the primary care setting: physicians felt caught in prescribing medication for what they saw as essentially social and economic problems, while from the patients' perspectives, women expressed fears of medication, and largely wished to avoid taking them – but were persuaded to seek help for the sake of others who depended on them in work and family roles (Maxwell, 2005). Interviews with physicians in Scotland by Macdonald et al. (2009), similarly, found clinicians who reported feeling caught up in increased prescribing and felt pressure to respond to their clients' presented needs in some way; this tended to take the form of prescription of antidepressants, even though physicians appreciated the part social circumstances seemed to play in their patients' mood distress.

In perhaps a more extreme case of Macdonald's findings, Salazar-Fraile, Sempere-Verdú, Mossakowski, and Page (2010) found a quite different experience in a study of primary care practice in Spain. Through interviews with both patients and physicians in a walk-in clinic, they discerned a picture of overworked doctors, not well supported by administrators in their clinical decision-making, feeling the weight of patient expectations – which they found they could only manage by "giving in" to demands for antidepressant medications, given their inability to provide more comprehensive care in the setting. For their part, although patients talked at length about the social causes of their distress, they nonetheless identified with popular biomedical discourses expressed by acquaintances and by advertising (Salazar-Fraile et al., 2010).

Physician perspectives as sketched in these studies reveal telling philosophical tensions and highlight some aspects of health care policy as it affects professional practice. We shall explore these divergences further in our Discussion. But it already seems clear from the data that by and large, our participants' primary care physicians and psychiatrists laid a safe groundwork for Brijnath and Antoniades' (2016) "games" of learning the rules and breaking them in order to exercise agency and reclaim self-determination as part of the recovery process.

Kendler's multifactorial model: Reevaluation. In our review of the literature, we had explored such dissenting perspectives as Meyer's and Engel's espousals of a biopsychosocial model, which, while not wholly discredited, seems today to play no appreciable part in informing the theoretical structure of psychiatry. The “explanatory pluralism” of Kendler’s multifactorial model was offered as a promising line of inquiry which abrogates nothing of the edifice of psychiatry, yet goes a long way toward transcending its reductionism by advocating for a new appreciation of context, acknowledgement of multiple layered and interacting causal processes and “difference-makers,” and a pragmatic focus on intervention at the optimal level(s). But in consideration of our findings, to what extent does such a model help account for individuals’ lived experience, and in what ways might it fall short?

Kendler certainly gives due attention to gender and gendered experiences. Using sophisticated statistical methods such as structural equation modelling, Kendler’s genetics research finds significant sex differences in the ætiologic pathways leading to the diagnosis of major depression (see for example, Kendler and Gardner, 2014; Kendler & Gardner, 2011); these include early experiences such as low parental warmth. Testing of the classic question of social causation *versus* social drift has even been possible, with the evidence coming down squarely in favour of social causation of depression (Mezuk, Myers, & Kendler, 2013; Kendler & Gardner, 2011). Stressful later life events factor prominently among the causal difference-makers identified in the genetics studies (for example, Kendler, Karkowski, & Prescott, 1998), although the authors’ identification of personality variables such as “neuroticism” – measured by a personality questionnaire – as significant mediators (Kendler and Gardner, 2014) is troubling, because this would suggest continued adherence to medical-model-driven positivist assumptions as well as a failure to problematise typically gendered concepts – of which “neuroticism” is arguably one.

Moreover, Kendler’s model, while nominally nondualist, fails to account for the inter-subjectivity which our analysis found so critical to the clinical encounter. There is no room in his multifactorial model for the interplay between the presenting individual and the more or less engaged professional, much less between the individual subject and the societal discourse. It would appear that Kendler’s research, like most work in mainstream psychiatry, is not informed by Foucault’s perspectives, and this restricts to some extent its power to effect meaningful change in health care.

Kendler’s work appears promising in that it allows space for myriad interacting contextual factors within a scientific paradigm that appears to have acceptance among the psychiatric establishment, but it remains rooted in the medical model view of the individual as the locus of pathology and *DSM* diagnosis as an unchallenged truth which precedes considerations of discourse and culture. Recognition of the roles of risk factors such as adverse childhood experiences and stressful life events is an important first step, but a truly multifactorial model of human affective distress would give greater recognition to a quite possibly lengthy chain of causation with proximal and distal causes equally deserving of attention, and might inquire more deeply and broadly into social structures, gender roles, and what might be driving power dynamics (Krieger, 2001; Schwartz, 1994). Seen from such an angle, findings from our study on the perceived roles of difference-makers such as domestic violence, differential parenting, and stressful life events can be seen as possibly stemming from upstream determinants, with intervention at those levels being likely more effective in the grand scheme (Link and Phelan, 1995; Schwartz, 1994) than the individual-level psychiatry still advocated uncritically by the Kendler model.

Theory – practice discrepancy. Our three original research questions interrelate theoretically. Understandings of the ætiology of emotional distress, and recovery from it, could be said to stem from one's concept of what the phenomenon is in the first place. If we take a positivist view of nature as static and objectively knowable, accept mind-body dualism, and privilege biology and the "expert" over individual subjectivity, we will logically conclude that human affective distress rests in the individual as a reified condition which can be defined in medical terms and which can be targeted with "magic bullet" treatments. If, on the other hand, we defer selection of the level on which to best understand the phenomenon (as, for instance, genetically determined, or chemically, or psychologically, or socially, or culturally, or structurally), recognise power imbalances including gender inequality, and acknowledge the inseparability of observer and observed, of helper and helpee, of patient and physician, we may arrive at a truly multifactorial-contextual conceptualisation of emotional suffering. Such an understanding would lead us then to pay attention not only to biology but to the complex swirl of human factors and processes involved in the negotiation of the recovery of health in the broadest sense of that term. This may come across as so much naïve academic idealism; however, in many respects this vision is already here, albeit unarticulated, hiding in plain sight in the study data.

If concept is key, we must begin with language. In order to bracket the biomedical discourse, we had set out to avoid the word 'depression' with its connotations of a static, knowable, medical entity with a medical cure, offering 'human affective distress' as a placeholder. On the surface, participants' use of language in their accounts of concept suggests a wholesale embrace of the contemporary medical concept of the affective distress phenomenon, but closer examination reveals much deeper understanding all around. Although for the most part participants did simply use the word "depression," they added rich detail about the complexity of the experience, as we have seen. Ultimately, the author's careful problematising of the language was irrelevant to actual experience; people simply seemed to feel it more important to discuss the substance rather than the label; similarly, the issue of diagnosis was either given a cursory answer, with reported emotional reaction at the time but little added meaning in hindsight, or was skirted entirely. It would appear that the problems suggested in the review of the literature, including medicalization, the questions of labelling, "met unneed," and over-prescription had little traction on the hard ground of day-to-day reality – for these nine people in this province at this time, anyway.

If not in the language, then, how does the subjective and interpersonal – the human – make its way into primary and specialist medical practice, as was reported by study participants in their accounts of effective working relationships with health care professionals? Anthropologist Michael Taussig, in a classic 1980 paper, identified the discrepancy between relationship and reification, "the thingification of the world, persons, and experience." Quoting the Marxist historian and writer Georg Lukács' 1922 essay on the subject, Taussig finds that "a relation between people takes on the character of a thing and thus acquires a 'phantom objectivity', an autonomy that seems so strictly rational and all-embracing as to conceal every trace of its fundamental nature: the relation between people" (Lukács, 1922, cited in Taussig, 1980, p. 3). Taussig proceeds to submit to rigorous analysis the way in which the semiotics of symptoms, signs, and therapy become crystallised into facts through the use of naturalistic terms which will be familiar to anyone who works in health care: “subjective” and “objective” data, physicians’ “orders,” and non-reciprocal “monitoring.” Human relational and phenomenological experience, according to Taussig, is categorised and interpreted by medicine into data, diagnosis, and treatment, with the power to define and delimit at each step being held by the professional. The inability of the patient and healer to resolve the ensuing contradictions and to harness the power of their social relationship toward the end of healing and not control results in alienation and resistance (Taussig, 1980). Taussig’s conclusion is pessimistic because it comes down on the side of reification as inevitable. Our study participants, by and large, drew a different conclusion. Is there another, more validating but still clinical, way for professionals to be with their patients?

This question touches on a much greater epistemological, and ancient, conversation within medicine itself, that of the juxtaposition of ‘hard’ science and ‘soft’ human factors in medicine; or, as George Engel presciently framed it in a 1992 paper, the complementarity of the *observational* and *relational* modes of inquiry in the doctor-patient encounter – the former addressing readily observed data, and the latter “the uniquely human realm of articulated language, symbols, thoughts and feelings” which have meaning for the patient as well as for the other levels of the natural hierarchy of the organism’s organisation (Engel, 1992, p. 7). Although this discussion is vast and therefore beyond the scope of this paper, for our purposes let us note here that Engel acknowledges the role played by Descartes’ “mechanism, reductionism, determinism, and dualism" in the rejection of "what is distinctively human from the realm of science" (Engel, 1992, p. 6). Engel proposes a more comprehensive view based on inclusion of the observer in the clinical or scientific encounter. He eschews the idea of the "art" of medicine as an afterthought to the science, advocating instead for inclusion of both the relational and the biological – the qualitative and the quantitative – as equal partners in good scientific method and therefore good clinical practice.

Engel's vision rings true in reading our study participants' accounts of the help they received from physicians. Where empathy, optimism, validation – of the experience, the context, and the goal – and willingness to listen within an ongoing relationship were perceived, these physician attributes were valued and viewed as paying great dividends in recovery. It seems that all nine participants, once they had negotiated trust in either a family physician or psychiatrist, felt they received much more than mechanistic biomedical care. In Engel's rendering of what we termed above the negotiation of ambivalence in the recovery trajectory, "a patient comes for help because he is experiencing something strange, different, discomforting, or disabling which he does not understand and/or does not know how or feel able to handle by himself" (1992, p. 10). In making the decision to seek medical help, the patient considers first, the competence of the physician; and second,

> "…the expectation, or at least the hope, that the physician will be understanding and that he, the patient, will feel understood. Thereby is the patient motivated to relinquish autonomy and share privacy, often to a degree greater than may be true of almost any other human relationship" (Engel, 1992, pp. 10-11).

