Living with Depression and Anxiety: an Interpretative Phenomenological Analysis.

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Abstract

Background

It is estimated that one in for people will suffer mental distress at some point in their lives, with depression and anxiety being the most common manifestations of distress in the UK.

Existing research into mental distress and treatment largely involves questionnaires which do not provide much detail or context. Studies involving participant interviews are able to provide richer accounts of what it is to live with mental distress on a day to day basis, and to find how people generate meaning through these experiences. It is hoped that this study provided a voice to a group that is broadly ignored within psychological research, allowing them to set out what they believe is important to them in terms of their mental wellbeing.

Aims

The research questions were as follows: what are the participants experiences of living with depression and/or anxiety? And; How has the context of their treatment and self-management influenced these experiences? Qualitative methods were used to answer these questions and to allow participants to tell their stories in their own voices.

Method

Four one-to-one semi-structured interviews were carried out with participants who had either a current or prior diagnosis of depression and/or anxiety. The interview transcripts were analysed using interpretative phenomenological analysis (IPA).

Results

Five superordinate themes emerged across the data sets. These were: living with mental illness is lonely and isolating, not knowing what's happening is *scary, wanting to feel 'normal' within and seem 'normal' to others, the importance of being understood by professionals, and what you can do for yourself.*

Conclusions

The findings supported the current literature, however, using qualitative methods generated data that provided richer information. The participants' experiences themselves are to be considered paramount in this study, and no attempt should be made to generalise the results.

I declare that the work in this thesis was carried out in accordance with the regulations of the University of Gloucestershire and is original except where indicated by specific reference in the text. No part of the thesis has been submitted as part of any other academic award. The thesis has not been presented to any other education institution in the United Kingdom or overseas.

Any views expressed in the thesis are those of the author and in no way represent those of the University.

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1. Introduction

1.1. Overview

This study sought to allow participants to share their experiences of living with symptoms of mental distress, specifically with symptoms of depression and/or anxiety. This introduction sets out the contextual basis and background for the study, drawing attention to the socioeconomic factors present within UK society at the time the research was carried out. The introduction will also cover some of the competing perspectives of mental distress, and some theories surrounding prevalent attitudes and stigma often associated with mental illness.

1.2. Context

Currently within the UK, there is a high prevalence of people experiencing common forms of mental distress, such as depression and anxiety, and mental health services are severely underfunded (Burn, 2018). There are many theories surrounding the rise of mental ill health throughout the country, but it can be argued that this rise is not unexpected if we are to consider the current socioeconomic and political climate (Burn, 2018). The pervasiveness of social media, the twenty-four hour news cycle, along with austerity and the uncertainty caused by Brexit can all be considered contributing factors towards the ongoing rise of mental distress (Ryan, 2019).

The British government has very recently pledged more funds for mental health services as they recognise the scale of the problem, however the National Health Service’s ability to cope with demand continues to be stretched (Burn, 2018). This has resulted in a ‘post-code lottery’ for access to mental health services in the UK, with many people who need support being made to join long waiting lists before they can receive treatment. In the UK, a survey is conducted every seven years to get an idea of the prevalence of certain mental health problems, the following figures have been taken from the Mind UK website.

Table 1 - prevalence of common forms of mental distress in the UK.

Generalised anxiety disorder	5.9 in 100 people
Depression	3.3 in 100 people
Phobias	2.4 in 100 people
OCD	1.3 in 100 people
Panic disorder	0.6 in 100 people
Post traumatic stress disorder (PTSD)	4.4 in 100 people
Mixed anxiety and depression	7.8 in 100 people
Suicidal thoughts	20.6 in 100 people
Suicide attempts	6.7 in 100 people
Self-harm	7.3 in 100 people

Mind (2016) notes that these statistics fall short of the true prevalence of common mental disorders in the UK as they were obtained by surveys sent to private residences. These figures are not inclusive of individuals who are homeless, residing in hospitals, prisons, or those in sheltered housing, many of which experience symptoms of mental distress. It also goes on to estimate that 1 in 8 of those with mental health problems are being treated, with medication being the most common form of treatment.

Within the UK, there is a growing awareness of mental health and its issues, and many young people no longer consider mental ill health to be stigmatising (Mind, 2016). This has led to a rise in discussions surrounding mental wellbeing and its associated issues within mainstream discourse, however, cases of mental distress continue to grow with more people approaching their GP to seek help for their mental health on a year by year basis (Mind, 2016) The following section will discuss the dominant perspectives of mental distress, focussing on the medical model of diagnosis and treatment as well as some of the social and cultural factors linked to distress.

1.3. Perspectives of mental distress

Johnstone (2001) describes mental illness as “referring to the spectrum of cognitions, emotions and behaviours that interfere with interpersonal relationships, as well as functions required for work, at home, and in school”. This is broad umbrella, however this study focussed on depression and anxiety, as they are the most prevalent manifestations of distress within the UK and are often comorbid with one another (Brady & Kendall, 1992). There are many competing theories that discuss the causes of distress, but the current dominant model of mental illness is the medical model (Johnston, 2001). The medical model of approaching any illness involves the recognition of symptoms, followed by a diagnosis and a prescribed treatment to alleviate or cure symptoms. In cases of mental ill health, this model assumes distress to be a biochemical deviation from the ‘norm’, which is treatable by prescribing the patient a course of medication (Johnstone, 2001). Depression is seen as a combination of both psychological symptoms, such as feelings of emptiness and lack interest, or joy in life, and somatic symptoms, for example weight loss or gain, and sleep disruption (Baghai, Eser, & Möller, 2008). The Diagnostic and Statistical Manual of Mental Disorders (DSM) which is used to define and describe the characteristics of psychological and psychiatric disorders, is now largely based on the medical model, having previously followed more psychodynamic and psychoanalytical approaches in its earlier editions (Surís, Holliday, & North, 2016).

The dominant biological theories surrounding the causes of depression and anxiety centre around the brain’s dysregulation of neurotransmitter systems such as noradrenaline (NA) and serotonin (5-HT) (Montoya, Bruins, Katzman, & Blier, 2016). Depression is linked to a combination of deficiencies of NA and 5-HT, issues surrounding the sensitivities of the noradrenergic and serotonergic receptors (Montoya, Bruins, Katzman, & Blier, 2016), and the activity of various circuits within the structure of the brain (Baghai, Eser, & Möller, 2008). Anti-depressants, such as tricyclics, selective serotonin reuptake inhibitors (SSRIs), and selective norepinephrine reuptake inhibitors (SNRIs), have been developed to target these factors, and have been found to be largely successful in reducing the symptoms associated with depression (Bennett, 2011).

The symptoms of anxiety differ to those of depression but also have both psychological and somatic elements (Brady & Kendall, 1992). Individuals struggling with anxiety may be irritable, feel disassociated from themselves, have a disturbed sleep pattern, or experience a racing heartbeat (Johnston, 2001). The medical model of anxiety attributes symptoms to overactivity in two main circuits within the brain, the septohippocampal system, and the Papez circuit (Bennett, 2011), together often known as the behavioural inhibitions system. This system retrieves sensory information from the environment and diverts attention from other behaviours upon sensing a threat. As well as NA and 5-HT, these systems also involve neurotransmitter, gamma-amino butyric acid (GABA). Individuals experiencing symptoms of anxiety may be prescribed benzodiazepines or SSRIs. SSRIs are often the preferred pharmacological treatment due to them having fewer side effects, and having a higher rate of adherence (Bennett, 2011). Despite often providing an effective boost for people struggling with their mental wellbeing, antidepressant and anti-anxiety medications are often looked at in a negative light. Some of this could be attributed to a range of unpleasant side effects that can be associated with taking the medication. Studies have shown that when taken over a long period of time, benzodiazepines can cause dependency, lethargy, cognitive impairment, and can lead to a higher risk of relapse to anxiety (Davidson, 2001). SSRIs can disrupt sleep, cause gastrointestinal problems, sexual dysfunction, and in some cases increase feelings of anxiety and agitation (Howland, 2007). Weight gain is another common side effect of psychotropic drugs. This has the potential of damaging self-esteem and is thought to be one of the main reasons as to why an individual may stop complying with their treatment (Sadock, Sadock, & Ruiz, 2017). All forms of psychopharmacological treatment can result in distressing withdrawal symptoms if the taker reduces their dosage too quickly, and it is advised that when stopping medication, these effects can be minimised by reducing dosage in increments over the course of several months (Bennett, 2011). Most mental health professionals prefer to combine courses of medication with a form a talking therapy, and studies have shown that combined therapies are more effective than either talking therapy or medication alone (Sadock, Sadock, & Ruiz, 2017). Medication may treat the neurological components of mental distress and help individuals cope with difficulties in their lives, but in cases where distress is caused by outside stimulus, it does not remove the problem, or teach appropriate coping and resilience building mechanisms (Sadock, Sadock, & Ruiz, 2017).

Despite the medical model often working successfully in terms of physical illness, it is now widely accepted that biology alone cannot provide the complete picture when it comes to mental distress (Gold, 2009). Gold (2009) argues that despite the dominance of the biological paradigm and the successes of pharmacological treatments for mental distress, there has yet to be a single instance where a psychological experience has been completely explained using only neurobiology. Modern psychiatry will often integrate theories and practices from psychology and sociology, and attempts to provide a range of treatment options, including medication and various therapies, as a means to treat symptoms of distress (Davidson, Campbell, Shannon, & Mulholland, 2015). Deacon (2013) argues for a biopsychosocial approach, which attempts to view mental distress through a number of different layers (including cognitive neuroscience and the external environment) with equal importance attributed to each, but with each layer being applied for different purposes. This approach would reject attempts to reduce complex psychological experiences into simple explanations, but instead rely on multidisciplinary collaborations to try and understand how each layer interacts with and affects the others (Deacon, 2013).

Scott (2010) argues that although many service users are appreciative of a medical diagnosis for their mental distress, as this type of labelling provides a name for what they are suffering and entitles them to access treatment pathways, some diagnostic labels such as ‘borderline personality disorder’, can be incredibly unhelpful and can prevent the service user from obtaining the care they need. This is due to the diagnosis bringing with it certain assumptions regarding the patient’s personality, attitude, and willingness to comply with the service providers (Scott, 2010). In this instance, the medical model is a hindrance to the effective treatment of mental distress as professionals may find themselves treating what is considered to be a ‘difficult’ label as opposed to an individual person (Scott, 2010). Reducing mental distress down to a biomedical phenomena also carries the risk of the distressed individual internalising the idea that something within them is ‘wrong’ or ‘deficient’, which in turn can negatively impact self-esteem (Kvaale, Haslam, & Gottdiener, 2013).

It can be argued that in addition to our genetic make up, we are also a product of the society in which we live, however, sociocultural factors are often overlooked by the NHS when it comes to the provision of mental health services (Tew, 2005). Social models of mental distress, look outside of the mental health patient, and attempt to understand symptoms of distress as a reaction to difficult life experiences (Tew, 2005). It is important to recognise the detrimental effect of modern society on mental wellbeing (Scott, 2010); many people in the UK are struggling with money and housing, and the number of people relying on food banks has reached a record high (Butler & Duncan, 2018). Tew (2005) lists several examples of ideas held by other disciplines which could account for various forms of mental distress. For example, sociology may focus on the effects of poverty and social labelling; feminist psychology may look at systematic discrimination and oppression; psychotherapy may look at how traumatic past events may account for some symptoms of mental distress. There are a number of competing evolutionary perspectives as to why an individual may suffer with depression and/or anxiety; for instance, Dickinson and Eva (2006) argue that these forms of distress may be seen as a negative reinforcer for a lack of social interaction; whereas Gilbert (2001) suggests that distress is result of arrested defence mechanisms, which keep the sufferer in an ongoing state of chronic stress. It has also been argued that social comparison and ranking can lead to depression, where feelings of depression can be linked to feelings of inadequacy in comparison to others (Thwaites & Dagnan, 2004). In a time of invasive social media influence, people are inundated with images, statuses, and videos of not only their peers, but also of celebrities looking a certain way or enjoying a certain lifestyle (Radovic, Gmelin, Stein, & Miller, 2017). Making comparisons in this instance could have an effect on mood, body image, or self-esteem, despite it being well known that many of these images have been altered and that people tend to only share the good things that happen to them online (Radovic, Gmelin, Stein, & Miller, 2017). Whereas medication may be effective in the treatment of the symptoms of mental distress, many people seek out alternative, talking therapies to mentally work through and gain a deeper understanding of the causes of their distress, whether these be negative thought patterns or a reaction to outside stimuli (Johnston, 2001).

Talking therapies aim to help individuals work through their behaviours, thoughts, and feelings and can take place on a one-to-one basis or as part of a group. Common therapeutic routes include cognitive behavioural therapy (CBT), psychotherapy, and counselling (Kinsella, Kinsella, & Patel, 2015). In recent years, CBT has become the most hegemonic form of therapy for mental distress, particularly for the treatment of depression (Pilgrim, 2011), and is often prescribed alongside a form of medication. Pilgrim (2011) describes CBT as a short-term but highly focussed form of talking therapy which requires participants to identify, challenge, and with practice, modify their negative thoughts, feelings, and behaviours. It requires active participation and will often involve homework and the use of journals. It treats distress as an internal, personal phenomena involving various ‘cognitive errors’. This understanding of distress has granted CBT a closer allegiance with the medical model than its counterparts, however this results in the therapy largely ignoring societal issues which often trigger and perpetuate mental distress (Pilgrim, 2011). Psychotherapy requires the participant to bring repressed feelings and memories to the surface, and to undergo the processes of recollection, repetition, and working through. It theorises that upon recalling and addressing unresolved childhood issues, the participant will be able to achieve a deep and meaningful understanding of themselves, and develop more adaptive patterns of thoughts and behaviours (Sadock, Sadock, & Ruiz, 2017). Studies have shown that a collaborative approach using a combination of talking therapies and a course of medication provide the best outcomes in terms of treating symptoms of mental distress (Sadock, Sadock, & Ruiz, 2017), and in an ideal world, people struggling with their mental wellbeing should be offered a variety of options focussing on their individual needs, and be given sufficient information from mental health professionals to make an informed choice of their own treatment pathways.