Engel goes on to frame this trust in terms of our “complementary and basic human needs… the *need to know and understand* and the *need to feel known and understood*” as derived by evolution (p. 10, emphasis in original), thus placing both the human need to seek help and the caring urge to help in the broadest possible paradigm, but a scientific paradigm nonetheless.

Lipowski, too, in arguing against the reductionist poles of “brainless” and “mindless” psychiatry, in 1989 challenged his profession to find ways of unifying the subjective and the objective, and the psychological, biological, and social as non-mutually-reducible and equally valued aspects which form the proper focus of inquiry and intervention (Lipowski, 1989). (To these we would add the cultural and structural.) Five of our study participants reported having seen at least one psychiatrist, and the extent to which these encounters were helpful seemed in participant accounts to be strongly linked to validation of the individual in context, along with empathy, hope, and the relationship being an ongoing one. From these findings we may take heart that to least some extent, clinical practice in Manitoba seems to have integrated such thinking as that advanced by Engel for general practice and Lipowski for psychiatry.

We are left with the theoretical tug-of-war between biomedicine and the recovery orientation which was mentioned above. Patient and physician are caught between Taussig’s reification and Engel’s orphaned relational mode, between scientific medicine and the recovery model. But in the nine examples considered here, meaningful resolution of these tensions appears to have been achieved in large degree, somehow, through dialogue, mitigation of power imbalances, and respectful acknowledgement of agency and self-determination. What could account for this apparent stepping outside of the biomedical discourse?

The systematic review by Schumann et al. (2012) of qualitative studies into primary care physicians' processes in diagnosing depression confirms much of our discussion. Their analysis found that a majority of European, UK, and American family physicians in multiple studies perceived the causes of their patients' emotional distress as a reaction to stressful social circumstances or due to other illnesses. While still making the diagnosis of distress as depression, physicians perceived this condition to be an expectable response in normal people facing overwhelming problems. Conversely, "Only a minority of FPs [family physicians] saw depression as a reaction to a biochemical imbalance especially when depression could not be attributed to events in their patients' lives" (Schumann et al., 2012, p. 258). A tension was noted between recognition of the medicalised discourse in the form of checklists and guidelines, and broad acknowledgement of individuals' circumstances (Schumann et al., 2012). Although this review does not explicitly address power dynamics, it seems to support our conclusions. And again to credit physicians, none of our study participants reported having heard "chemical imbalance" as the causal explanation for their distress.

The Schumann (2012) review, along with other qualitative inquiries into the physician experience (for example, Macdonald et al., 2009; Maxwell, 2005), also echoes our findings on building rapport and familiarity with the person and their life circumstances, and regarding ambivalence and negotiation. Physicians emphasised the importance of the establishment of trust and time as essential to the diagnostic process, and spoke of making a global consideration of not only how the person is functioning but also of exploring patients’ potential responses to a depression diagnosis before pronouncing as such (Schumann, 2012). Family physicians were aware of their patients’ reluctance to admit to emotional symptoms, to accept diagnosis, and to start and then also continue treatment; many identified handling of patient preferences and resistance as a task best approached carefully and respectfully, and with self-awareness and intuition. Primary care physicians questioned the validity of the *DSM* diagnostic concept, and perceived mere symptom counts as too narrow an understanding for their more contextually oriented clinical practice; indeed, some doctors included in the studies remarked on the usefulness of symptom checklists only as a tool to facilitate conversations with their patients (Schumann, 2012). Practically speaking, family physicians seemed to feel that exact diagnosis was of less importance than assessment of functioning in the person’s environment and then respectfully negotiating an acceptable course of action, which could include watchful waiting (Schumann et al., 2012). These authors conclude that uncritical acceptance of a ‘gold standard’ of psychiatric interviews according to an algorithm does not make sense in primary care; family physicians use different heuristics, which are particular to their practice settings (Macdonald et al., 2009; Maxwell, 2005; Schumann et al., 2012). In summary, it seems that physicians eschew medicalization, understand and appreciate context, feel some frustration with the limitations of their role, and prefer to do what experience and practical wisdom has shown to work. This paints a quite different picture from the understanding one might obtain from reading the *DSM* or from watching direct-to-consumer advertising for pharmaceutical products.

In the best of all worlds, the tug-of-war is settled quietly. People experience irresolvable distress which has multifarious roots but which consists in large part of a sense of powerlessness. The context may entail social or gender-related or vocational or economic or any of a thousand other causes, but in accordance with our culture’s discourse around this, the suffering is nonetheless localised in the individual, and so individuals present to physicians. These fulfil the complex tripartite roles of legitimator, healer, and supporter. But the legitimation risks communicating stigma, loss of agency, and even further erosion of self-concept and authenticity. And the healing on offer is through means plagued by unwanted unpleasant effects and which are external to the patient, which again reinforces powerlessness. No wonder, then, that patients respond with ambivalence, an ambivalence further compounded by the confusion wrought by the emotional distress which started it all in the first place. A reified concept of the problem could never hope to solve a puzzle involving such dynamics. But if both can play skilfully with the contradictions raised by the philosophical gulf between them, respect agency even if this means stepping outside of the dominant cultural narrative, and keep a hopeful yet grounded eye on the outcome, the power in each can indeed be harnessed toward the end of healing and not alienation and control.

8. Strengths and Limitations

Our study is unique in its problematising of the psychiatric concept of human affective distress or depression while exploring the perceived causal factors involved in the lived experience and recovery. Although the question of conceptual understanding was largely met with surface responses reflecting the mainstream language, participants nonetheless availed themselves of the time and space which were opened up to provide rich descriptions of their experiences.

Care was taken to ensure rigour in methodology. Consistent with Wieck's (2007) standard of requisite variety, the author brought clinical skills honed through years of experience with diverse clientele to the interview situations, but was careful to not take on the therapist role or to lead participants. The question of whether participants were still taking antidepressant medication at the time of study participation was purposely phrased neutrally and was asked in an unbiased manner; this allowed participants to express their own opinions of medication.

It must be recognised that such qualitative study is by most definitions an interpretive process; another researcher could well have produced different findings. The author reflected on his positionality as a mental health clinician working in the same community where the research took place, and took care to consider how this position holds power and produces and reproduces discourses, values, and interests (Lupton, 1995). An epistemological position of critical realism, or soft constructionism, was borne in mind throughout the course of the research. Transparency of methods was further ensured through ongoing discussion with the thesis advisor, use of a reflective journal to keep track of conceptual thinking and the research process, and abundant use of direct quotes in the Findings section.

Although the sample of volunteer participants was diverse in many respects, in others it did not capture adequate representation from the particular groups identified in our review of the descriptive epidemiology – for example, those who experience low income, unemployment, or under-employment, or chronic health conditions. Three individuals reported precarious employment and financial stress at the time of their experiences of affective distress; however, for one this had improved in recent years. Only one person reported a diagnosis of a chronic health condition. One spoke of recurring troubles with finding and maintaining adequate housing. However, all participants had at least some post-secondary education. More purposive sampling of individuals affected by poverty and marginalisation – for example, by targeting particular geographic areas – might have yielded greater diversity and richer perspective on these likely significant difference-makers. Gender was given emphasis in the analysis because, of the demographic descriptors associated with depression, it was expected to be – and was indeed – the most readily available comparator.

This qualitative study recruited participants using materials which clearly used the word “**RECOVERY**” in the title. This resulted in a particular sample of persons who had lived experience of depression, but identified as recovered. Qualitative research cannot determine whether such persons attained their well-being through the means described or because of some pre-existing characteristic or characteristics they may have shared; for example, it was not lost on the investigator that seven of the nine who enrolled were professionals with post-secondary education. Consideration of the impact of our findings and conclusions must take the uniqueness of this sample into account. That said, because language is critical to conceptual understandings, the precise wording of recruiting materials in qualitative research in this field would appear to bear greatly on variety in sampling. It should be common practice to spell this out in the Methods sections of qualitative papers (as an example, Anderson et al., 2007 do not address specific methods of recruiting).

9. Implications

As to practical implications of our conclusions, first would be simply to validate the efforts of primary care physicians and psychiatrists who daily meet the needs of their emotionally distressed patients with optimism, empathy, and respect for autonomy, and who are able to prioritise the carefully assessed needs of patients over any predetermined pharmaceutical or scientific hegemony. Even where client agency takes the form of discontinuing treatment, in our study, physicians appear to have met such resistance with respect and an apparent attitude of standing side-by-side to look at the situation rather than the confrontational exercise of power bestowed through narrow interpretations of science. Such relationships, while they take time and energy to cultivate, seem to be treasured on both sides. It is to be hoped that health care funding and administrative structures in Canada will continue to recognise the value of this privilege and not fall prey to any temptation to reduce human affective distress and the therapeutic relationship to mere checklists and algorithms. The study by Salazar-Fraile, Sempere-Verdú, Mossakowski, and Page (2010) of physicians and patients in Spain sounds a cautionary note, and points out a paradox: Physicians not empowered by their administrative structures lack the power to in turn fully care for their patients whose demands are inordinately influenced by advertising and popular discourse.