Despite attempts to achieve an efficient and well balanced mental health service, resources in the UK are currently stretched (Burn, 2018). For many individuals, it is difficult to secure an appointment with a GP in a timely manner, and it is even more difficult for a GP to fully and accurately assess the needs of their patients within a ten minute appointment window. In recent years, there has been a rise of self-help materials and mindfulness courses, which attempt to provide people with some of the tools they need to manage their own symptoms (Warrilow & Beech, 2009). This research involved participants who have required the care of mental health professionals, or have received treatment for their mental health, and experienced a range of quality levels from their service providers. For this study, it is important to note that the participants were recruited from a small sample, and that when discussing their experiences of mental health services, these services were the ones provided locally by both the NHS and by private mental health professionals. These experiences were specific and unique to the participants, and are not necessarily the same as those had by the wider population of service users in the UK.

1.4. Attitudes and Stigma

This section will explore how the historical treatment of those who suffer from mental distress has shaped attitudes towards the mentally unwell, as well as the social stigma still attached to mental illness.

Historically, within western cultures, those who suffer from mental distress have been painted as dangerous, unstable, and something to be feared. In medieval times, mental distress was seen as moral corruption and a manifestation of the weakness of mankind (Overton & Medina, 2008). This idea resulted in asylums designed to forcibly segregate the mentally unwell from other members of society. In the early twentieth century, asylums and the treatment for mental illnesses were experimental, dangerous, and often inhumane (Overton & Medina, 2008). For example: injecting malaria infected blood into patients to instil high fevers; insulin or Metrazol shock therapies which induced seizures so violent that the vertebrae could fracture; lobotomisation; or submerging patients in cold water for hours at a time (Fabian, 2017). Treatment for mental ill health in western cultures is nowadays more humane but some of the old ideas surrounding mental illness and the mentally unwell being something to fear have persevered over time. This is often evident in how mental illness is portrayed within film and television. People who have mental illnesses have often been the subjects of horror movies, displaying violent and unpredictable behaviours, and mental illness has been found to be the top health related problem experienced by characters in the American soap opera world (Wahl, 1997). Derogatory language or slurs used to describe people with mental illnesses such as ‘crazy’, ‘nuts’, or ‘retarded’ are still pervasive and often casually used without much thought about the damage they cause (Hinshaw & Cicchetti, 2000). Beliefs and attitudes develop from a young age, and it is surprising how frequently the concept of mental health appears in films and television shows targeted at younger audiences (Wahl, 1997). The ways in which characters experiencing mental distress are treated in these films can contribute towards how children develop their ideas surrounding mental illness, and what it means to be mentally unwell. Wahl (1997) points out two poignant instances within classic Disney films where characters are labelled as ‘crazy’ and treated in a less than favourable manner. In ‘Aladdin’, the Princess Jasmine pretends to suffer from delusions to escape prosecution for theft and is infantilised and treated as incompetent. More upsettingly, in 'Beauty and the Beast’, Belle’s father is ostracised by his village for being an intellectual, and is later dubbed as ‘Crazy old Maurice’ by several of the village members. He is later thrown into a carriage to be driven to the creatively named ‘Asylum de Loons’ by a sinister looking old villain. Not only does this foster the idea that the mentally unwell are to be treated in a certain way, it may also instil a fear of what happens if one becomes unwell or is seen as different to the other members within their society.

Stigma arises when an individual or a group fail to adhere to a societally defined ideal (Crawford & Brown, 2002). Those with mental illnesses often fall prey not only to societal stigma, but also to self-stigma, where they believe that they are unworthy to be a part of society, resulting in low self-esteem and shame (Lenhardt, 2004). Overton and Medina (2008) discuss three theories surrounding stigma and how it relates to mental health. The first is social identity theory, where stigma arises when a person or group does not conform to social norms. In some cases, people may internalise the idea that they do not meet the standards set out by society and develop self-stigma. This internal process destroys self-esteem and causes intense feelings of shame and self-hate. In terms of mental health, people may be judged unfavourably by society due to the traits and behaviours often associated with being mentally unwell.

This can result in what is described as a spoiled collective identity (Goffman, 1963). Here the stigmatised individual or group may be seen as deficient or flawed in comparison to someone who is ‘normal’. This can lead to negative stereotyping which in turn can encourage prejudice towards or discrimination against the mentally unwell. Similar to this is structural stigma, which again adopts an ‘us versus them’ approach to looking at the mentally unwell, but focusses on the ways in which some cultures have systematically set up processes that restrict those with mental illness accessing what ‘normal’ members of society take for granted (Goffman, 1963). Thornicroft et al. (2016) express concern that those most likely to be affected by mental health stigma, are those who have already been pushed to the outer fringes of society. Those who experience the most discrimination are the homeless, those with criminal convictions, those struggling with addiction, and those with personality disorders.

The way in which mental illness is portrayed within the media is often problematic, with over-simplifications of complex disorders being common, and unhelpful stereotyped depictions of mental ill health (Francis et al., 2004). This is most prominent in printed news media, particularly in cases where incidents involve individuals with mental health problems and violence. Traditionally, when researching a story relating to mental health, journalists approach medical professionals for information as opposed to those who have lived experience of mental distress (Putman, 2008). It may be argued that working in this way provides an objective, professional point of view, however, this practice strips power from the targeted groups and reinforces the idea that they are not able to effectively speak for themselves (Putman, 2008). This is slowly beginning to change in the UK, with an increased dialogue surrounding mental illness (Mind, 2016). More public figures are speaking out about their experiences of mental distress and some online news sites such as the Guardian have sections devoted to the self and wellbeing, where many of the articles are written by people sharing their experiences of physical illness, mental illness, therapy, and of distressing life events. Tew (2005) calls for an end to the concept of ‘us’ and ‘them’ and for distress to be considered an acceptable feature of lived experience. He argues that those who struggle with mental distress should not be considered fundamentally different from those who can be described as ‘normal’ by societal standards.

The following section will summarise the background and rationale for this study before moving on to the methodology.

1.5. Background

Within the existing literature, the majority of investigation into mental health service users’ experiences of distress and treatment have been conducted via surveys or through telephone interviews (Elsom, Sands, Roper, Hoppner, & Gerdtz, 2013). These data collection methods are valuable in the sense that they are able to reach a large sample size and obtain more generalisable data than qualitative methods, they do not provide much in the way of detail. Qualitative methods of data collection, such as interviews or focus groups generally use much smaller sample sizes, however, the data obtained are much richer in detail (Braun & Clarke, 2013). There have been some studies detailing participants’ individual experiences of living with depression, from first person accounts of being distressed (Gregory & Thompson, 2013), to qualitative analysis of interviews (Rhodes & Smith, 2010; Smith & Rhodes, 2015). These investigations provide rich, in-depth accounts of what it is to experience life with depression and its associated feelings of loss, as well as participants’ experiences of engaging in help seeking behaviours. There is a gap within the literature, as little covers the participants’ subjective day to day experiences of mental distress; from making the decision to seek a diagnosis to how they manage their symptoms in the present day. Tew (2005) argues that medical professionals and academics working with those struggling with their mental wellbeing, need to refrain from stepping back and trying to objectively understand their participants. Instead, he suggests that a better understanding can be gained by engaging with and working collaboratively with those who experience mental distress, treating them as equals and drawing from their direct lived experience. Interpretative phenomenological analysis lends itself to working in this way, as it places experience at the forefront, and requires the researcher to adopt an open mind and to try and understand phenomena through the participant’s perspective (Smith, Flowers, & Larkin, 2009). Given that interpretative phenomenological analysis is an inductive methodology, it prohibits a comprehensive literature review within the early stages of the research; this will be carried out as part of the discussion, after the analysis of the data.

2. Method

2.1. Aim

This study involved the recruitment of participants with diagnoses of depression and/or anxiety. These manifestations of distress were chosen for their prevalence in UK society, and because they can often manifest together with overlapping symptoms (Brady & Kendall, 1992). The decision was made not to focus on depression or anxiety, or on purely co-morbid experiences of the two as it was considered that to do so would limit the recruitment of participants, and it was felt at the time of recruitment that allowing for participants experiencing either depression or anxiety, or both manifestations together would allow for more inclusivity. Brady and Kendall (1992) question whether it is appropriate to strive for homogenous samples of participants with ‘pure’ depression or anxiety due to their similarities and historical confusion in defining their relationship. Brady and Kendall (1992) argue that it can be difficult to differentiate between depression and anxiety due to their considerable overlap of symptoms, and due to both being mood disorders with cognitive, affective, physiological, and behavioural elements. A significant difference between the two, however, relates to the key associated emotion, with fear being the key emotion in anxiety, and sadness being the key emotion in depression.

Although allowing for participants who have experienced depression and/or anxiety, as opposed to narrowing down to one diagnosis or a co-morbid experience, facilitated easier recruitment, this risked the homogeneity of the sample. A cross-case Interpretative Phenomenological Analysis typically requires a homogenous sample, and the participants could have the potential to have had vastly different experiences depending on their diagnoses. All of the participants for this study were recruited from a voluntary mental health support group, following a poster presentation and group discussion of the initial proposal. The initial research proposal had a stricter inclusion and exclusion criteria and it transpired that although the members of the support group were interested in the research and desired to take part, they felt the exclusion criteria prevented them from doing so. Permission was sought from the University Research Ethics Committee to allow the study be more inclusive and this was granted. Although widening the inclusion criteria risked the homogeneity of the sample, this built a positive rapport and trust within the support group and allowed participants to feel heard and be more active in the research designing process. A small sample of four participants was recruited for the research. Small sample sizes are typical of studies involving interpretative phenomenological analysis as although there are fewer participants, each case is analysed in greater detail (Reid, Flowers, & Larkin, 2005).

Through one-to-one semi-structured interviews, participants were asked to share details of their journey from receiving their diagnosis through to the present. Depression and anxiety are common manifestations of mental distress in the UK with a variety of treatment options. Existing research largely comprises of surveys completed by former service users, but these do not account for the unique and personal nature of recovery and the steps taken to get there. This research aimed to listen to each participant's individual story, in depth. The interviews explored the former service users' subjective experiences of their journeys and contexts of their treatment, including the services provided to them by the NHS. This included exploration of the formation of patient identity, the relationships formed and maintained between the patient and their GP and/or therapist, experiences and thoughts surrounding therapy and medication, and thoughts about what went well for them, and what they might have done differently.

The study also aimed to investigate what (if any) self-help/care practices the participants engage with in order to aid the management of their symptoms. These practices are relevant to the overall experience of living with mental distress as many people receiving treatment for depression and/or anxiety also employ self-help techniques such as mindfulness, regular exercise, or mediation. These practices can be, and often are, continued once treatment has ended to manage any recurring symptoms. The interviews were transcribed verbatim (with identifying details made anonymous) to ensure that the participants' stories are told in their own voices. The transcripts were then coding and analysed using the guidelines set out by Interpretative

Phenomenological Analysis (IPA). IPA is a qualitative method of analysis which attempts to identify recurring patterns or themes within and across data sets.

2.2. Research questions

The research questions were as follows:

1. What are participant’s experiences of living with depression and/or anxiety?
2. How has the context of their treatment and self-management influenced these experiences?

These questions did not seek to establish any form of causality between the nature of context and experience and no attempt has been made to generalise the findings to everybody who has ever experienced (or will experience) depression and/or anxiety. The objective of this research was to conduct semi-structured one-to-one interviews in order to obtain highly detailed and rich subjective accounts told in the participants’ own voices. This was followed by a detailed analysis of each data set to identify any recurring patterns both within and between these accounts. It was felt that the research questions were best answered through the use of qualitative methods, and the adoption of a relativist ontology is appropriate as the research was situated within a social and cultural context. This method of analysis involves both the participant and researcher interpreting the participant’s experiences through their own lenses, shaped by their existing values and beliefs systems, and as such the data cannot be viewed as reality but rather a collaboration the participant’s and researcher’s interpretations of their realities.

Narrowing down the diagnoses to depression and/or anxiety in this research allowed for the recruitment of participants who could provide insight into very common manifestations of mental distress, and although their experiences would be unique to them, it was assumed that they would not be wildly dissimilar when conducting the cross case analysis. Although the research proposal acknowledged that depression and anxiety were the chosen manifestations of distress due to their prevalence and high instances of comorbidity, It transpired that most of the participants had current or prior diagnoses in addition to depression and anxiety. These included borderline personality disorder and bipolar disorder. This further highlighted the variances in symptoms and experiences of those who live with mental distress, and the challenges presented by attempts to reduce these experiences into a single, overall diagnosis.

2.3 Using a qualitative approach

Whereas positivism and realism largely remain the dominant paradigm and ontological position within psychological research, this project adopted an interpretivist approach. The research was undertaken whilst embracing a relativist ontology with a phenomenological epistemology, and data was gathered and analysed using a wholly qualitative methodology. Hepburn (2000) argues that finding a universal definition of relativism is a difficult process, particularly since many definitions come from realist researchers who place relativism as the antonym of realism. She suggests that relativism would be better treated more as ‘systematic doubt’ that rejects the idea that knowledge can be objective and free from social foundations. Relativism has been previously criticised for treating all types of knowledge as equally valid (Stainton-Rogers, 2003); but this argument has been extrapolated from the fact that relativist researchers are sceptical about the existence of objective knowledge. Potter (1996) expands upon this theory and emphasises the need for reflexivity within research. Willig (2001, cited in King & Horrocks, 2010) describes two different types of reflexivity; epistemological reflexivity, where existing theoretical knowledge within the discipline is acknowledged, and personal reflexivity, where the researcher’s existing values and beliefs are acknowledged. It is important that the researcher reflects on how these factors may have affected their research, but care must be taken to ensure that this reflection is critical and not self-indulgent (King & Horrocks, 2010). This can be aided with the keeping of a research diary, where the researcher can note down how their pre-existing assumptions may be affecting how they are going about their investigations. Keeping a diary in this way also comes into its own when it comes to writing up a thesis, as it can ensure that, even after months of data collection and writing, the research questions remain at the forefront. A diary also provides the researcher with space to critically reflect on their own experiences, thoughts and feelings surrounding their research throughout all points of the project (Cunliffe, 2004). Some extracts from the research diary kept for this project can be found in Appendix 9, and epistemological, methodological, and personal reflections have been made.

The following section will describe the qualitative method of analysis used in this study, Interpretative Phenomenological Analysis (IPA), along with the rationale for using IPA for this type of research.

2.4. Interpretative Phenomenological Analysis

The gathered data was analysed using interpretative phenomenological analysis (IPA). This methodology is suited to analysing data collected from interview transcripts and emphasises the lived experiences of participants and how these may be interpreted. Smith, Flowers and Larkin (2009) describe IPA as being concerned with what happens when something happens within the everyday lived experience that causes the experience to take on a particular significance. This can be anything from recovering from major surgery, to bringing up a first child. The creators of IPA intended for it to be strongly idiographic in nature; therefore, this method will focus on conducting an in-depth analysis of each data set on an individual basis before searching for recurring patterns across multiple cases. IPA is suited to research conducted across a small sample as it does not attempt to generate universal claims or make predictions but instead emphasises the meanings that participants attribute to their experiences (Sullivan, Gibson, & Riley, 2012). Other methods of analysis were considered for the proposed project, such as thematic analysis or critical discourse analysis. Whereas these methods work well when it comes to identifying patterns within and between interview transcripts (Braun & Clarke, 2013), they do not have the same emphasis on the interpretation of experience that makes IPA particularly suitable to answer the research questions posed by this project. It is a method of analysis which has been used previously for mental health research, for instance, Macdonald, Sinason, and Hollins (2003) investigated participants with learning disabilities' experiences of group analytic therapy, and Newton, Larkin, Melhuish, and Wykes (2007) explored peoples' experiences of group therapy for auditory hallucinations. IPA has also been used to explore phenomena associated with depression and participants' feelings towards, and perceptions of the self (Shaw, Dallos, & Shoebridge, 2009; Smith & Rhodes, 2015).

IPA takes its roots from phenomenology, hermeneutics and idiography. Developed in the 1990s by Jonathan Smith, it is gaining popularity as an accessible approach which focuses on individual experience. It takes an individualistic approach, analysing each data set in great detail on its own before being compared with other cases, emphasising that each case is valuable in its own right (Smith, Flowers, & Larkin, 2009). IPA can be used across a variety of subject areas and is particularly popular with health psychology. It is a 'bottom up' approach which emphasises the ways in which participants make meaning out of their everyday experiences (Sullivan, Gibson, & Riley, 2012) and what happens when something within the everyday takes on a particular significance. As an analytical approach, it is reasonably flexible with a basic methodological framework. IPA takes its theoretical underpinnings from the core ideas found within the philosophical school of phenomenology. Oxley (2016) identifies its three main theoretical underpinnings; idiography, phenomenology and hermeneutics. The idiographic nature of IPA allows it to select a small sample of participants who are treated as experts of their own experiences. It does not aim to make broad claims from the data that it gathers, but instead chooses to treat each individual case as valuable. When the data is analysed, each case is done so in great detail in its own right before being compared with others within the data set (Oxley, 2016). Phenomenology was originally developed by Husserl at the beginning of the 20th century and has been built upon by other philosophers such as Heidegger, Merleau- Ponty and Sartre (Smith, Flowers, & Larkin, 2009). Husserl's idea was to adopt a reflective approach in an attempt to engage directly with phenomena and 'go back to the things themselves'. This would, however, require a researcher to ignore their own interpretations, beliefs and values; Heidegger argued that, in practice, this would not be possible and suggested that interpretation would be the closest we could come as researchers to understanding phenomena (Oxley, 2016). Hermeneutics places more of a focus onto the contextual elements of experience, and requires the researcher to be continually reflexive. Throughout the project, the researcher must be aware of and acknowledge how their own world-view influences each and every aspect of their research; from how they conduct their interviews, to how they interpret and analyse their gathered data. It may be that the researcher only becomes aware of certain preconceptions whilst conducting the study, therefore IPA requires that they attempt to maintain an open minded approach as they engage with the data (Smith, Flowers, & Larkin, 2009). Although reflexivity and subjectivity remains and important factor within IPA, the researcher must be able to adopt a ‘phenomenological attitude’ which allows them to both acknowledge their own assumptions, but to also attempt to view the world through the lens of the participant (Finlay, 2009). Finlay (2008, cited in Finlay, 2009) describes this attitude as ‘maintaining an empathic wonderment in the face of the world’.

Smith, Flowers, and Larkin (2009) set out a basic guide for completing a piece of IPA research: once the research questions have been decided upon, an appropriate method of data collection (for example, semi-structured interviews) is chosen. Participants are then recruited specifically for their expertise of a particular phenomena, and as such, they can be considered experts. Once the data has been collected, it needs to be systematically analysed. The researcher must immerse themselves in the data, focussing on each data set at an idiographic level. Themes emerge through the reading and re-reading of the data and the researcher can then compare these across cases. The researcher must be continually reflective throughout the research process, taking into account their pre-existing assumptions, beliefs and values. There is no fixed ontology or epistemology for IPA, and relatively little literature on the subject. It is considered important for the researcher to have a level of existing knowledge surrounding the particular study area; as this is integral to the interpretations that they make. It can therefore be argued that this method of analysis cannot be objective and value free, as the researcher must have this existing knowledge which in itself contributes to their assumptions about the world. Grix (2004) argues that within social research, objectivity is impossible as the researcher will always be influenced by their preconceptions. Bhattacharya (2008) goes further to argue that there is no independently existing social world, and that all of our knowledge of social phenomena can only be taken from our interpretations of them. Reid, Flowers, and Larkin (2005) suggest that psychological theory can be used in making interpretations but the focus must be on the participant's phenomenological account. The primacy of experience is paramount and it is unlikely that the participant considers theory when attributing meaning to life events. The paper recommends semi-structured interviews as a means of gathering data. This method is widely used within interpretivist research (Shinebourne, 2010; Hussain, 2015). Such interviews involve a flexible collaboration between participant and researcher to identify and interpret meaning. The authors praise one-to-one interviews as they allow for the researcher-participant relationship to develop and gives way for deep and meaningful discussion. The use of interviews within research builds rapport between researcher and participant, and allows for researcher to probe for more information that would not necessarily be forthcoming within written text (for example, diary entries or questionnaires with open ended questions). The interview experience could be potentially helpful for participants, allowing them space to work through the thoughts and feelings that they have surrounding their experiences. There is a possibility for them to step back and think about their experiences in a different light, and reflect, learn, and grow. The recordings from the interviews are transcribed verbatim, and the analyses punctuated with relevant direct quotes (made anonymous). The amount of extracts from the transcripts used depends on their length, nature of the interview transcripts, and the sample sizes. The inductive method gives the researcher an 'insiders perspective' of the phenomena of interest. Reid, Flowers, and Larkin (2005) suggest that the researcher prioritises listening to the detailed account given by participant, then uses their interpretations to make sense of this, and to answer their research questions. This can be done through coding, organisation, integration and interpretation. This is a very time consuming method which is why a small sample size is more ideal. The authors also advocate analysis on certain projects being conducted by more than one researcher, in an attempt for further 'triangulation' or cross-validation. The coding results in a list of themes which can be organised into a thematic map or table. The researcher then chooses one or more of the emergent themes as focal topics for the discussion. Braun and Clarke (2013) suggest that the method for coding in IPA is unlike other methods. They describe the process as a brief commentary of the data which happens across three levels; descriptive, linguistic and conceptual. IPA also allows for free association. The emergent themes should reflect the commonalities as well as the variances across different participants' accounts.

Some papers allow for a theme to be discussed on its own if it’s particularly salient (Braun & Clarke, 2013).

3. Materials

This section will describe the materials used throughout the research and where examples of these materials can be found within the appendices.

3.1. Research poster (Appendix 1)

The research poster was designed to be presented to the members of the mental health support groups. It provides a brief background to the study, includes the research questions, and some detail as to what potential participants can expect from taking part in the study. After the initial feedback, a slightly modified poster was produced reflecting the changes made to the inclusion and exclusion criteria. This was sent out via email to the support group mailing list.

3.2. Participant information sheet (Appendix 2)

The participant information sheet provides more in depth detail as to what participants could expect from taking part in the research. It addressed some potential questions regarding the benefits of taking part, participant confidentiality, and possible distress, and was written using accessible but non-patronising language, and a friendly, non-intimidating tone. Again, a slightly modified information sheet was produced following the changes made to the inclusion and exclusion criteria, and this was sent out via email along with the updated research poster.

3.3. Interview schedule (Appendix 3)

A funnel method was used to design the interview schedule, beginning with shallower questions before moving onto the wider breadth of the interview and eventually closing in again towards the end. The questions followed a chronological timeline beginning from when participants first noticed a change in their mental wellbeing and ending with what advice (if any) they would give to others who may be experiencing symptoms of distress for the first time. The interview schedule was presented to the support groups at the time of the research poster and information sheet to make sure they considered the questions to be relevant and appropriate. This was edited slightly following the change to the research design, and participants were forwarded a copy of the schedule prior to the interview so that they knew what to expect in the day.

3.4. Consent form (Appendix 4)

Participants were provided with a consent form to sign before commencing the interviews. By signing this document, they confirmed that they had read and understood the participant information sheet, understood that the interviews would be audio recorded and transcribed with every effort being made to ensure their confidentiality, and also that they understood that the purpose of the interview was for them to share their experiences of living with mental distress, and that the researcher is not a qualified therapist.

3.5. Debrief form (Appendix 5)

The debrief form provides a bit more context to the research and thanks the participants for taking part and sharing their stories. The form also provided a list of mental health services available to participants should they have felt adversely affected by taking part in the study.

4. Participants

This section will discuss participant recruitment along with inclusion and exclusion criteria.

4.1. Recruitment

Prior to the interviews taking place, two local support groups were contacted and asked if they would be willing to provide feedback on the research proposals. Both groups agreed and two sessions were attended, where group members were presented with a research poster (Appendix 1), and provided with research information sheets (Appendix 2). Members were invited to ask questions about the project and to offer their opinions surrounding its design and value. These sessions were valuable as they allowed for the building of a rapport with the target population of the study, and to gain a feeling as to what factors the support groups felt were important regarding their mental wellbeing. The feedback provided was taken on board, and the design of the project was modified accordingly, the main change allowing participants who are still being treated for symptoms of mental distress to be able to take part. Once these changes had been agreed and ethical considerations made, invitations to participate were sent to one of the support groups' mailing lists. IPA adopts an individualistic approach to research, and therefore advocates the use of a small sample. Smith, Flowers, and Larkin (2009) recommend a sample size of between three and six participants for a study of this nature, and therefore a small sample of four participants were selected to take part in this study.

4.2. Inclusion and exclusion criteria

Selected participants had either an existing, or a prior diagnosis of depression and/or anxiety and had received treatment for their diagnosis through the NHS. There was no restriction on gender, however participants were required to be over 18 years of age and needed to be able to provide informed consent. A strong understanding of the English language was also required, due to the interviews and supporting documents such as the consent and debrief forms being in English. Initially the exclusion criteria prohibited potential participants still actively engaging in treatment for their mental health from taking part, but this was lifted in order for the study to be more inclusive. Participants were trusted to make their own decisions regarding their wellness to take part and were given the option to withdraw at any point should they have wished to do so. At the time of the interviews, none of the participants were regularly attending therapy sessions, and only one was actively taking medication to manage their symptoms of mental distress.