To stay with medical care for a moment, the meta-ethnography by Malpass and colleagues offers an intriguing conceptual framework with likely practicable implications for clinicians. These authors propose several time points in the trajectory when opportunities for shared decision-making present themselves, and argue that if physicians can be aware of patients' competing considerations at each juncture, greater likelihood of "concordant relationships" will result (Malpass et al., 2009). In contrast to our finding of participants taking shared responsibility for the therapeutic relationship, Leydon, Rodgers, and Kendrick advocate for physicians actively pursuing ongoing consultation with their depression patients, rather than leaving the responsibility for contact with the patient (Leydon, Rodgers, & Kendrick, 2007). Overall, our study, together with the works cited above, points toward three main recommendations: (1) acknowledgement by physicians of the many questions and grounds for ambivalence which emotionally distressed individuals face at the various points in their trajectories, especially initially; (2) shared decision-making and respect for the beliefs, opinions, and expertise of patients, in the context of therapeutic relationships marked by continuity, hope, empathy, and consideration of history and context; and (3) integrated yet multi-pronged approaches to intervention which respect choice and agency.

In terms of the health care system and policy, access to a broad range of resources for recovery appears indicated. In myriad ways, the people in our study brought home the message that they had experienced something with no single origin and no single remedy. Yet primary care physicians lack the resources to fully address this multiplicity (Macdonald et al., 2009; Maxwell, 2005; Sareen, Cox, & Afifi, 2005), and would benefit from better integration of services which take a variety of approaches.

Among the difference-makers which participants valued were counselling, self-help organisations, and spiritual practices and spiritual community – to say nothing of caring friends and family, stable housing, exercise and nutrition, and employment at workplaces which are flexible, non-stigmatising, and welcoming upon return to work. A systems approach to mental health services such as the one enjoyed in Manitoba, while not perfect, seems best positioned to continue to meet the identified needs, through such service models as Shared Care (Winnipeg Regional Health Authority, 2012) and access to brief therapy, among others; the funded agencies including the self-help organisations and community health centres are appreciated as an integral part of this system (Sareen, Cox, & Afifi, 2005). Women facing unacceptable circumstances such as domestic violence are helped by issue-specific expertise delivered through programming such as that offered at a community health centre.

An array of services means choice: the opportunity to exercise agency. It then follows that freedom of choice to accept treatment should also mean freedom to decline. The utility of *de rigeur* first line treatment with SSRIs, still firmly embedded in our culture, is called into question by this study and much other evidence besides. The presumption that all persons who present with affective distress comply with treatment with antidepressant medication becomes an unreasonable expectation when uncritically foisted by insurance companies and health care organisations.

Care must be taken, too, that recovery does not become a new imperative, a project again at the individual level. Fullagar and O'Brien (2014) caution that particular constructions of recovery can normalise 'truths' and expectations for change which colour the way individuals think and evaluate themselves; such prescriptive notions risk disempowering women when they find that they cannot easily change the gendered context of their lives. Their evidence suggests that women do not benefit from being given biochemical explanations for their socially produced generated distress. Situating recovery in a social perspective rather than a strictly individual one may avert the self-blame potential of the individualised vision of recovery (Fullagar & O'Brien, 2014; Lupton, 1995; O'Brien, 2014).

Following on this important *caveat,* and at the risk of stating the obvious, there is clearly a place in public health and education for prevention by addressing the well known 'distal' or 'upstream' causal difference-makers for depression. Continued efforts to name, address, and ultimately reduce or eliminate such preventable causes as poverty, childhood abuse and neglect including sexual abuse, and gender inequality and racial/structural inequality will reduce human suffering and the need to medicalize it. Simple screening for things such as work stress, relationship breakdown, and domestic violence may bear much more therapeutic fruit than do impersonal screening programmes for symptoms of depression (Horwitz & Wakefield, 2007).

We had heard in our review of the literature on depression a warning from Kendler that no one level of explanation would emerge as obvious or broadly agreed upon, and that no level of difference-maker could be prioritised above any other. But in acknowledging process factors, in honouring our participants' trajectories, ambivalence, and processes of negotiation and coming to terms with their situations, we add another dimension, a human-relations dynamic, to our original multifactorial-contextual model.

Finally, we have made the argument that our conceptual understanding of human affective distress needs to evolve. Our analysis stands on a body of inductively derived evidence pointing toward a new way of thinking about mental health and on theoretical discussion which in many ways fits a critical realist ontology, a kind of soft constructionism which respects existential fact but does so in the context of cultural and individual experience.

There is some evidence that the discourse and popular perceptions around depression are already changing to reflect the irreducible nature of the phenomenon. To cite one high-profile example, the World Health Organization's new *Depression Fact Sheet,* with accompanying video, acknowledges the complexity and multifactorial nature of depression in terms of both ætiological and treatment considerations, advocates attention to non-psychiatric factors such as diet, exercise, and social supports, and advises against pharmacological treatment as a first-line approach for mild presentations (World Health Organization, 2016). If a more hopeful and compassionate message which is respectful of context and complexity begins to reach those who contemplate engagement with the health care system for reasons of emotional distress, and if health professionals uphold it, the uncertainty surrounding help-seeking may resolve more often in favour of recovery. Further qualitative research into the cognitive processes of help-seeking, such as that begun by Malpass and colleagues (2009), could extend this knowledge.

A conceptual understanding of “depression” should privilege epistemological humility, context, and relating over dualism, reification, and seventeenth century reductionist science. Our study suggests that such an understanding has partially arrived. It remains only to make it explicit by incorporating it into psychiatric theory, model of practice, and medical education. If the authoritative theory can first acknowledge itself as a theory; second, incorporate social context; and third, accommodate process factors, then public awareness and popular discourse could well follow suit.

References

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal, 16* (4), 11-23.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, 5th ed.* Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders, 3rd ed.* Washington, D.C.: American Psychiatric Association.

American Psychiatric Association. (1952). *Diagnostic and Statistical Manual of Mental Disorders.* Washington, D.C.: American Psychiatric Association.

Anderson, C., Kirkpatrick, S., Ridge, D., Kokanovic, R., & Tanner, C. (2015). Starting antidepressant use: A qualitative synthesis of UK and Australian data. *British Medical Journal Open,* 5, 1-9.

Bassett, E., & Moore, S. (2013). Gender differences in the social pathways linking neighbourhood disadvantage to depressive symptoms in adults. *PLOS ONE, 8* (10), e76554.

Batstra, L. & Frances, A. (2012). Holding the line against diagnostic inflation in psychiatry. *Psychotherapy and Psychosomatics, 81,* 5-10.

Beck, A.T. (2005). The current state of cognitive therapy: a 40-year retrospective. *Archives of General Psychiatry, 62,* 953-959.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* London: Sage.

Brijnath, B., & Antoniades, J. (2016). Playing with antidepressants: Perspectives from Indian Australians and Anglo-Australians living with depression. *Qualitative Health Research, June 16,* 1-12.

Brown, R.L., Leonard, T., Papasouliotis, O., & Saunders, L.A. (2001.) A two-item screening test for alcohol and other drug problems. *Journal of Family Practice, 44* (2), 151.

Camus, A. (1970). *Lyrical and critical essays.* New York: Vintage.

Caron, J., & Liu, A. (2010). A descriptive study of the prevalence of psychological distress and mental disorders in the Canadian population: Comparison between low-income and non-low-income populations. *Chronic Diseases in Canada, 30* (3), 84-94.

Conrad, P., & Barker, K.K. (2010). The social construction of illness: Key insights and policy implications. *Journal of Health and Social Behavior, 51* (S), 67-79.

Conrad, P. (2005). The shifting engines of medicalization. *Journal of Health and Social Behaviour, 46,* 3-14.

Deacon, B.J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*, 846-861.

Dowrick, C., & Frances, A. (2013). Medicalising unhappiness: New classification of depression risks more patients being put on drug treatment from which they will not benefit. *British Medical Journal, 347:*f7140.

Duncan, B.L., Miller, S.D., & Sparks, J.A. (2004). *The heroic client : A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy.* San Francisco: Jossey-Bass.

Engel, G.L. (1992). How much longer must medicine's science be bound by a seventeenth century world view? *Psychotherapy and Psychosomatics, 57,* 3-16.

France, C. M., Lysaker, P.H., & Robinson, R.P. (2007). The "chemical imbalance" explanation for depression: Origins, lay endorsement, and clinical implications. *Professional Psychology: Research and Practice, 38,* 411-420.

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life.* New York: Morrow.

Foucault, M. (1989). *The birth of the clinic: An archaeology of medical perception.* Sheridan, A.M., trans. London: Routledge. (Originally published 1963.)

Foucault, M. (1978). *History of sexuality. Volume I: An introduction.* Hurley, R., trans. New York: Vintage.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason.* New York: Pantheon.

Fullagar, S., & O'Brien, W. (2014). Social recovery and the move beyond deficit models of depression: A feminist analysis of mid-life women's self-care practices. *Social Science & Medicine, 117,* 116-124.

Goldstein, J.M., Holsen, L., Handa, R., & Tobet, S. (2014). Fetal hormonal programming of sex differences in depression: Linking women's mental health with sex differences in the brain across the lifespan. *Frontiers in Neuroscience, 8,* 1-8.

Good, B., & Kleinman, A., eds. (1985). *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder.* Berkeley: University of California Press.

Greenberg, G. (2010). *Manufacturing depression: The secret history of a modern disease.* New York: Simon and Schuster.

Grime, J., & Pollock, K. (2003). Patients' ambivalence about taking antidepressants: A qualitative study. *Pharmaceutical Journal, 271* (7270), 516-519.

Hemels, M., Koren, G., & Einarson, T.R. (2002). Increased use of antidepressants in Canada: 1981-2000. *Annals of Pharmacotherapy,.36* (9), pp.1375-9.

Horwitz, A.V. (2007). Transforming normality into pathology: The *DSM* and the outcomes of stressful social arrangements. *Journal of Health & Social Behaviour, 48,* 211-222.

Horwitz, A.V. (2002). *Creating mental illness.* Chicago: University of Chicago Press.

Horwitz, A.V., & Wakefield, J.C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder.* New York: Oxford.

Jackson, S. (1986). *Melancholia and depression.* New Haven: Yale.

Jacob, K.S. (2012). Depression: Disease, distress, and double bind. *Australian & New Zealand Journal of Psychiatry, 47* (4), 304-308.

Karp, D. (1993). Taking anti-depressant medications: Resistance, trial commitment, conversion, disenchantment. *Qualitative Sociology, 16* (4), pp. 337-359.

Kemp, J.J., Lickel, J.J., & Deacon, B.J., (2014). Effects of a chemical imbalance causal explanation on individuals' perceptions of their depressive symptoms. *Behaviour Research and Therapy, 56,* 47-52.

Kendler, K. (2012a). Levels of explanation in psychiatry and substance use disorders: Implications for the development of an etiologically based nosology. *Molecular Psychiatry, 17,* 11-21.

Kendler, K. (2012b). The dappled nature of causes of psychiatric illness: Replacing the organic-functional/hardware-software dichotomy with empirically based pluralism. *Molecular Psychiatry, 17,* 377-388.

Kendler, K. (2005). Toward a philosophical structure for psychiatry. *American Journal of Psychiatry, 162* (3), 433-440.

Kendler, K.S., & Gardner, C.O. (2014). Sex differences in the pathways to major depression: A study of opposite-sex twin pairs. *American Journal of Psychiatry, 171* (4), 426-435.

Kendler, K.S., & Gardner, C.O. (2011). A longitudinal etiologic model for symptoms of anxiety and depression in women. *Psychological Medicine, 41,* 2035-2045.

Kendler, K.S., Karkowski, L.M., & Prescott, C.A. (1998). Stressful life events and major depression: Risk period, long-term contextual threat, and diagnostic specificity. *Journal of Nervous and Mental Disease, 186* (11), 661-669.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R., Rush, A.J., Walters, E.E., & Wang, P.S. (2003). The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association, 289* (23), 3095-3105.

Kleinman, A. (1988). *Rethinking psychiatry.* New York: Macmillan.

Krieger, N. (2008). Proximal, distal, and the politics of causation: What's level got to do with it? *Government, Politics, and Law, 98*(2), 221-230.

Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology, 30,* 668-677.

Leydon, G.M., Rogers, L., & Kendrick, T. (2007). A qualitative study of patient views on discontinuing long-term selective serotonin reuptake inhibitors. *Family Practice, 24,* 570-575.

Link, B.G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior,* Extra Issue, 80-94.

Lipowski, Z.J. (1989). Psychiatry: Mindless, brainless, both, or neither? *Canadian Journal of Psychiatry, 34*, 249-253.

Lukács, G. (1971). Reification and the class consciousness of the proletariat. In *History and Class Consciousness,* pp. 8-222. London: Merlin.

Lupton, D. (1995). *The imperative of health: Public health and the regulated body.* London: Sage.

Lupton D. (2003). *Theoretical perspectives on medicine and society.* London: Sage.

Macdonald, S., Morrison, J., & Maxwell, M., et al., (2009). ‘A coal face option’: GPs’ perspectives on the rise in antidepressant prescribing. *British Journal of General Practice, Sept 2009.*

Malpass, A., Shaw, A., Sharp, D., Walter, F., Feder, G., Ridd, M., & Kessler, D. (2009). “Medication career” or “moral career”? The two sides of managing antidepressants: A meta-ethnography of patients’ experience of antidepressants. *Social Science & Medicine, 68,* 154-168.

Manitoba Health, Healthy Living and Seniors. (2011). *Rising to the challenge: A strategic plan for the mental health and well-being of Manitobans.* Available:

http://www.gov.mb.ca/healthyliving/mh/docs/challenge.pdf. Accessed 21 August 2016.

Mansfield, P.R., Mintzes, B., Richards, D., & Toop, L. (2005). Direct-to-consumer advertising. *BMJ, 330,* 5-6.

Maxwell, M. (2005). Women's and doctors' accounts of their experiences of depression in primary care: The influence of social and moral reasoning on patients' and doctors' decisions. *Chronic Illness, 1,* 61-71.

McMullen, L.M. (2003). "Depressed" women's constructions of the deficient self. In Stoppard, J.M., & McMullen, L.M., eds. *Situating sadness: Women and depression in social context.* New York: New York University Press.

Mezuk, B., Myers, J.M., & Kendler, K.S. (2013). Integrating social science and behavioral genetics: Testing the origin of socioeconomic disparities in depression using a genetically informed design. *American Journal of Public Health, 103,* S145-S151.

Mintzes, B. (2009). Should Canada allow direct-to-consumer advertising of prescription drugs? *Canadian Family Physician, 55,* 131-133.

Mintzes, B. (2002). Direct to consumer advertising is medicalising normal human experience. *British Medical Journal, 324,* 908-11.

Mintzes, B., Morgan, S., Wright, J.M. (2009). Twelve years' experience with direct-to-consumer advertising of prescription drugs in Canada: A cautionary tale. *PLOS ONE, 4* (5), e5699.

Mintzes, B., Barer, M., Lexchin, J., & Bassett, K.L. (2005). Introduction of direct-to-consumer advertising of prescription drugs in Canada: An opinion survey on regulatory policy. *Research in Social and Administrative Pharmacy, I,* 310-330.

Mojtabai, R., & Olfson, M. (2011). Proportion of antidepressants prescribed without a psychiatric diagnosis is growing. *Health Affairs, 30* (8), 1434-1442.

Mojtabai, R. (2008). Increase in antidepressant medications in the US adult population between 1990 and 2003. *Psychotherapy and Psychosomatics, 77,* 83-92.

Morse, J.M. (1994). Qualitative nursing research: A free-for-all? In Morse, J., ed. *Qualitative nursing research: A contemporary dialogue.* Newbury Park, CA: Sage.

Moynihan, R., & Cassels, A. (2005). *Selling sickness: How the world's biggest pharmaceutical companies are turning us into patients.* Vancouver: Douglas & McIntyre, 2005.

Nolen-Hoeksema, S. (1987). Sex differences in unipolar depression: Evidence and theory. *Psychological Bulletin, 101* (2), 259-282.

O'Brien, W. (2012). The recovery imperative: A critical examination of mid-life women's recovery from depression. *Social Science & Medicine, 75,* 573-580.

Pagura, J., Katz, L.Y., Mojtabai, R., Druss, B.G., Cox, B., & Sareen, J. (2011). Antidepressant use in the absence of common mental disorders in the general population. *Journal of Clinical Psychiatry, 72* (4), 494-501.

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology.* New York: Routledge.

Patten, S.B., Williams, J., Lavorato, D.H., Wang, J.L., McDonald, K., & Bulloch, A. (2012). Descriptive epidemiology of major depressive disorder in Canada in 2012. *Canadian Journal Of Psychiatry-Revue Canadienne De Psychiatrie, 60* (1), 23-30.

Patten, S.B., Wang, J.L., Williams, J.V.A., Currie, S., Beck, C.A., Maxwell, C.J., & El-guebaly, N. (2006). Descriptive epidemiology of major depression in Canada. *Canadian Journal of Psychiatry, 51,* 84-90.

Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future? *Journal of Mental Health, 11* (6), 585-594.

Public Health Agency of Canada, 2006). The human face of mental health and mental illness in Canada 2006. Available: http://www.phac-asp.gc.ca/ publicat/human _face_e.pdf/. Accessed 8 August 2014.

Salazar-Fraile, J., Sempere-Verdú, E., Mossakowski, K., & Page, J.B. (2010). 'Doctor, I just can't go on:' Cultural constructions of depression and the prescription of antidepressants to users who are not clinically depressed. *International Journal of Mental Health, 39* (1), 29-67.

Sareen, J., Cox, B.J., Afifi, T.O., Clara, I., & Yu, B.N. (2005). Perceived need for mental health treatment in a nationally representative Canadian sample. *Canadian Journal of Psychiatry, 50,* 643-651.

Scattolon, Y. (2003). "I just went on…. there was no feeling better, there was no feeling worse:" Rural women's experiences of living with and managing depression. In Stoppard, J.M., & McMullen, L.M. , eds. *Situating sadness: Women and depression in social context.* New York: New York University Press.

Schumann, I., Schneider, A., Kantert, C., Lowe, B., & Linde, K. (2012). Physicians' attitudes, diagnostic process and barriers regarding depression diagnosis in primary care: A systematic review of qualitative studies. *Family Practice, 29,* 255-263.

Seidler, Z.E., Dawes, A.J., Rice, S.M., Oliffe, J.L., & Dhillon, H.M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review, 49,* 108-118.

Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac.* New York: Wiley.

Spaniol, L.R., & Wewiorski, N.J. (2012). Phases of the recovery process from psychiatric disabilities. *International Journal of Psychosocial Rehabilitation, 17* (1).

Spaniol, L.R., Koehler, M., & Hutchinson, D. (1994). *The recovery workbook: Practical coping and empowerment strategies for people with psychiatric disability*. Boston: Centre for Psychiatric Rehabilitation.

Stainton Rogers, W., & Stainton Rogers, R. (1997). Does critical psychology mean the end of the world? In T. Ibáñez and L. Iñiguez (eds.), *Critical social psychology.* London: Sage.

Stoppard J.M., & Gammell, D.J. (2003). Depressed women's treatment experiences: Exploring themes of medicalization and empowerment. In Stoppard, J.M., & McMullen, L.M. , eds. (2003). *Situating sadness: Women and depression in social context.* New York: New York University Press.

Stoppard, J.M., & McMullen, L.M. , eds. (2003). *Situating sadness: Women and depression in social context.* New York: New York University Press.

Sunderland, A., & Findlay, L.C. (2013). Perceived need for mental health care in Canada: Results from the 2012 Canadian Community Health Survey–Mental Health. *Statistics Canada, Catalogue no. 82-003-X, Health Reports, 24* (9), 3-9.