4.3. The sample

The sample consisted of one male and three female participants, all over the age of 30 and currently residing in the South West of England. Sampling in IPA is often homogenous, as participants are selected specifically for their experiences of particular phenomena (Pietkiewicz and Smith, 2012), in this case experiences of living with depression and/or anxiety. All participants had experience of taking medication and attending therapy for their mental health and diagnoses included depression, generalised anxiety disorder, post-natal depression, bipolar disorder, and borderline personality disorder. It was mentioned in the rationale for choosing the research questions that anxiety and depression were both chosen due to their prevalence and frequency of co-morbidity, but it became clear throughout the study that depression and anxiety also had the potential to be co-morbid with other manifestations of distress, and physical illnesses. The decision was made not to exclude participants experiencing multiple forms of distress, as it was felt that doing so would not allow for inclusivity, or a true reflection of the target population. This sample was also homogenous in other ways, largely due to pragmatic reasons. All of the participants were from a white ethnic background, heterosexual, in a similar age bracket, and from a similar socio-economic demographic. IPA does not make an attempt to generalise its findings and it should be acknowledged that the results of this study may have been very different if the sample had been recruited from a different part of the country, or from a population with a different ethnic background, or sexual orientation.

5. Data collection and analysis

This section will explore the method of data collection, transcription, and the coding and analytical processes chosen for this study.

5.1. Interviews

Semi-structured interviews were held either in the psychology laboratory or within the Faith Space at Francis Close Hall campus of the University of Gloucestershire, and took place over a two week period. Interviews were on a one-to-one basis and lasted between 35 minutes to an hour, one participant brought a friend along to her interview for emotional support, and another brought her child. Participants were provided with a copy of the interview schedule but were encouraged to talk naturally about their experiences of living with mental distress. The interviews were audio-recorded with permission of the participants and were transcribed verbatim in order to allow for greater immersion within the data. All identifying information has either been altered or removed to protect participant confidentiality and to address anonymity.

5.2.Transcription

The interview data was personally transcribed verbatim. Although time consuming, transcribing this way allows for greater immersion within the data and a better understanding of what is being said by the participants. The interviews involved a lot of emotive storytelling from the participants and their inflections, tones of voice, and audible gesticulations (such as table tapping) may have been missed if transcribed by a third party. Participants were offered the chance to view their transcribed interviews before coding as a means of member checking to ensure that they felt the transcriptions to be accurate, and to allow them to make any omissions should they have wished. Worked on transcripts have been bound separately as qualitative data.

5.3. Analysis

The coding used in this study followed the guidelines set out by Smith, Flowers, and Larkin (2009), and took place over three levels: descriptive, linguistic, and interpretative. Prior to coding, it was important to become immersed within the data to ensure that the notations made would not be a result of superficial reading. Completing the transcription process personally aided this level of active engagement, and this was assisted further by the reading and re-reading of the transcripts. At this point, exploratory comments were beginning to be made around the content of the transcripts, attempting to understand the experiences through the participants eyes. The descriptive comments take things at face value, and are focussed on describing the subjects discussed by the participants within the transcripts. The linguistic comments were more concerned with how the participants used specific language when sharing their experiences, and these also included pauses within speech, laughter, repetition, and changes in tone. The interpretative comments began to engage with the transcripts at a more conceptual level, and attempt to uncover the participants understandings of their specific experiences on a broader level. These levels of commentary interact with one another throughout the transcripts and pull together ideas as to what is important to the participants, as well as why it is important. Going through the transcripts multiple times, and focussing on different levels of coding led to the themes emerging from the data. Having made a note of these, the theme could then be grouped into subordinate and superordinate themes for each participant, and later again for the cross-case analysis. Emergent themes have been documented along with subordinate and superordinate themes, and can be found tabled in Appendix 7 alongside relevant quotations from the transcripts. Pietkiewicz and Smith (2012) argue that in IPA, the researcher must choose between completing an in-depth analysis on a particular participant's experiences or a less comprehensive analysis of the experiences of a more general population. For this study each individual case has been presented in its own right prior to the cross-case analysis. This choice has been made in order to emphasise that although there may be recurring themes that link the participant's experiences of living with anxiety and/or depression, each individual's experience and understanding of what they have experienced is unique to them. No participant experienced the exact same phenomena in the exact same way, and it is important to acknowledge this, especially when the stories shared may hold a strong emotional significance to the story teller. The themes may be the same between cases, but the experiences within these themes can vary. Thematic tables have been presented for each participant, along with a ‘pencil portrait’ and are available in the appendices (Appendix 7).

6. Ethical considerations

Participant safety was held at the forefront of this project. There was a potential risk of participants feeling distressed as a consequence of participating in the interview due to the sensitive nature of the interview topic. In order to reassure participants, the objectives of the study were made transparent and the participants were provided with the proposed interview schedule several days before the interviews were to commence. Participants were assured that they were not required to answer any questions that they may have felt uncomfortable with, and that they could pause or stop the interview at any point should they begin to feel distressed. Time was made before each interview to answer any questions the participants may have had and to discuss and sign the consent forms. At this point, some boundaries were discussed, primarily to ensure that the participants were aware that no professional advice could or would be provided to them, and that the purpose of the interviews were for them to share their experiences. Potential trigger topics were also discussed so that these areas could be avoided. After each interview, participants were given a verbal and written debrief and were provided with their own copy of the consent form to take home. The written debrief included a list of services available for the participant to contact should they feel that they have been adversely affected by their participation. Participants also had the right to withdraw from the interview at any time and to withdraw their data within three weeks of taking part. They were given the opportunity to check that they are happy with the data they shared, and to make any omissions within a specific time frame. No omissions were made and all but one participant declined to see their transcribed interviews. Each participant was provided with a pseudonym in order to address anonymity as far as possible. Pseudonyms were used during the write-up stages of the project (as direct quotes have been used) and personal information was stored within encrypted files. The direct quotes used within the write-up have been selected carefully so as to minimise the risk of participant identification from within the voluntary group. Physical information, such as signed consent forms, have been kept in a lockable room. Any identifiable information will be securely destroyed once the project has been assessed, but a copy of the write-up that includes anonymised extracts will be available within the university library. Participants were welcome to read their transcribed data and to make any omissions they feel are necessary within a specific time-frame prior to analysis. They will also be welcome to read the final write-up of the study should they wish.

Initially ethical approval was sought from the NHS, and an application was made to their research ethics committee using the integrated research application system (IRAS). The NHS confirmed that they did not consider this study to be research (Appendix 6) but rather a service evaluation, therefore ethical approval was instead sought and granted through the University of Gloucestershire's Research Ethics Committee.

7. Abbreviations

Some common abbreviations have been made within the thesis and these are as follows:

CBT - Cognitive Behaviour Therapy
DSM - Diagnostic and Statistical Manual of Mental Disorders
GP - General Practitioner
ME - Myalgic Encephalomyelitis (chronic fatigue syndrome)
NA - Noradrenaline
NHS - National Health Service
EPP - Expert Patient Program
5-HT - Serotonin

8. Results

8.1. Overview

The results section will explore each IPA on an individual basis, looking at the superordinate themes which emerged during each interview. The discussion will bring these together to explore the overall superordinate themes which emerged from the research as a whole, and will attempt to see how these relate to the existing literature. Although many of the themes tie in with current literature, it is important to remember that the experiences shared by the participants in their interviews are important in their own right, and should not be reduced to or explained away by psychological theory. There are superordinate themes that are occur between the participants, and these will be explored in the discussion, however a case study will be also be presented for each participant. This decision has been made to gain a deeper understanding of each participant in their own right, and to emphasise that although the same themes may arise in each participant's transcript, the participants' experiences within these themes are unique to them. Smith (2008) suggests that with smaller sample sizes, such as that used for this study, it can be helpful for each transcript to be treated as an individual case study rather than using the superordinate themes highlighted in the first transcript as a starting point for the analysis of the rest.

8.2. Ron

Ron is in his 50s and first sought treatment for his mental health as a young adult. He is not currently taking any medication for mental distress, or engaging with talking therapy. All identifying information has been altered or removed to protect participant confidentiality. The superordinate themes that will be explored in this section are set out in the below table and are as follows: Living with mental illness is lonely and isolating, Mental illness is something to escape, and The importance of being understood by professionals.

Thematic Table - Ron

Superordinate themes	Subordinate themes
Living with mental illness is lonely and isolating	- Loss and loneliness - The impact on relationships - Feelings of abandonment - Searching for understanding and human connections - Community mental health
Mental illness is something to escape	- Distress as its own entity - taking on a role - A skewed sense of self - Self help techniques
The importance of being understood by professionals	- The idea of an 'expert patient' - A 'mixed bag of care' - The cumulative effect of treatment - The 'then and now' of treatment - Levels of wellness - Searching for the answer

Superordinate themes

8.2.1. *Living with mental illness is lonely and isolating*

Throughout the interview, Ron talks often about searching for, and a longing to find solidarity and deep personal connections with others. After leaving home for the first time to attend college, Ron suddenly found himself incredibly lonely, and it was at this point he began his first course of anti-depressants. His struggles to relate to others continued, and this impacted upon both his social and romantic life. Ron acknowledges that from the outset, his relationship with his wife was not idyllic, and describes them as being very separate people. He struggled to come to terms with the loss of their first child, and despite having further children, he felt that this caused the distance between them to widen, leaving him isolated within their relationship. Throughout this period, Ron became desperate to find a deep and meaningful connection, and after finally finding and later losing this bond with another woman, his mental wellbeing took a severe downturn.

> *I've always wanted that deep passionate love, I've wanted to pour myself into someone, and the one point in my life where it actually happened was after I lost the baby, I fell in love with this person, poured myself into*

> *her, and then when it ended, I fell apart. The biggest, the biggest crunch point was going back about 4-5-no, time's a bit of a blur, 5-6 years ago, when that relationship ended after 18 months, I fell apart. I just absolutely, I fell apart at work, my professional life ended, as a consequence of it [L: oh really?] yeah, I was working in the [organisation] as a manager, and I couldn't cope, so my working life fell apart. I ended up losing my job, and having to start from [...] bloody scratch.*
> *(Ron, pg.16, line 2)*

Ron was dismissed by occupational health and his employers' reactions to his distress were unhelpful, leaving him feeling abandoned and without support. After being asked about whether his family are available to him as a support network, Ron expressed sadness at being estranged from one of his brothers. He feels that because his family experience a shared history of difficulty, there are some things which will never be right between them.

> *I think the thing is with the family relationships is that they are-it's such a long history of difficulty and it's not easy to put that right [L: No], with the best will in the world. And some of my family are less able to talk about this than I am. My brother, the one that I'm estranged from, cannot talk about it, cannot deal with it, shuts it away.*
> *(Ron, pg.19, line 21)*

This is hard for Ron as having experienced the same upbringing as his siblings, he believes they should understand each other better than anybody else and be there to support one another. He harbours some resentment towards his family over this dispute and says how it is as though he is being punished by his brother for something that isn't necessarily his fault. Ron does have a support network outside of his family, and does not feel short of people to talk to about his mental wellbeing. He highlights that in recent years, communities have begun to work together to improve general mental wellbeing, and how he feels this is a positive step forward, especially in such a time where the NHS is struggling with various cuts and lack of staff. He provides examples of activities, such as poetry readings, which bring people together, and create platforms for support and to relieve feelings of loneliness.

8.2.2. *Mental illness is something to escape*

When asked about his coping strategies, Ron reports a number of activities that he has engaged with in an attempt to alleviate his symptoms. These range from a number of creative outlets, to less healthy pastimes such as smoking and excessive alcohol consumption. After leaving his wife, Ron describes his life as becoming a ‘rollercoaster’. He found himself recklessly pursuing a string of bad romantic relationships and developed a skewed sense of self, experiencing high levels of confidence that he describes as irrational.

> *Interestingly when I was going through some of my darkest days of my mental health, I’ve felt more confident about standing up, and doing some stand-up comedy and did some open mic as well. It’s crazy that within that difficult time, I found more confidence to do that than I’ve got right now.*
>
> *(Ron, pg.31, line 16)*

High levels of distress masked some of Ron’s inhibitions and prevented him from overthinking his actions. Although this allowed him to take part in activities that he would not ordinarily have the confidence for, such as performing on stage, it also had an impact on his decision making, leading to some poor choice and unhealthy behaviours.

Ron talks frequently about escapism, and mentions several creative outlets that he uses to achieve this, his passion being photography. He studied photography at college and maintained an interest in this throughout his life. When talking about coping strategies aside from medication or therapy, photography was at the forefront

> *I think photography always helped, you know, when I was making photographs, it was always a form of escape, something, you know, looking at the world through a camera can be quite, quite escapist really.*
>
> *(Ron, pg.10, line 2)*

In addition to photography, Ron also escapes from his negative feelings through exercise, music, art, and performance. He does, however, emphasise that although engaging with these activities can provide a release and be healthy, it is still important that the underlying issues should be addressed. For Ron, these escapes are temporary, and sooner or later, the problem must be faced head on.

8.2.3. The importance of being understood by professionals

Ron's history of mental health treatment does not begin with his own experiences, but with those of his mother. He recalls that he was initially fearful of where treatment might take him, knowing what his mother went through. Throughout the interview, Ron talks about a 'then' and 'now' of mental health care, and occasionally references 'old-school' doctors, which suggests a shift to a new way of thinking when it comes to mental health.

> *Knowledge of mental health, GPs probably wasn't great back then. And I knew that my mum had been through, erm, being treated for her mental health, and I knew that that had been pretty horrendous for her. I knew that she had been put on tranquillisers, and she'd been in a psychiatric hospital [L: oh right, okay] and she'd tried to commit suicide. So [...] I had anxiety about where mental health treatment might take me.*
>
> *(Ron, pg.7, line 4)*

In most cases, a GP is the first healthcare professional people encounter when they seek help for their mental wellbeing. This first conversation will influence the path that they take in terms of their treatment, and it is important that enough information is provided at this point for them to make an informed choice that is right for them. Ron first sought help for himself as a young adult, and his symptoms were initially dismissed.