Taussig, M.T. (1980). Reification and the consciousness of the patient. *Social Science & Medicine, 14* (B)*,* 3-13.

Thorne, S. (2008). *Interpretive description.* Walnut Creek, CA: Left Coast.

Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3* (1), 1-21.

Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20,* 169-177.

Tracy, S. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16* (10), 837-851.

Verbeek-Heida, P.M., & Mathot, E.F. (2006). Better safe than sorry – why patients prefer to stop using selective serotonin reuptake inhibitor (SSRI) antidepressants but are afraid to do so: Results of a qualitative study. *Chronic Illness, 2,* 133-142.

Ward, E.C., Mengesha, M.M., & Issa, F. (2014). Older African American women's lived experiences with depression and coping behaviours. *Journal of Psychiatric and Mental Health Nursing, 21,* 46-59.

Weissman, M. (2014). Treatment of depression: Men and women are different? *American Journal of Psychiatry, 171* (4), 384-387.

Wieck, K.E. (2007). The generative properties of richness. *Academy of Management Journal, 50,* 14-19.

Winnipeg Regional Health Authority. (2012). Shared Mental Health Care Program: Evaluation Report. Available: http://www.wrha.mb.ca/staff/familyphysicians/files/SC_Eval_May5-2012.pdf. Accessed 8 November 2016.

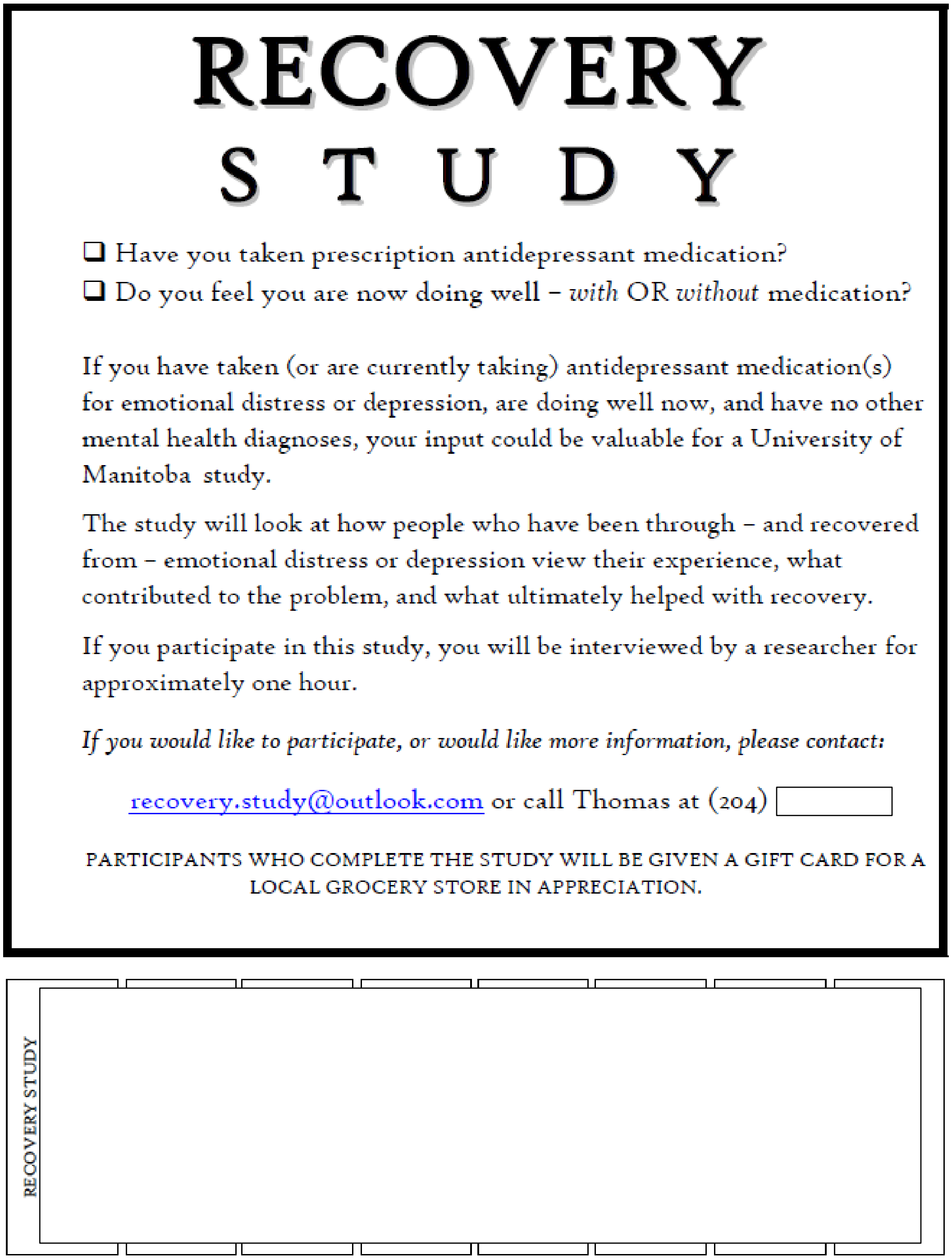
Winnipeg Regional Health Authority. (n.d.). *Adult mental health role statement.* Available: http://www.wrha.mb.ca/prog/mentalhealth/index.php. Accessed 21 August 2016.

World Health Organization. (2016). *Depression fact sheet.* Available: http://www.who.int/mediacentre/factsheets/fs369/en/. Accessed 22 August 2016.

WHO World Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental health disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association, 291* (21), 2581-2590.

Appendices

Appendix A: Recruiting Poster



RECOVERY STUDY

☐ Have you taken prescription antidepressant medication?
☐ Do you feel you are now doing well – *with* OR *without* medication?

If you have taken (or are currently taking) antidepressant medication(s) for emotional distress or depression, are doing well now, and have no other mental health diagnoses, your input could be valuable for a University of Manitoba study.

The study will look at how people who have been through – and recovered from – emotional distress or depression view their experience, what contributed to the problem, and what ultimately helped with recovery.

If you participate in this study, you will be interviewed by a researcher for approximately one hour.

If you would like to participate, or would like more information, please contact:

recovery.study@outlook.com or call Thomas at (204) ☐

PARTICIPANTS WHO COMPLETE THE STUDY WILL BE GIVEN A GIFT CARD FOR A LOCAL GROCERY STORE IN APPRECIATION.

Appendix B: Study Application Form and Screening Interview Guide

1. Study Application Form

Study identification number	
Gender	☐ M ☐F ☐ Other
Age group	☐ 18 to 25 ☐ 26 to 35 ☐ 36 to 45 ☐ 46 to 55 ☐ 56 to 65 ☐ Over 65 ☐ Refused
Neighbourhood in Winnipeg	
Household income, annual	☐ Under 20,000 ☐ 20,000-40,000 ☐ 40,000-60,000 ☐ 60,000-80,000 ☐ 80,000-100,000 ☐ 100,000-120,000 ☐ Over 120,000 ☐ Refused
Education level	☐ Less than Grade 12 ☐ Grade 12 or GED ☐ Some postsecondary ☐ Postsecondary degree or certificate ☐ Postgraduate ☐ Refused
Chronic health conditions (please list)	☐ ____________________ ☐ ____________________ ☐ ____________________ ☐ ____________________ ☐ ____________________ ☐ ____________________

2. Screening Interview Guide

Thank you for agreeing to be interviewed. The goal of this University of Manitoba research project is to develop some understanding of emotional distress or depression from the point of view of the person experiencing it. Your participation will help us better understand how emotional distress fits into a person's unique story. We will talk about how emotional distress or depression happened, what might have contributed to it, and about what helped or is helping you in your recovery. This information will help us better serve people experiencing distress and/or depression because we will get a fuller picture of the experience.

The interview should take approximately 60 minutes. Your participation in this project is voluntary, you may withdraw at any time, and your responses will be kept confidential. You do not have to tell me your real name or last name. Do you have any questions so far?

Today I would just like to ask you a few preliminary questions, and if you qualify for the study, we'll do the full interview in person next time. Okay?

1. Within the last ten years, did you experience a period of emotional distress or depression lasting at least two weeks, from which you feel you have now mostly recovered? How long ago did the period of __________ begin?
2. Participating in this study will mean talking about this period of distress with me in some detail. Do you feel well enough now to talk about it and how it came about, or would you rather not participate in the study? ***(If the latter, thank the participant for their time and end the screening interview.)***
3. Do you currently have a health care professional you can access quickly in case you feel distressed after the interview, to provide ***follow up care?***
4. Did you see a family physician or other doctor about this distress? Was antidepressant medication prescribed to you by a doctor?

5. Did you ever see a psychiatrist for this distress? Was your medication ever prescribed to you by a psychiatrist? ***(If no medication treatment, thank the participant for their time and end the screening interview.)***
6. Did you ever receive a diagnosis that you know of?
7. To the best of your knowledge, were you ever diagnosed with another mental health problem other than depression? Examples are: bipolar disorders, psychotic disorders such as schizophrenia, personality disorders, and anxiety disorders including OCD. ***(If other major mental disorder, thank the participant for their time and end the screening interview.)***
8. In the last year, were there times when you ever drank or used recreational drugs more than you meant to?
9. Have you felt you wanted or needed to cut down on your drinking or recreational drug use in the last year? ***(If yes to 8 AND 9, thank the participant for their time and end the screening interview.)*** (Two-Item Conjoint Screen for alcohol and other drug use and dependence from Brown, Leonard, Saunders, and Papasouliotis, 2001.)
10. Do you have any chronic health conditions – for example, diabetes, MS, chronic pain, heart disease, or anything else that affects your day-to-day functioning?

Appendix C: Interview Guide

1. I want to ask you about one period of emotional distress in your life. First off, there are many words and descriptions of emotional distress – for example, “stress,” or “depression,” or “a rough patch.” What do you call your experience of emotional distress? In this interview, what word or phrase shall we use to refer to this time in your life? ***(Use this term wherever the blanks occur in the rest of the guide).***
2. Tell me about how this __________ began for you. ***(Affirm, validate, reflect, paraphrase, probe, summarise as seems appropriate, in order to elicit a rich narrative with experiential and contextual description.)***
3. How do you see your experience now? How do you make sense of it, or explain, what was going on with you?

Now I would like to talk about the next part – your recovery. We will discuss things that you have found helpful in overcoming __________.

1. How did you begin the process of recovery? Tell me what happened, and what you did, that helped in any way. ***(Affirm, validate, reflect, paraphrase, probe, summarise as seems appropriate, in order to elicit a rich narrative with experiential and contextual description.)***
2. Of all the things we’ve talked about, which problem factors and which recovery factors stand out most for you? What makes them important?
3. Was medication treatment helpful? How? What was/were the name(s) of the medication? Do you have some thoughts as to how the chemical or medical aspect of the __________ and the other factors we discussed interact or fit together?
4. Is there anything that I did not ask that you wish I would have asked? What? And what would your answer be?
5. I have no more questions. Is there anything else you would like to ask or add?

Thank you for your time and participation.

[Provide all participants with card which lists available mental health resources – such as Klinic, the WRHA Mobile Crisis Service, CMHA Winnipeg and Manitoba, and the Manitoba Suicide Line – for participants to contact should they experience significant distress as a result of participation in this study.]

Appendix D: Thesis Timeline

July 2015: Complete and defend thesis proposal

September 2015: Submit protocol to Health Research Ethics Board

January - June 2016: Data collection and analysis

June - December 2016: Finalization of results and dissertation

January - February 2017: Defence of dissertation and dissemination of findings

Appendix E: Study Budget 2016

Proposed

Item	Maximum Quantity	Cost	Total
Honoraria (Gift Certificates)	15 Interviews	$25/Interview	$375.00
Total Expenses			**$375.00**

Actual

Item	Maximum Quantity	Cost	Total
Honoraria (Gift Certificates)	9 Interviews	$25/Interview	$225.00
Total Expenses			**$225.00**

Appendix F: Ethical Consent and Approval Forms

UNIVERSITY OF MANITOBA

Faculty of Health Sciences
College of Medicine
Department of Community Health Sciences
S113 – 750 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: Difference-makers in the experience of human affective distress: Perspectives on causation and recovery gained from qualitative inquiry into lived experience.

Principal Investigator: Thomas Steur, S113 - 750 Bannatyne Avenue, 1-204-xxx-xxxx
Co-Investigators: Dr. Sharon Bruce, S101E - 750 Bannatyne Avenue, 1-204-xxx-xxxx

You are being asked to participate in a research study. Please review this consent form and discuss any questions you may have with the investigators. Feel free to take your time and discuss participating in this study with your friends, family and/or your doctor before you make your decision. Please ask the investigators to provide any further information or explain anything that you do not clearly understand.

Purpose of Study

This research study is being conducted to better understand the lived experience and perceptions of people who have lived through emotional distress or depression treated with antidepressant medications. A total of 15 people will participate in this study.

Ultimately, this study will provide researchers with information on people's experiences of distress and recovery, and may help in developing public health programs, policies, and interventions that reflect the reality of people's experiences and better serve people's needs.

Study procedures

If you take part in this study, the primary researcher will sit down with you to talk about your experiences of emotional distress and your experience of recovery. The interview will take place at the University of Manitoba Bannatyne Campus or a location of your choice, and will last about 60 to 90 minutes. The interview will be recorded and later placed on a computer. This recording will be destroyed after the completion of the study.

You can stop participating at any time in the study. However, if you decide to stop participating in the study, we encourage you to talk to the primary investigator first.

Group results from all participants will be all that is reported in research papers or presentations. For example, the researcher will discuss overall public health recommendations from all participants in related presentations and papers. No complete individual interviews will be given or reported to anyone. Your personal identity will not be revealed in any paper or presentation.

Risks and Discomforts

The risks to you for participating in this study are minimal. Talking about past emotional distress may be upsetting. Contact your health professional to discuss these feelings if needed.

Benefits

There may or may not be a direct benefit to you from participating in this study. It may be helpful to discuss past experiences of distress and recovery, and share ideas on how to improve the lives and health of others. We hope the information learned from this study will benefit people’s lives by exploring: (1) factors involved in bringing about emotional distress or depression, (2) factors involved in recovery, and (3) ways of improving our understanding of these things from people’s actual experiences.

Costs and Payment for Participation

There is no cost to you for participating in this study. Participants will receive a $25.00 gift certificate to a major department or grocery store upon completion of each interview as a token acknowledgement of their time and effort.

Confidentiality

Information gathered in this research study may be published or presented in public forums; however, your name or other identifying information will not be used or revealed. Your name will not appear on any study-related documents. At the start of the study, you will be assigned a study number. Only that number will appear on study-related materials. Data from all procedures described above will be entered into a computer on a network only the researchers identified above can access. When these data are entered into the computer, only your study number will be entered. All efforts to keep your personal information confidential will be made; however, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area. Only the research investigators identified above will have access to hard copy and electronic records. If any of your research records are copied to any of the above investigators, your name and all identifying information will be removed. No information revealing any personal information, such as your name, address or telephone number will leave the University of Manitoba.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your health care or any current or future relationship with the University of Manitoba. If the investigator feels that it is in your best interest to withdraw you from the study, you will be removed from the study without your consent.

You will be told about any new information that may affect your health, welfare, or willingness to stay in this study.

Questions

You are free to ask any questions about the study, your treatment, or your rights as a research participant. If you have any questions during the study, please contact the primary investigator: Thomas Steur at 1-204- xxx-xxxx**.**

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at 1-204-xxx-xxxx.

Do not sign this consent form unless you have had a chance to ask questions and are satisfied with the answers to all of your questions.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Thomas Steur. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant signature_______________________________ Date __________________

(day/month/year)

Participant printed name: ______________________________

Relationship (if any) to study team members:_____________________

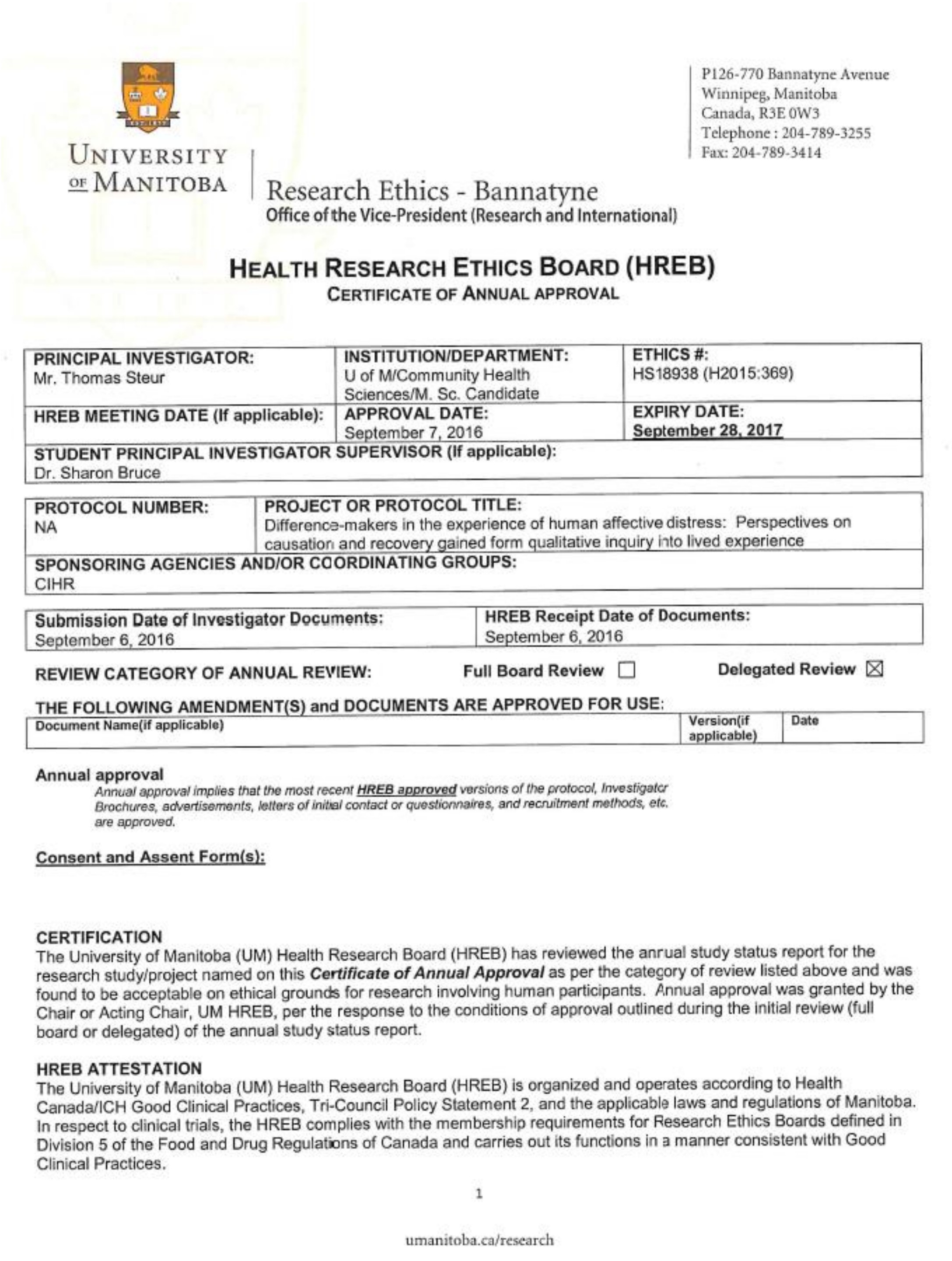
I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _________________________ Date _________________
(day/month/year)