> *I was still living at home when I went to the doctors for the first time, yeah. I think, my doctor said, 'there's nothing wrong with you' [laughs] yeah, 'pull yourself together' basically. And it took a long time for them to-to work out that I was suffering, from anxiety and possibly depression as well.*
>
> *(Ron, pg. 5, line 21)*

This encounter heightened Ron's sense of fear and confusion at not knowing what was causing his symptoms. His later experiences were more positive, and he attributes this to a generation of healthcare professionals who are better informed when it comes to mental healthcare. Over the years, Ron has found different talking therapies to be effective in managing his symptoms. He talks about these treatments building up a cumulative effect on his mental wellbeing but that the strength of these effects depend on the quality of the counsellor and how they relate to him. The patient-counsellor relationship is a prominent factor in the efficacy of talking therapy, and Ron describes a few circumstances in which this had a negative impact on recovery journey.

> *Erm, there was a, after I lost the baby, we lost the baby, down in [City] I went to see a, a counsellor at the surgery and, I remember her clock-watching, and also, when I was talking about my own feelings about the way that I'd laughed at other people's behaviour, I, I remember her just, just talking to me in a way that made me feel like I was, you know, a bad person. Erm, that she lacked patience and empathy.*
>
> *(Ron, pg.13, line 9)*

After losing his career, Ron persevered with a number of therapies and self-help practices, determined not to let mental distress take such a hold on him again. He has reached a point in his journey where he is able to recognise when he needs help, and is also able to determine the nature of the help he requires.

> *The last bout of depression I had was before Christmas. Erm, went to the GP, GP said, 'so what are the options, what have you considered?' and we talked about health and fitness, we talked about medication, we talked about talking therapy. The last time I was offered talking therapy I said, 'no I don't think I need it' [laughs], it's not always the answer. I think if you understand what-what the causes are, and what's going on, sometimes there are other, you know, you just need to work through your depression.*
>
> *(Ron, pg.14, line 18)*

Looking at Ron's responses to the interview questions, it becomes evident that he does not currently see mental distress as something that can be fully recovered from. He has developed a number of coping strategies and combines these with professional treatment in order to effective manage his symptoms as and when they arise. His responses suggest that in terms of mental wellbeing, there are various levels of wellness, and his coping strategies allow him to feel ‘well enough’ to deal with day to day life.

8.3. Ginny

Ginny is in her 30s and lives alone. She is currently not working due to her mental health, and has recently been told that her existing diagnosis of bipolar affective disorder is incorrect and has been re-diagnosed with borderline personality disorder. She is currently awaiting help for this, and has been for some time. The superordinate themes that will be explored in this section are set out in the below table and are as follows: Living with mental illness is lonely and isolating, Wanting to feel ‘normal’ within and seem ‘normal’ to others, The importance of being understood by professionals, and Being hopeful for a symptom free future.

Thematic Table - Ginny-1

Superordinate themes	**Subordinate themes**
Living with mental illness is lonely and isolating	- Loss and loneliness - ‘Putting on a brave face’ - Bottling up emotions
Wanting to feel ‘normal’ within and seem ‘normal’ to others	- The desire to be a ‘normal person’ - The effects of medication - Being pigeonholed - Acceptance and stigma - Effects of medication
The importance of being understood by professionals	- A ‘mixed bag of care’ - The rush to a diagnosis - Inappropriate courses of treatment - Idea of a ‘true counsellor’ - The NHS do their best
Being hopeful for a symptom free future	- Learning to face your fears - Living a normal life - ‘When I can —‘ - Feelings of empowerment and achievement

Superordinate themes

8.3.1. Wanting to feel ‘normal’ within and seem ‘normal’ to others

Ginny openly admits to the fact that she is struggling to come to terms with her mental health diagnosis. She worries that accepting a diagnosis will prevent her from being considered a normal person, and expose her to the potential stigma that comes with mental distress. She does, however, acknowledge that some of her thoughts are not considered ‘normal’ and conveys a desire to live her life without them.

> *Um, I find it really hard, like to accept that-my diagnosis? [L: Yep] I just wanna be a normal person [laughs] and like work again, and be able to go food shopping without thinking that everyone is looking at me, or talking about me.*
>
> (Ginny, pg.5, line 14)

After initially seeking help, Ginny was provided a course of medication but it later transpired that she had been misdiagnosed. She expresses feelings of resentment about this and says that she feels as though she has been treated like a guinea pig. When asked about the effects her medication had upon her, Ginny once again mentions feeling as though she had been stripped of some of her humanity.

> *I felt a bit like a zombie, I felt like, like just in a haze, like just flat, like no personality. I’d rather have a bit of a fun personality than just be flat.*
>
> *(Ginny, pg.4, line 4)*

Ginny worries that her diagnosis along with the side effects of her treatment will make her an outcast and that people will avoid her if they knew that she struggles with her mental health. She desperately wants to be accepted but feels under pressure to conform to what she believes other people want to her be.

> *There’s a big stigma though isn’t there? ‘They’ve got mental health, stay away from her’ [L: Mm] it’s like, depression anxiety- I mean, ‘I’ve got anxiety, accept me as I am’ and people try and make you change to be more like them, but it’s hard isn't it?*

> *(Ginny, pg.23, line 4)*

Ginny repeatedly refers to feeling under extreme pressure throughout the interview and how this has been detrimental to her mental well-being. She has found that the pressure to perform as a normal person has been overwhelming and has resulted in her withdrawing and experiencing the subsequent feelings of loneliness.

8.3.2. Living with mental illness is lonely and isolating

When asked how she manages her feelings of distress, Ginny initially responds by saying that she used to withdraw. Despite this, she actively attempts to overcome her anxiety and continue to try and live her life as normally as she can.

> *Um, I used to kind of isolate. So just stay in - but I know that's not helpful [laughs] but you've just got to try and face it, feel the fear but do it anyway. Tackle your fears. Try and- try and get on regardless.*
> *(Ginny, pg.7, line 1)*

Ginny worries about other people knowing that she struggles with her mental wellbeing, and has felt that in the past, her symptoms have caused some of her friendships to break down. Unfortunately this was not helped by her initial course of medication. She experienced memory loss and weight gain as side effects to her treatment, and this in turn affected her confidence and relationships with others.

> *I would always be a people person, and quite happy, outgoing and then when I got really big [...] I just isolated for like 3 years, and lost a lot of friends, and people all thought I was being difficult on purpose, and I was forgetting things 'cause of medication. Forgetting people's birthdays, or not turning up and things like that.*
> *(Ginny, pg.22, line 17)*

Throughout the interview, Ginny occasionally struggled to talk about how her diagnosis and treatment made her feel. She ascribes this to her fear of coming to terms with her diagnosis, and talks about how she was more likely to keep everything to herself than to share with others.

> *I didn't really wanna talk about it, like you say, keep it within [L: Mm] don't wanna talk about it, don't wanna tell anyone, it-it doesn't happen. And I think, blocking it out for so many years was the cause of everything coming out at once*
>
> *(Ginny, pg.3, line 4)*

A catalyst towards the Ginny seeking help for her mental wellbeing was losing her retail job in a high pressure environment. When asked if she talked to her employers about her mental health, she states that at the time she did not feel as though she could, but in hindsight recognises that this may have helped alleviate some of the pressure she was feeling. She describes feeling paralysed and completely disabled by anxiety during this role, and again in her subsequent attempts to return to work.

8.3.3.The importance of being understood by professionals

Ginny is frustrated by the lack of appropriate care that she has received in recent years. She expresses a desire to understand the root cause of her distress and feels that this can only be effectively achieved through intensive talking therapy.

> *I think I probably need like, deep counselling, rather than just someone to talk to for an hour a fortnight. Like deep therapy, with a qualified therapist.*
>
> *(Ginny, pg.17, line 6)*

The idea of a 'qualified therapist' comes up again during the interview, when Ginny talks about her dissatisfaction at not receiving the treatment that she feels she actually needed in a timely manner, and instead being assigned to a back to work therapist.

> *I still see a lady from the NHS, but she's just a 'back to work' therapist, not a true counsellor. And I did go to a psychiatry team in August 2017, but they're so booked up, they haven't had time to see me.*
>
> *(Ginny, pg.5, line 1)*

Ginny feels as though she is currently being placated by her local mental health services and insists that her current form of therapy is inappropriate, and that it is jumping too far ahead of where she is in terms of managing her mental distress.

> *I'm seeing a 'back to work' therapist and I'm not ready to go back to work- and she knows this! So she's trying to put me into the thing of like doing a craft fair, and getting out there, and I tried it and it was too much pressure. Because 17 people turned up, and I'm like, 'oh my god, complete meltdown' [L: Mm] and then I told my friend who works in, like a, office environment in [City] - and she's quite an outgoing person, she says, 'I couldn't even do that [Ginny], I can't believe they kind of made you do that!'*
>
> *(Ginny, pg.11, line 4)*

Ginny feelings of being pushed too far too soon are corroborated by her friend. She feels that her recovery and wellbeing are not being put at the forefront of her treatment, but instead, she is being forced back into a line of work that she knows serves as a trigger to her anxiety attacks. She describes a further instance of being encouraged to engage in treatment she was not ready for, this time cognitive behaviour therapy.

> *Because they did discharge me, sorry, they did discharge me for not being able to concentrate or focus, with the CBT. She said, 'I've tried to give you CBT, but you're not engaging with me', and I'm like, 'Well I've tried my best- maybe the medication they gave me 6 years ago...' - I think it adds too- you're ability to focus, and my memory's rubbish and [...]*
>
> *(Ginny, pg.16, line 10)*

This encounter left Ginny feeling disheartened and frustrated by her local mental health services. She makes a point of recognising that services are stretched and that mental health professionals are doing the best they can in tough circumstances but she has been made to feel that she is not being heard which has resulted in inappropriate and impersonal care. She has been left alone to come to terms with a difficult diagnosis and feels let down by those who are there to help her.

8.3.4. Being hopeful for a symptom free future

Despite having a negative experience of professional care, Ginny is positive and engages with a number of self care practices. She goes to the gym a few times a week, an activity that she describes as making her feel empowered. She has lost a lot of the weight she gained when she first began taking medication and is determined to try and remain healthy.

> *G: Ah okay, yeah I need to try that. I do go to the gym 3 times a week, but just cardio and weights - that helps a little bit.*
> *L: Yeah? So how does that feel?*
> *G: Empowerment [L: Empowerment] because I was doing really well. Because I was a size 18 3 years ago [L: Oh really? Wow!] I was 14 and a half stone, and now I'm- I'm 12, and I did get down to 11, but it's just maintaining that- the weight loss. I gotta try and just-*
> *L: That's a huge improvement though!*
> *G: I know! I was really, really big! I was really big-14- and I'm only 5'2" as well [laughs] so I can't let that happen again! It's not healthy.*
> *(Ginny, pg.20, line 16)*

Ginny also enjoys creating jewellery and aims to one day set up her own website from which to sell her pieces. Her use of language throughout the interview suggests that she can envision a positive future for herself where she can live life normally without struggling to overcome symptoms of distress. She repeatedly refers to a time in the future when she feels more settled, feels ready to return to work, and ready to overcome her fears.

> *Eventually I do want to get back out there, but when I feel more well in myself [L: Yeah], when I can concentrate again.*
> *(Ginny, pg.13, line 2)*

> *I can eventually try and overcome it. Eventually.*
> *(Ginny, pg.9, line 10)*

Ginny has positive plans for her future but would like to understand the root cause of her distress so that she can take steps to overcome it and effectively manage her symptoms. Her lack of professional support is currently blocking her from feeling confident enough to fully face her fears, and she is instead left feeling frustrated and ignored by the care she is being provided.

8.4. Molly

Molly is in her 30s, married, and has recently had a child. She has struggled with depression and anxiety throughout her adult life and is working through post-natal depression. At the time of the interview, she was not taking medication for her symptoms but had been prescribed a new course and was considering beginning to take these. The superordinate themes that will be explored in this section are set out in the below table and are as follows: Living with mental illness is lonely and isolating, The importance of being understood by professionals, What you can do for yourself, and Distress is a normal reaction to bad things.

Thematic Table - Molly

Superordinate theme	**Subordinate themes**
Living with mental illness is lonely and isolating	- Loss and loneliness - The impact on relationships - Searching for understanding and human connections - ‘Life isn’t worth living if —‘ - Effects on significant others - Loneliness of motherhood - Loss of independence - ‘Putting on a brave face’ - The effects of long term illness

Superordinate theme	Subordinate themes
The importance of being understood by professionals	- A ‘mixed bag of care’ - The cumulative effect of treatment - Searching for the answer - Building tolerance to treatment - Inappropriate courses of treatment - Therapeutic relationships
What you can do for yourself	- Mindfulness - Efficacy of practice - Keeping up practice - Exercise
Distress is a normal reaction to bad experiences	- The pathologising of the human experience - Bad things happen - Distress is a reasonable reaction

Superordinate themes

8.4.1. Living with mental illness is lonely and isolating

Molly first received treatment for her mental health as a young adult attending university for the first time. This was her first time living away from her family and was attending a university far from home, she recounts suddenly falling very ill and unable to get any answers as to why. When talking about this period of her life, she rationalises her symptoms as resulting from an understandable fear regarding her situation.

> *Erm, really, you know, upsetting- you know, I was in this brand new- this new city hundreds of miles away from home, I didn’t know anybody, and I just couldn’t get out of bed and it was just horrendous. So, obviously that had a massive impact on my mental health. Erm, and it just kind of [sighs] well, I don’t know what to say, obviously I was worried, ‘what on Earth is wrong with me?’*
>
> *(Molly, pg.2, line 6)*

Upon seeking help for the first time, Molly was dismissed by her counsellor and later told to take medication for depression. When looking back upon this time, Molly voices surprise at how little inquiry was made about her situation, especially having later trained as a counsellor herself and understanding the principles being counselling. She believes that if the healthcare professionals she encountered had taken the time to assess what was going on properly, her symptoms would have been considered a normal response to a frightening situation.

> *M: I did go to counselling actually, it was the first thing I did. And they kind of took one look at me and said, 'Oh, you- you look like you're depressed, go to the doctor' which was just [...] not really what I wanted to hear! I mean like, it just seemed like-*
>
> *L: So was the counselling part of the- provided by the university?*
>
> *M: Yeah, yeah, and I was really surprised to have that reaction- I've actually since trained in counselling myself- and I'm really- I'm still really surprised that any counsellor would say that- 'cause that's not what I was trained at all. Like, you know, basically, 'Go away', you know, 'You're- you're ill, just get some pills' type of thing, just seems completely opposite to the-the, sort of, idea behind counselling.*
> *(Molly, pg.4, line 5)*

Molly talks about her later experiences of anxiety and again refers to these as originating from rational fears surrounding long term illnesses, injury and other circumstances which could adversely affect her life. Having endured Myalgic Encaphalomyelitis (ME), Molly is very aware of what it means to undertake a lengthy recovery process, the energy required to get through and what will be lost to her should her illness recur in the future.

> *When I first had it, one of the- one of the sort of after effects from having ME for so long was- I got a real fear about my health, I got a real anxiety about my health, just kind of, you know, going down the pan. Things going wrong, because it just came out of nowhere, and when you have ME, there's no- you may get a diagnosis, but you don't get any treatment, you don't get any explanation, it just appears, and erm, so I was left with that real intense anxiety about health- and I've always kept myself really, really healthy.*
> *(Molly, pg.8, line 6)*

8.4.2. The importance of being understood by professionals

After recovering from ME, Molly was able to move on with her life and build up her self-esteem and mental wellbeing. She describes beginning to struggle with anxiety surrounding her physical health again when she and her husband began to talk about having children. At this point she sought help from her GP and then engaged with CBT for the first time.

> *So when it came time to sort of really think about maybe having kids, it just prompted enorm- like, massive, massive anxiety. It's just huge, there were so many different worries that I had about it, erm, so I was at the point where I was thinking, basically, like my husband and I were thinking, we think we want children, but I was too frightened to actually like go about trying to even, even get pregnant. Erm, so that's when I tried to get help from erm, 'Let's Talk' on that, well, just through my GP I think, she referred me, and it took ages, it was probably about 2 years, I think, by the time I saw somebody, but I had CBT from then, for the anxiety about birth and erm, you know, all the anxiety about the different things I had.*
>
> *(Molly, pg.8, line 15)*

Molly's experience of CBT was largely positive but she makes a point of stating that she believes that although it can work well for certain things, she does not like that it is often the first route of therapy available. She expected a more empathetic and warmer relationship with her therapist and was upset by the clinical manner in which her sessions went ahead.

> *I dunno- there seems to be almost like a lack of empathy often, I think - when you have CBT. You sort of walk into the room, and you say, 'Oh you know, I'm feeling terrible', and they're like, 'Yes, yes, yes, but what about your thoughts? What about your blah', you know, it's-it's all very, kind of erm, formalised, and I still had two sessions left after I had her, and I tried to use one of them as a phone session, and I- I was really- I was really, really distressed, I was physically in so much pain. Erm, because I had a lot of- well I have had, and am still having a lot of*

> *problems physically after having her. And erm, I was in so much pain and I- I was saying, 'Oh yeah, you know, I'm in pain', and it was like, 'Yes, okay, well can you get your, you know, notes out? And can you look at this? And can you, you know, formulate that? And blah blah blah' and it was just- I felt like, you know, not being listened to really.*
> *(Molly, pg.10, line 12)*

Since having her first child, Molly has struggled with feelings of isolation, both physically and socially. Her injury prevents her from walking long distances or cycling, and leaves her feeling frustrated and bored through having to stay home more frequently. And despite making friends through activities such as pregnancy yoga, she feels out of place amongst other new mothers.

> *I find it quite an isolating- it can be very isolating because a lot of the things I go to, you know, everyone's just, oh full of the joys, 'oh isn't it wonderful having babies? Blah blah blah blah blah, oh I can't wait for this, can't wait for that,' and I just sit there going- I just don't think, I don't agree with any of that, you know? Just like, 'Oh I can't wait for weaning' oh you know, it just fills me with dread, the idea of weaning! Uh god, weaning, no- I just can't be dealing with it, and no I just don't find it adorable and wonderful, and I just find it a drag, you know, most of the time. Looking after a baby is hard, and it's thankless, and it's 24-7 you know?*
> *(Molly, pg.20, line 11)*

At home, Molly has often relied on her husband for emotional support but describes this as placing a strain upon their relationship. Her family remains a long distance away and although they have been supportive of her since her birth injury and post-natal depression, her husband is struggling to remain her main pillar of support.

> *Unfortunately it's taken it's toll. You know, I mean, years of it. We've been together for over 10 years and, years of years of depression, years of anxiety- it massively takes its toll on- on the partner, I would say. And [sighs] yeah, I mean this last sort of- well since we've had her, has just*

> *been the most testing time. I mean yeah, he's angry with me, he's frustrated with me, it's not great.*
> *(Molly, pg.21, line 11)*

Molly feels guilty about the wider effects that her mental health has had on her family and describes a profound 'ripple effect'. She is aware that her symptoms may affect her child, and briefly mentions that she believes her own mother struggles with depression, but intends to actively teach her daughter coping strategies such as mindfulness from a young age.

8.4.3. What you can do for yourself

In the past, Molly has actively engaged in a range of self-care practices, including exercise, singing, mindfulness, and art therapy. When asked about how her mental health affected her work life, Molly talked about how generally, going to work provided an escape from her feelings of anxiety and depression. She developed coping mechanisms and used her commute to practice mindfulness.

> *I mean, now with her, it's incredibly challenging, but I used to- because I used to commute to [City]- my train journey in the morning, that was sort of the perfect time, because it's kind of a protected space. You can't really do anything else, so, that's definitely been the most helpful thing.*
> *(Molly, pg.7, line 10)*

Molly has found that, overall, mindfulness has had the most positive impact on dealing with her symptoms of anxiety, and in the past, has practiced this regularly. Since becoming a mother, however, Molly has found that she now no longer has enough time to remain vigilant with her self-care practices, and her birth injury has prevented her engaging in the regular exercise that she used to enjoy.

> *I think after this long, I have a lot of strategies and ways of dealing with things, I mean, you know, there are so many different things. Journals, and affirmations, and this practice, or that practice, or do this, or have a*

> *bath, or read a book, or whatever. But actually being able to- in the moment, be able to get to any of that is, is so difficult. And even more difficult now I have her, because there's no time when you have a baby. There's just zero time.*
>
> *(Molly, pg.42, line 14)*

Molly's mental wellbeing took a severe downturn after she gave birth, and she describes feeling the worst she has ever felt during the subsequent months. She has also felt that the professional advice that she has received during this time has been unhelpful, and often inconsiderate of her specific needs.

> *Yeah, it's very difficult though, when you're, when you physically can't do activity, and you're constantly being told, 'Oh you should exercise, oh exercise is good for you' [L: I know] Yeah, it's really, it really makes things worse.*
>
> *(Molly, pg.37. line 12)*

Despite not currently being able to do much exercise due to her birth injury, Molly still advocates exercise, along with mindfulness as a very effective method of self-managing symptoms of distress.

When talking about the future, Molly expresses a desire to teach her daughter to practice mindfulness from a young age. She believes that being aware of one's thoughts and feelings, as well as being aware of one's physical wellbeing can make a big difference when it comes to maintaining good mental health. She also talks about the importance of providing children with the vocabulary to effectively describe their emotions, and feels like she would have benefitted from this herself.

> *I would definitely want to try and teach her to deal with her emotions and, you know, cope better with normal parts of experience, feeling bad is normal. I mean, I remember when I first went to counselling, I didn't know what emotions were. But the counsellor gave me a list of words to describe emotions- because I couldn't think of any! The only thing I could think of was 'upset' it was the only word I could come up with. He had to give me this list, and then suddenly it was like, 'Oh, okay' and I think that emotional awareness [L: Mm-hm] is massively lacking.*

> *(Molly, pg.38, line 23)*

8.4.4. Distress is a normal reaction to bad experiences

Throughout the interview, Molly makes it clear that she does not consider her symptoms of depression and anxiety to be attributed to mental illness, but rather reasonable (if heightened) reactions to negative outside stimuli.

> *I mean yeah, I've been diagnosed with depression, but to me it-it's stemmed from events that have happened in my life. And I had ME for 7 and a half years, and erm, at times I was, you know, unable to get out of bed with it- I had to give up uni, it was, you know, completely devastating. So, yeah, that's when I got depression, but I don't see it as kind of a separate illness, if you know what I mean? It-it's just- It's a reaction to life event.*
>
> *(Molly, pg.3, line 10)*

Molly has experienced a number of distressing life events which have severely affected her mental wellbeing. She describes her anxiety as stemming from a fear of similar events occurring again, or from worrying about other unpleasant situations - for example starting a workday in a role she did not like. She argues that these feeling are normal, human responses and that they should not be immediately labelled as symptoms of depression, anxiety, or another form of mental distress. Instead she believes that we can be taught to accept and appropriately manage these feelings.

> *I think that it's worrying that every time the DSM comes out there's more and more different, you know, illnesses to do with the mind that you can get. And I feel like more and more, kind of quote, 'normal human experience' is being pathologised in to that sort of- yes, I mean - with her I would definitely want to try and teach her to deal with her emotions and, you know, cope better with normal parts of experience, feeling bad is normal.*
>
> *(Molly, pg.38, line 18)*

She mentions experiencing periods where she does not experience any symptoms at all, and creates the idea of building up a credit of good mental wellbeing, linked to the positive things that have happened to her over the years. This became coupled with a fear of losing this credit as a consequence of her fears coming true.

> *And slowly, slowly, you know, I've rebuilt my life, I've got, erm, I've got a full time job, didn't work full time until I was 30, so you know, that's made a massive difference. Erm, you know in terms of having something to do, you know? And being able to be healthy and well, and having money to go out and have a nice time, and my husband and I bought our own house - so with that kind of security we got married etcetera so it felt like, you know, it was built up- so yeah. I was really afraid of post-natal depression, and just crashing back down to absolute doom and gloom, and to be honest- it's been horrendous.*
> *(Molly, pg.16, line 6)*

Having this outlook means that she does not believe that there is a cure, or a prospect of eventually living entirely symptom free. Molly feels that there is not a be all or end all answer, but instead a number of avenues to explore and try and find what works at the time.

> *I dunno, it's never really felt like things are resolved, but I don't know, I just think that's the way things have gone, I don't know how things can ever really feel like they're completed or resolved.*
>
> *L: So do you not feel that you can foresee a future where you're not going to have some form of depression or anxiety, or a combination of the two, on a low level?*
>
> *M: Not really, no. To be honest. I mean, it's- it's really difficult because like, most- most of my life, I've just sort of just pretended that it's just a temporary thing- and after it, you know, a period of feeling bad kind of ends, I sort of just forget about it.*
> *(Molly, pg.31, line 10)*

This outlook suggests that Molly does not feel that, for her, there is likely chance a cure, or a prospect of eventually living entirely symptom free. She does not believe in a 'be all or end all' answer regarding her periods of distress, but instead attempts to put on a brave face and find what works to manage her symptoms at the time.

8.5. Fleur

Fleur is in her 30s and has two children. She was first referred to the mental health services when her first child was a toddler and has been on and off treatment since then. At the time of the interview she was taking medication to treat symptoms of anxiety. The superordinate themes that will be explored in this section are set out in the below table and are as follows: Living with mental illness is lonely and isolating, Wanting to feel 'normal' and seem 'normal' to others, and The benefits of learning to be self-aware.

Thematic Table - Fleur

Superordinate theme	**Subordinate themes**
Living with mental illness is lonely and isolating	- Loss and loneliness - The impact on relationships - Feelings of abandonment - Loneliness of motherhood - Fading away - Trust and communication
Wanting to feel 'normal' within and seem 'normal' to others	- The effects of medication - Compliance - Feeling caged - Feeling superhuman - I am underserving of care - Detachment from the self
The benefits of learning to be self-aware	- The quest of recognition - Illness as a cycle - Foreshadowing - Educating our children

Superordinate themes

8.5.1. Wanting to feel 'normal' within and seem 'normal' to others

When recounting her first experience of becoming involved with the mental health services, Fleur struggles to remember any specific details. During that time, she found herself surviving on autopilot and felt detached from her situation. At her worst, she describes herself as feeling almost ghostly and insubstantial

> *Because it's- that's always the way I saw myself, just slowly becoming more and more transparent until I just faded away, and no-one noticed.*
> *(Fleur, pg.38, line 4)*

Fleur felt very self involved during this time and believed herself to be undeserving of care. She was therefore very surprised and frightened to be suddenly surrounded by a team of mental health professionals. When discussing treatment for distress, Fleur mentions that she has issues with compliance and provides examples of hoarding medication and not attending therapy sessions. She feels as though treatment restricts her freedom, keeping her caged in one place.