Signature: _____________________________________

Role in the study: ______________________________

University of Manitoba Health Research Ethics Board Approval:



UNIVERSITY OF MANITOBA

Research Ethics - Bannatyne
Office of the Vice-President (Research and International)

P126-770 Bannatyne Avenue
Winnipeg, Manitoba
Canada, R3E 0W3
Telephone : 204-789-3255
Fax: 204-789-3414

HEALTH RESEARCH ETHICS BOARD (HREB)

CERTIFICATE OF ANNUAL APPROVAL

PRINCIPAL INVESTIGATOR: Mr. Thomas Steur	**INSTITUTION/DEPARTMENT:** U of M/Community Health Sciences/M. Sc. Candidate	**ETHICS #:** HS18938 (H2015:369)
HREB MEETING DATE (If applicable):	**APPROVAL DATE:** September 7, 2016	**EXPIRY DATE:** **September 28, 2017**
STUDENT PRINCIPAL INVESTIGATOR SUPERVISOR (If applicable): Dr. Sharon Bruce		

PROTOCOL NUMBER: NA	**PROJECT OR PROTOCOL TITLE:** Difference-makers in the experience of human affective distress: Perspectives on causation and recovery gained form qualitative inquiry into lived experience
SPONSORING AGENCIES AND/OR COORDINATING GROUPS: CIHR	

Submission Date of Investigator Documents: September 6, 2016	**HREB Receipt Date of Documents:** September 6, 2016

REVIEW CATEGORY OF ANNUAL REVIEW: **Full Board Review** ☐ **Delegated Review** ☒

THE FOLLOWING AMENDMENT(S) and DOCUMENTS ARE APPROVED FOR USE:

Document Name(if applicable)	Version(if applicable)	Date

Annual approval

*Annual approval implies that the most recent **HREB approved** versions of the protocol, Investigator Brochures, advertisements, letters of initial contact or questionnaires, and recruitment methods, etc. are approved.*

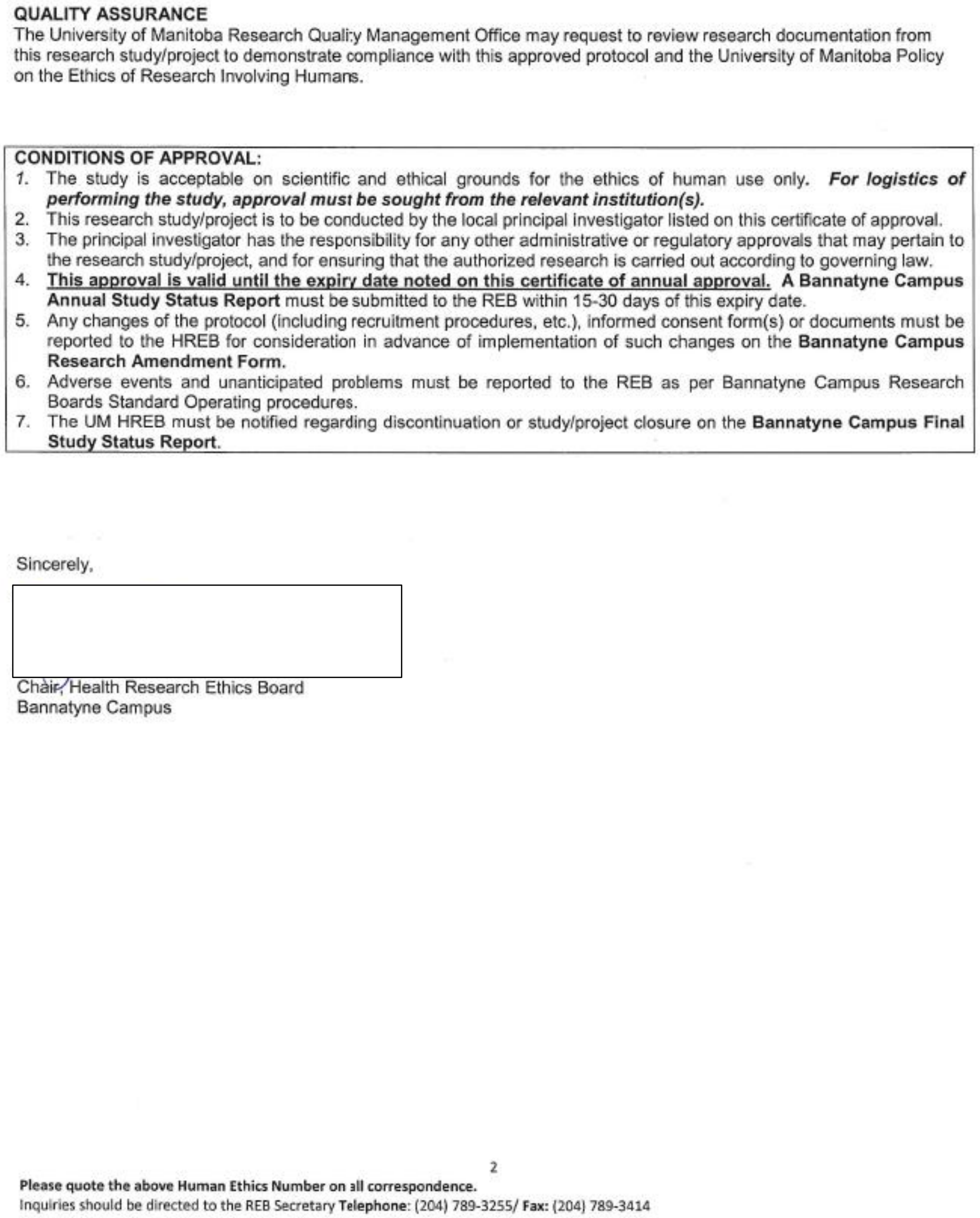
Consent and Assent Form(s):

CERTIFICATION

The University of Manitoba (UM) Health Research Board (HREB) has reviewed the annual study status report for the research study/project named on this ***Certificate of Annual Approval*** as per the category of review listed above and was found to be acceptable on ethical grounds for research involving human participants. Annual approval was granted by the Chair or Acting Chair, UM HREB, per the response to the conditions of approval outlined during the initial review (full board or delegated) of the annual study status report.

HREB ATTESTATION

The University of Manitoba (UM) Health Research Board (HREB) is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement 2, and the applicable laws and regulations of Manitoba. In respect to clinical trials, the HREB complies with the membership requirements for Research Ethics Boards defined in Division 5 of the Food and Drug Regulations of Canada and carries out its functions in a manner consistent with Good Clinical Practices.



QUALITY ASSURANCE

The University of Manitoba Research Quality Management Office may request to review research documentation from this research study/project to demonstrate compliance with this approved protocol and the University of Manitoba Policy on the Ethics of Research Involving Humans.

CONDITIONS OF APPROVAL:

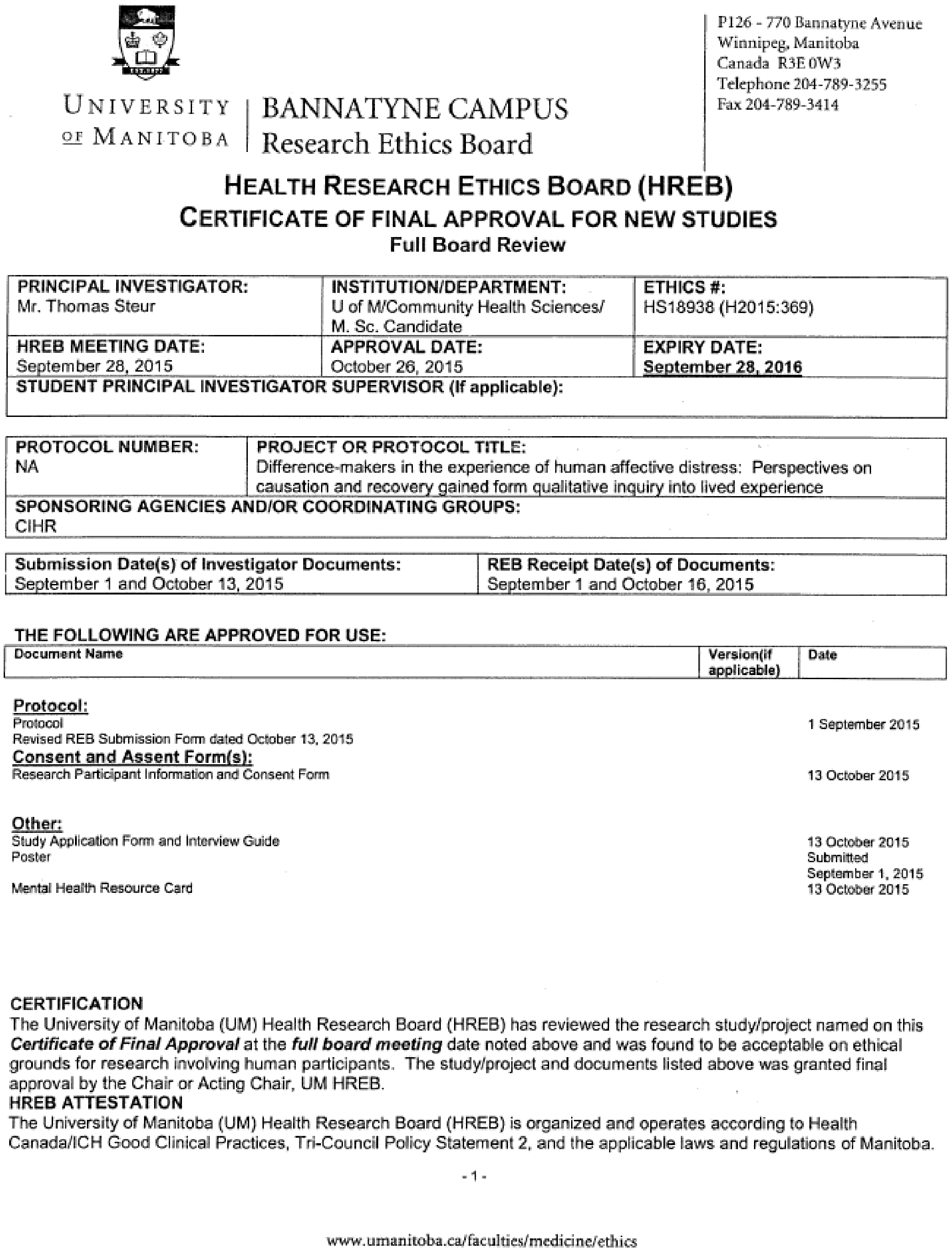
1. The study is acceptable on scientific and ethical grounds for the ethics of human use only. ***For logistics of performing the study, approval must be sought from the relevant institution(s).***
2. This research study/project is to be conducted by the local principal investigator listed on this certificate of approval.
3. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to the research study/project, and for ensuring that the authorized research is carried out according to governing law.
4. **This approval is valid until the expiry date noted on this certificate of annual approval.** **A Bannatyne Campus Annual Study Status Report** must be submitted to the REB within 15-30 days of this expiry date.
5. Any changes of the protocol (including recruitment procedures, etc.), informed consent form(s) or documents must be reported to the HREB for consideration in advance of implementation of such changes on the **Bannatyne Campus Research Amendment Form.**
6. Adverse events and unanticipated problems must be reported to the REB as per Bannatyne Campus Research Boards Standard Operating procedures.
7. The UM HREB must be notified regarding discontinuation or study/project closure on the **Bannatyne Campus Final Study Status Report**.

Sincerely,

[redacted]

Chair, Health Research Ethics Board
Bannatyne Campus

Please quote the above Human Ethics Number on all correspondence.
Inquiries should be directed to the REB Secretary **Telephone**: (204) 789-3255/ **Fax:** (204) 789-3414



UNIVERSITY OF MANITOBA | BANNATYNE CAMPUS
Research Ethics Board

P126 - 770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Telephone 204-789-3255
Fax 204-789-3414

HEALTH RESEARCH ETHICS BOARD (HREB)
CERTIFICATE OF FINAL APPROVAL FOR NEW STUDIES
Full Board Review

PRINCIPAL INVESTIGATOR: Mr. Thomas Steur	**INSTITUTION/DEPARTMENT:** U of M/Community Health Sciences/ M. Sc. Candidate	**ETHICS #:** HS18938 (H2015:369)
HREB MEETING DATE: September 28, 2015	**APPROVAL DATE:** October 26, 2015	**EXPIRY DATE:** **September 28, 2016**
STUDENT PRINCIPAL INVESTIGATOR SUPERVISOR (If applicable):		

PROTOCOL NUMBER: NA	**PROJECT OR PROTOCOL TITLE:** Difference-makers in the experience of human affective distress: Perspectives on causation and recovery gained form qualitative inquiry into lived experience
SPONSORING AGENCIES AND/OR COORDINATING GROUPS: CIHR	

Submission Date(s) of Investigator Documents: September 1 and October 13, 2015	**REB Receipt Date(s) of Documents:** September 1 and October 16, 2015

THE FOLLOWING ARE APPROVED FOR USE:

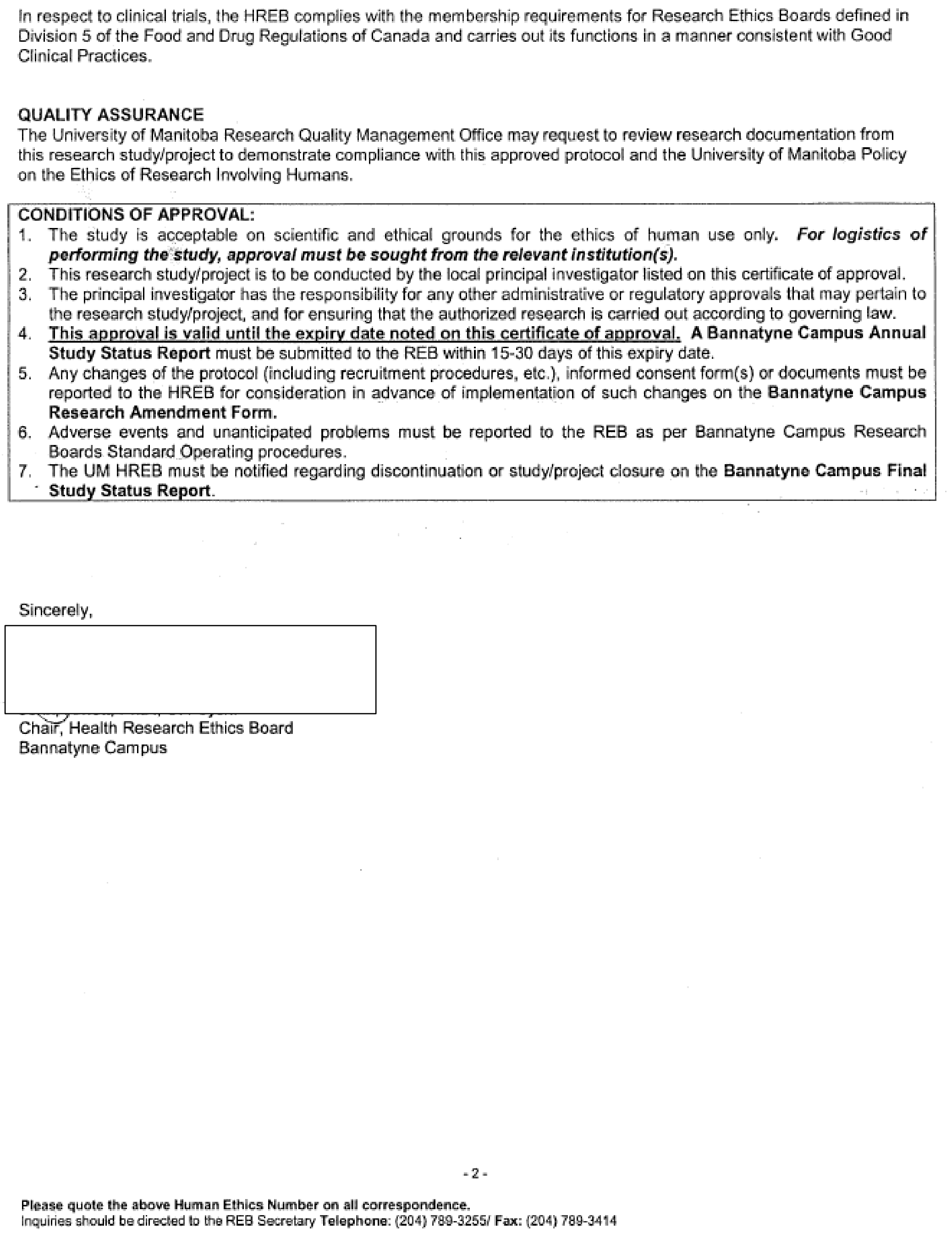
Document Name	Version(if applicable)	Date
Protocol:		
Protocol		1 September 2015
Revised REB Submission Form dated October 13, 2015		
Consent and Assent Form(s):		
Research Participant Information and Consent Form		13 October 2015
Other:		
Study Application Form and Interview Guide		13 October 2015
Poster		Submitted September 1, 2015
Mental Health Resource Card		13 October 2015

CERTIFICATION
The University of Manitoba (UM) Health Research Board (HREB) has reviewed the research study/project named on this ***Certificate of Final Approval*** at the ***full board meeting*** date noted above and was found to be acceptable on ethical grounds for research involving human participants. The study/project and documents listed above was granted final approval by the Chair or Acting Chair, UM HREB.

HREB ATTESTATION
The University of Manitoba (UM) Health Research Board (HREB) is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement 2, and the applicable laws and regulations of Manitoba.

- 1 -

www.umanitoba.ca/faculties/medicine/ethics



In respect to clinical trials, the HREB complies with the membership requirements for Research Ethics Boards defined in Division 5 of the Food and Drug Regulations of Canada and carries out its functions in a manner consistent with Good Clinical Practices.

QUALITY ASSURANCE
The University of Manitoba Research Quality Management Office may request to review research documentation from this research study/project to demonstrate compliance with this approved protocol and the University of Manitoba Policy on the Ethics of Research Involving Humans.

CONDITIONS OF APPROVAL:

1. The study is acceptable on scientific and ethical grounds for the ethics of human use only. ***For logistics of performing the study, approval must be sought from the relevant institution(s).***
2. This research study/project is to be conducted by the local principal investigator listed on this certificate of approval.
3. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to the research study/project, and for ensuring that the authorized research is carried out according to governing law.
4. **This approval is valid until the expiry date noted on this certificate of approval. A Bannatyne Campus Annual Study Status Report** must be submitted to the REB within 15-30 days of this expiry date.
5. Any changes of the protocol (including recruitment procedures, etc.), informed consent form(s) or documents must be reported to the HREB for consideration in advance of implementation of such changes on the **Bannatyne Campus Research Amendment Form.**
6. Adverse events and unanticipated problems must be reported to the REB as per Bannatyne Campus Research Boards Standard Operating procedures.
7. The UM HREB must be notified regarding discontinuation or study/project closure on the **Bannatyne Campus Final Study Status Report**.

Sincerely,

[redacted]

Chair, Health Research Ethics Board
Bannatyne Campus

Please quote the above Human Ethics Number on all correspondence.
Inquiries should be directed to the REB Secretary **Telephone:** (204) 789-3255/ **Fax:** (204) 789-3414

x