> *And I don't like that I'm tied down to where I am, because I- I need a prescription every month, because they will only give me a 1 month prescription [L: Okay] because I've hoarded tablets before. And so I have to- I hate being constricted in that way. It's the same as I felt when I was in the therapy. Like, I had to go every week. I'm tied to that [L: Mm-hm] like, I don't-I don't like the feeling of being boxed in?*
> *(Fleur, pg.12, line 2)*

Fleur experiences episodes of feeling manic, and is still learning to effectively handle these. During these periods, she feels almost superhuman and will take on more than what is reasonably possible to complete. Once the manic period subsides, she is left with a lot of half finished projects, resulting in her feeling overwhelmed and as though she has failed.

> *I still really struggle with recognising when I'm going through a bit of a manic phase, which- so I feel so capable, then, and I feel so on top of things, and I feel so unstoppable, that I take on so many things. I will be*

> *the person that will do anything for anyone- goes above and beyond in every area, and it literally is like flying- and then, I'll just get to the point where I'm- I'm just starting to crack, because I can't quite keep up with it [L: Mm-hm] and then- admitting that I can't do everything, that will be the peak of the- then we go very rapidly downhill.*
>
> *(Fleur, pg.15, line 4)*

Fleur is extremely hard upon herself and struggles with the idea of being considered a failure as a person, and a failure as a mother. Having not intended to have a family, Fleur again describes feeling like her freedom has been taken from her.

> *Yeah. I do- yeah they're probably like- my biggest worry is that they're probably better off without me, and that I'm having a negative impact on them, that they'll then carry until they're adults. It's just a lot of pressure. I never wanted children. And they are- you know, from someone who has had very few social- long lasting social ties, through choice or not, they're like 'for ever' and I find that suffocating [L: Mm-hm] I feel like the home is a cage, motherhood is a cage.*
>
> *(Fleur, pg.28, line 18)*

Having generally lived a fairly solitary life, Fleur has been left feeling overwhelmed by having children and suddenly having a team of mental health professionals involved in her life. This feeling has been exacerbated by a build up of anxiety through feeling trapped, or caged, in one place and has led to downturns in her mental wellbeing.

8.5.2. Living with mental illness is lonely and isolating

Until recently, Fleur has struggled to maintain close personal relationships and acknowledges that in some ways, this is due to her troubles with her mental wellbeing.

> *I'm quite, erm, I find social relationships quite difficult, I find them really challenging, because [...] I think probably I'm quite hard to take. From*

> *the other person's perspective sometimes, erm, but also, I read into things a lot, and I worry, and erm, because I haven't had a lot of success in the past with friendships, they've always ended quite badly, I- I don't feel very secure in friendships generally.*
>
> *(Fleur, pg.16, line 4)*

Low self-esteem causes Fleur to feel as though she is hard to love, and combined with her poor experiences of previous relationships, she struggles to let her guard down with others. She recognises the benefits of having a strong support network, and is actively trying to show more vulnerability around others but states that this is easier said than done.

> *So I'm trying to let my guard down more with- with people and accept that actually, people generally, like-that have you in their life want the best for you. They're not- they're not all trying to trip you up. [L: Mm-hm] You don't have to put on a show all the time. But it's-it's really hard. Like, yeah.*
>
> *(Fleur, pg.16, line 11)*

When asked about her support networks, Fleur talks about mostly relying on her partner. He takes on some of the responsibility for her mental wellbeing and makes a point to encourage her to remain complaint with her treatment plan.

> *I get a lot of support from [Partner] my other half, he has reminders and stuff on his phone for when I should take my medication, and sometimes he has to be sort of quite, 'No. Stop. Take your medication now, so I see you take it', he looks after my tablets so I can't hoard them, or run out. Because he will prompt me to order them*
>
> *(Fleur, pg.14, line 18)*

Fleur does struggle, however, to talk to the rest of her family about her mental wellbeing. When describing her lack of family support, and her abrasive relationship with her mother, Fleur makes it clear that she believes that any request for help from her parents will likely be harshly dismissed.

> *My mum believes that I am a born hypochondriac. And I've always wanted something wrong with me, and now I've found something that I can tell the world is wrong with me. Erm, and I'm not depressed, I was just a cold child from the day I was born.*
>
> *(Fleur, pg.17, line 13)*

Further anecdotes from her childhood suggest that, despite not commencing treatment for mental distress until she was in her 20s, Fleur struggled with her mental wellbeing from a young age but was made to believe that her symptoms were fabricated and that her isolation was her own fault.

> *My mum always, [sighs] she'd say, 'Turn the- stop the fucking waterworks, [L: Mm-hm] the reason that no-one wants to be your friend is 'cause you're so fucking miserable all the time. Sullen, and you think you're better than everyone else, so you shut them out'*
>
> *(Fleur, pg.32, line 2)*

Fleur struggles to trust and acknowledges that this has contributed to her difficulties with forming close and meaningful relationships. It has also prevented her from fully opening up to the mental healthcare professionals that she has encountered, and she has had few individuals working with her whom she has felt she can trust. After building up a positive relationship with her most recent therapist, she has been left feeling deflated after receiving no aftercare following being discharged.

> *But I'm really disappointed in him. I feel like he's let me down and abandoned me, so [...] I emailed him a few weeks after I was discharged, because I was really struggling. And I got no response, and I thought that he'd resigned- like I thought that he'd retired, because he'd mentioned it, but erm, obviously that was the first bit of information I squeezed out of my mental health nurse, 'where is he now?' [L: Oh right, okay] and he is still there.*
>
> *(Fleur, pg.13, line 8)*

Fleur was hurt by her therapist's choice of not to respond to her request for support, and was left feeling ignored and unvalued. She goes on to express her annoyance that there is no aftercare available to those who have been discharge from the mental health service. Fleur feels that some infrequent supervision would be beneficial to prevent relapse, and believes that an action plan or coping mechanisms should be provided to the wider family so that they can recognise symptoms and provide effective emotional support when it is needed.

8.5.3. The benefits of learning to be self-aware

Fleur is on a mission to be able to identify patterns in her mental wellbeing so that she can better manage her symptoms and try to prevent serious instances of mental distress. She has discovered that her symptoms happen in a cycle but although she is able to see this after the cycle has finished, she is still struggling to notice it when it starts.

> *But yeah, I don't- I think I'm on a quest at the moment, to notice those things. Because I'm not very- I think I'm very very self aware- but I can't really- but only in hindsight?*
>
> *L: So you experience it, and then you look-reflect and you're like, 'Oh, I need to make a note of that'*
>
> *F: Yeah, but then it's really hard to notice, by yourself- and I think this is where the support networking helps [L: Because if people notice you doing it] well like, I'll disappear into my phone [L: Mm-hm] I will just play games, and I talk to men that aren't my fiancé - which he knows about, and is fine with, but I only do it when I'm manic. I know- I've noticed that this time- this time round, because I just- so I go from have this sort of, insatiable sex drive to bam! [L: nothing] Don't. Touch. Me. [laughs] No, but yeah, I don't- I don't really understand it still. I think- I've literally only just realised, like I've only just noticed that it's a cycle*
>
> *(Fleur, pg.24, line 14)*

She also feels that it would be helpful for her support networks to be able to identify her manic behaviours, or catch the warning signs of her sinking into a low in case she is unable to recognise these herself. Having struggled to trust others in the past, she is beginning to feel like she should share more to prevent herself going into another crisis.

> *Also I just think that people are going to find out eventually, because eventually, it will show [L: Mm, maybe] because you can't- it's not even that I try and hide it all time, but I can't be okay all the time [L: Mm-hm] and I think I've accepted that, that I can't be okay all the time, and that actually, it's better if people know.*
> *(Fleur, pg.21, line 4)*

Fleur also mentions a noticing a pattern with her mood before her wellbeing declines after taking anti-depressants. She found herself distrustful of the artificial uplift in mood as she has come to recognise extreme happiness as a foreshadower of extreme distress.

> *And just because I've never been like that. So when-whenever I'm happy generally, like really happy, it's because I'm- I'm just about to have a real bad downhill.*
>
> *L: And is that consistently true?*
>
> *F: Yeah. And it can last for like, a few weeks, or just a day- but it-it's always followed by something that is really difficult to pull myself out of, and [...] so I think, that-that worries me, but also, I think oh, like, there's something bad just around the corner, like all the time. Like, and whenever I'm really like happy, I can feel it coming, hanging over me, like, it- there's a penance to be paid.*
> *(Fleur, pg.10, line 7)*

Although Fleur worries about the effects her mental health may have on her children, she mentions being proactive in teaching them about being mindful of their emotions and mental wellbeing, especially as her eldest attends counselling sessions at school.

> *Well she was aware enough at 4 to tell me that she felt sad [L: Mm-hm] deep, deep inside. Like inside sad, which is what prompted us to get her counselling at school which has really helped. So I think, yeah, I think that's a responsibility we all have to children, is to breed this sort of awareness of mental health.*
>
> *(Fleur, pg.30, line 6)*

She believes that it is important to normalise negative emotions, and to teach children that it is okay to feel sad, and to work towards removing the stigma associated with mental illness. Despite this, she describes sometimes having difficulties in maintaining this attitude.

> *But I do have to tell you that in practice it's really hard. [L: Mm-hm] Because, if they tell you they're sad, then in an ideal world, you'd be like, 'Okay, you know, is there anything in particular? Or do you just feel like that' in the real world, you're like, 'Why? [L: Mm-hm] like, do you not have everything you need? Like why'- because it makes you feel like- It makes you feel like you're not doing a good job, it's really difficult*
>
> *(Fleur, pg.31, line 3)*

Negotiating the different aspects of dealing with mental distress is still somewhat difficult for Fleur but she is working hard to be able to take control over her own wellbeing whilst also managing the wellbeing of her children. When asked if she had any advice for those dealing with distress for the first time, she is pragmatic and positive, she recommends seeking help from a GP as soon as possible, to not come off medication without any help, and to not accept that it is okay to live a whole life feeling that something is wrong and there is nothing that can be done.

9. Discussion

9.1. Overview

This section will present a cross-case analysis of the emergent themes. Whilst comparing the data sets from each participant alongside one another, the following have emerged as the five superordinate themes: Living with mental illness is lonely and isolating, Not knowing what's happening is scary, Wanting to feel 'normal' within and seem 'normal' to others, The importance of being understood by professionals, and What you can do for yourself. These themes will be discussed within this section and considered against existing literature.

Cross-case Analysis - Table of themes

Superordinate theme	**Subordinate themes**
Living with mental illness is lonely and isolating	- Loss and loneliness - Community mental health - The impact on relationships - Loneliness of motherhood - Feelings of abandonment - Fading away - 'Life isn't worth living if —' - Effects on significant others - Loss of independence - 'Putting on a brave face' - Trust and communication - Searching for understanding and human connections
Not knowing what's happening is scary	- Sudden influx of others - Succumbing to pressure - Effects of medication
Wanting to feel 'normal' within and seem 'normal' to others	- The desire to be a 'normal person' - Compliance - The effects of medication - Feeling caged - Detachment from the self - Being pigeonholed - Acceptance and stigma - Feeling superhuman - I am underserving of care
The importance of being understood by professionals	- The idea of an 'expert patient' - A 'mixed bag of care' - The cumulative effect of treatment - The 'then and now' of treatment - Levels of wellness - Searching for the answer - The rush to a diagnosis - Building tolerance to treatment - Inappropriate courses of treatment - Idea of a 'true counsellor' - The NHS do their best - Understanding medication - Therapeutic relationships

Superordinate theme	Subordinate themes
What you can do for yourself	- Mindfulness - Efficacy of practice - Keeping up practice - Exercise - Finding support networks

9.2. Living with mental illness is lonely and isolating

It is evident from Ron and Fleur's answers to the interview questions that their relationships with others, and their struggle to make meaningful connections have had prominent influences upon their mental wellbeing. The lack of family support in difficult times can contribute to the persistence of feelings of depressions, and although existing studies focus on groups where close family ties are culturally ingrained (Gask, Aseem, Waquas, & Waheed, 2011), they can provide some context for Ron's experiences of struggling through a family conflict. Ron maintains that sharing childhood hardships should bring him closer to his brothers and is saddened that they are unable to talk about and deal with the past together. In terms of recovering from periods of mental distress, studies involving self-reporting from mental health patients have found that relationships with family and friends were considered to be the most important factor in terms of improving mental health (Stein, Leith, et al., 2015). Relationships with professionals are also deemed very important, and are expected to have positive impact on mental wellbeing. All participants described their encounters with mental health professionals as being a 'mixed bag', with some being helpful and constructive, and others less so, with less helpful practitioners being described as lacking empathy, or inhuman. Breeze and Repper (1998) suggest that patients who challenge the competency and authority of medical professionals are often labelled as difficult by their caregivers, despite not behaving badly or being non-compliant. They may consider the treatment they receive to be inappropriate or unhelpful, and struggle for control over their care. Participants in Breeze and Repper's study described how they felt that their voices were unheard by medial professionals and that all the decisions regarding their care had been made without them being consulted. They did, however, describe positive, helpful relationships with staff who treated them as valued human beings and who displayed empathy and kindness towards them. Both Ginny and Molly describe feeling as though some therapists and GPs that they encountered made minimal enquiries in to their situations and rushed to prescribe medication or a course of therapy that was not yet appropriate. Gilmore and Hargie (2000) recommended a patient-centred approach when it comes to treating mental distress, where patients are treated as experts and are actively involved in the decision making regarding their cases. They criticise the biomedical model for ignoring the social dimensions of mental illness and for treating patients as passive receivers of care, which can leave them feeling unheard, trapped, and without answers.

9.3. Not knowing what's happening is scary

During Fleur's interview, she describes herself as feeling 'boxed in' by the various courses of treatment she has undergone. Existing studies investigating depression suggested that depression can be an expression of arrested entrapment, an arousal of the 'flight' defence mechanism which is not acted upon (Gilbert, Gilbert, & Irons, 2004). It has been argued that severe life difficulties, such as a chronic illness, may instil the desire within a person to flee, but this desire cannot be fulfilled, leaving sufferers feeling trapped and distressed. The idea of depression occurring alongside stressful life events is not a new one. Oatley and Bolton (1985) suggested that depression is more likely to occur following an event that disrupt a persons sense of self. For instance, in Molly's case, she describes falling chronically ill during her first year of university and being treated for symptoms of depression shortly afterwards. Feelings of hopelessness and despair can take over when an escape is not in sight, and Baumeister (1990, as cited in Gilbert, Gilbert, & Irons, 2004) suggested that in extreme cases, this might result in a suicide attempt. Molly describes her periods of depression as feeling all encompassing and, after feeling hopeless and trapped after her initial illness and her subsequent birth injury, struggles with anxieties surrounding falling ill again. Ginny, when struggling to deal with pressure at work chose to withdraw, arguably exhibiting a flight response from her feelings of panic. She does, however, talk about the desire to fight her fears head on and trying to build her confidence to do this. Bonney and Stickley (2008) discuss the challenges of integrating experience of mental distress into a new patient identity as this challenges the existing perceptions of the self. In her interview, Ginny describes a fear of coming to terms with her diagnosis and taking up the identity of somebody with borderline personality disorder and repeatedly expresses a desire to just be seen as 'normal'. However, a rediscovery of the self does not have to be a negative experience, and can provide an opportunity for healing and growth. Ginny worries that accepting her diagnosis will result in her being labelled and her first instinct was to withdraw from others, yet gaining a social identity aside from that of a mental health patient can allow for greater self-esteem and a higher quality of life (Bonney & Stickley, 2008). Ginny demonstrated in her interview that there is more to her than a mental health diagnosis, and described feeling empowered after facing her fears when going out to shop, attending the gym and losing a substantial amount of weight, and taking pride in creating pieces of jewellery and having her own stall at craft fairs. Having a mental health diagnosis will not diminish her existing achievements. Accepting a mental health diagnosis and treatment can be a daunting prospect for many individuals, and this is not surprising given that stigma still surrounds mental illness and medication. Ron describes feeling scared when he first began experiencing symptoms, fearing that he had a disease of the brain, and worrying what medication might mean knowing his mother's history. There have been a number of campaigns in recent years to help reduce the stigma of mental illness, however more needs to be done to tackle unfavourable opinions and to provide a more realistic impression of what having a mental health diagnosis entails. This could take the form of policies in schools (Moses, 2010), in the workplace (De Lorenzo, 2014), or even in the form of campaigns over social media (Livingston, Cianfrone, Korf-Uzan, & Coniglio, 2014).

9.4. Wanting to feel 'normal' within and seem 'normal' to others

It has been suggested that patients regress emotionally when unwell, and this can lead to the adoption of the sick role, where the patient passively accepts care and instruction from healthcare professionals. Rather than encouraging this, it has been argued that professionals should work to instil hope, attempt to boost patient morale, and encourage patients to take a more active role within their own treatment (Salole, 1997). It has been found that patients who actively engage with their own treatment fare better than those who do not. Patients less likely to engage in their own healthcare are more likely to be older, and less educated than those who become involved in the decision making surrounding their treatment (Laine, 1997). Stiggelbout and Kiebert (1997) suggest that this could partially be down to having a fear of making the wrong decisions and the potential consequences of bad decision making. In her interview, Ginny admits that she is afraid to learn about her diagnosis as she wants to be accepted as a ‘normal’ person. She has not been provided with any information or support from her GP, but instead has been directed to some information regarding borderline personality disorder on the internet, that has left her feeling confused and helpless. When it comes to diagnosing mental illness, GPs or nurses have a short (ten minute) appointment window in which to make the decision as to whether or not they need to refer their patient to the mental health services. This is often achieved by the completion of the standardised questionnaire known as the Patient Health Questionnaire 9 (PHQ-9). These questionnaires administered within the ten minute appointment window are often seen by GPs as intrusive, inappropriate, and potentially distressing for the patient (Mitchell, Dwyer, Hagan, & Mathers, 2011). GPs would prefer to use their clinical judgment when referring a patient to the mental health services as scores on a questionnaire might be misleading. Another commented that making patients fill out the questionnaire results in them feeling as though they are treating the test score as opposed to a person. Diagnostic questionnaires often only reflect the patient’s transient mental state rather than how they feel in general. The validity of the score obtained on these questionnaires could be affected by confounding variables present in the patient’s life which are unknown to the GP. Molly talks about feeling as though her therapist was just going through the motions and completing a checklist of actions, when she looking to talk to somebody about her distress and in the fact that she was in constant pain. She found this lack of empathy to be disheartening, but this may have been down to her therapist not being appropriately trained in the sort of support that Molly required. A study by Mitchell, Dwyer, Hagan, and Mathers (2011) suggests that many GPs work under the assumption that care which might not be exactly what is needed is better than no care at all. This can, however, leave their clients feeling frustrated and that they have not been listened to, and their needs not met. Ginny mentioned that she was reluctant to seek help for her mental wellbeing, and to conduct any research into her diagnosis because she wanted to be considered ‘normal’ and was scared of what accepting her diagnosis could mean. Newman et al. (2015) argue that perceived stigma is a common barrier to help seeking for those experiencing mental distress. They attribute the feelings of shame, personal failure, and the loss of adulthood reported by mental health patients in an inpatient setting. Many people struggling with mental distress feel that they are unable to disclose their illness to their employers or colleagues through fear of dismissal, a lack of support, or derogatory remarks (Putman, 2008). Surprisingly, two studies conducted six years apart (Read & Baker, 1996; Warner, 2002) found that the employers least supportive of staff with mental health issues are those involved in the health and social care sector. It goes without saying that individuals with mental health diagnoses should be treated as people (as opposed to a list of symptoms, or as a negative stereotypes derived from stigma), and Pitre et al. (2007) suggest that society can work towards this through educating children about mental health from a young age. Educational programs designed to encourage positive attitudes towards those with mental health diagnoses have been found to have some success, particularly when delivered at an age before opinions have stabilised. However, Pitre et al. (2007) argue that this success is unlikely to be lasting if these programs are one off occurrences, and suggest that a more permanent change in attitude would occur if mental health awareness was included within school curriculums.

9.5. The importance of being understood by professionals

Research suggests that GPs do not like to prescribe anti-depressants if there is a non-medication based treatment option available, but with the strain on the NHS and a finite number of resources, they often find themselves prescribing what they have available at the time (Mitchell, Dwyer, Hagan, & Mathers, 2011). This might not necessarily be the right choice for their client and may result in feelings of frustration and of being let down, such as in Ginny's case where she feels that seeing a back to work therapist is a waste of time and resources. Scott (2010) argues that it is naive to believe that cognitive behaviour therapy can provide a cure-all treatment for mental distress. She expresses worry that those who fail to engage with CBT will be held accountable as opposed to mental health professionals recognising that CBT was an inappropriate treatment path. It appears that in Ginny's case, this is exactly what happened. Many GPs do prefer to work collaboratively with their patients and accept clients with high levels of knowledge surrounding their condition as experts of their own illnesses. Furthermore, Salole (1997) argues that patients should be educated on any condition that they may have been diagnosed with, so that they can make better informed decisions surrounding their treatment pathways. Care must be taken, however, as although patients should be encouraged to be involved in the decision making processes regarding their treatment, the mental healthcare professional should not agree to take inappropriate courses of action at their patients' insistence (Salole, 1997).

It has been found that people who have engaged with the expert patients program (EPP) report better relationships with their family, better management over their emotions, more confidence around others, and heightened self-awareness amongst other benefits (McMahon, 2011). In contrast to this, many people who struggle with symptoms of mental distress do not realise that they may have a diagnosable mental illness, and therefore may not seek professional help (Dahlberg, Waern, & Runeson, 2008). Mental health campaigns implemented nationally within the UK have been successful in raising awareness of mental health issues, particularly depression, and have encouraged the recognition of symptoms.

Those who have been detained under the mental health act are, by law, entitled to aftercare following their release. This aftercare should be free of charge, and should encompass any services that meet needs that arise from a patient's mental illness, including supported accommodation, employment services, and wider social needs (Griffith, 2018). It is acknowledged that services are stretched, and the provision of services may fall under a post-code lottery. This right to aftercare, however, does not appear to be available to mental health patients who have not been detained for treatment.

It has been suggested that there is a critical time window following discharge from the mental health services, during which a client is most at risk of non-compliance with planned aftercare. A survey suggested that the majority of clients felt that they required easier access to mental health services following discharge, along with readily available interpersonal support (Bostelmen et al., 1994). A community support network was tested with an aim to reduce non-compliance. This involved tailoring relapse identification information to the client's specific needs, clear and simple language used on medication and appointment information cards, and a volunteer run ‘warm line’ telephone service providing non-critical support. In Fleur’s interview, she talks about the lack of aftercare provided to her by her local mental health services, and also that compliance can sometimes be an issue regarding her routinely taking and ordering her medication. In Powell and Clarke’s article (2006), it is discussed how patients feel more empowered when they are provided with more substantial information regarding their diagnosis, and often disrespected by their GP or other mental health professional when they are provided with insufficient information. Other barriers to seeking help for mental health issues include language barriers, being over a certain age, worries about the potential cost of treatment, waiting lists, potential stigma, and in some cases of comorbidity, the need to navigate multiple services (Tran & Ponce, 2017). The need to interact with multiple services can be a frustrating and distressing experience, and it is important that the different services effectively communicate with one another to aid their patients’ journeys.

9.6. What you can do for yourself

Each participant that was interview confirmed that they engage with a number of self-help practices to manage their symptoms, with most of them finding creative outlets to be particularly effective. Engagement with the arts has been found to increase self-esteem, emotional wellbeing, and relaxation (Heenan, 2006). Music can be a great relaxer of the mind and body, and there have been a number of studies which suggest that music therapy is effective in the reduction of the symptoms of depression and anxiety, particularly when combined with a talking therapy such as CBT (Bidabadi & Mehryar, 2017). Despite not having attended music therapy, in their interviews, both Ron and Molly discussed how engaging with music related activities such as playing instruments or singing helped ‘take them out of themselves’ and alleviated their symptoms. Gutiérrez and Camarena (2015) suggest that music is effective due to its capacity to allow individuals to enter a deeper state of concentration and abstraction, and potentially allow for the recollection of positive emotions and memories. Music listening can also be combined with the practice of mindfulness (Eckhardt & Dinsmore, 2012), where the participant enters a mindful state of consciousness and pays attention to the emotions and physical sensations that are drawn from them whilst listening to a piece of music. Art therapy can take many forms but the most common generally involves two main stages of self-exploration; the creation of a piece, followed by a discussion as to what the piece means to the creator and how they found the creative experience (Blomdahl, Gunnarsson, Guregård, & Björklund, 2013). This type of therapy aims to facilitate the participant finding a greater depth of self-understanding and acceptance. Art therapy can also be a group activity, which in turn fosters a sense of community, and alleviates the isolation often associated with depression as well as encouraging self-expression. Ron discussed his preference for engaging with art based activities with his support group, as he often found that if left to just talking about their weeks, the group could fall into rumination about the negative aspects of their lives. The art group was something in which he could take pride, and this was evident in the way he talked about it. Art encourages people to take a more active role in their recovery and provide empowerment, whereas the medical model of treatment can often be too passive. Creative activities can take people out of themselves and allowing them the freedom to become more aware of the surrounding world (Murrock & Graor, 2016). This can distract from ruminative thoughts and can allow instead for the focus to be on enjoyment, for instance, Ginny discussed feeling a sense of empowerment and achievement through creating jewellery which she could later sell. When talking about group therapy, Ron mentions preferring engaging in activities (such as art therapy) with his local support group rather than sitting down and talking as he feels these sort of things are more beneficial to him. Engaging with activities as a group can instil the sense of belonging that Ron desired, and a safe, non-judgemental atmosphere can work to break down the stigma surrounding mental health and encourage discussion and a sense of hope (Heenan, 2006). Despite engaging in a number of activities which he has found to provide a level of escapism, Ron was careful to note that whilst escapism can provide a temporary release, finding the right balance is paramount. These activities are often more appropriate as a complement to talking therapies and medication, and should not be used as a distraction from a potentially larger problem. Mindfulness and other meditative techniques have been widely acknowledged as being helpful towards alleviating symptoms of mental distress (Mamtani & Cimino, 2002). In the interviews, participants mentioned not only using mindfulness as a means of managing their symptoms, but as a way of self-scanning and being aware of both their mental and physiological wellbeing at that time.

10. Reflection

In the past, subjectivity within psychological research has been viewed as a contaminant, however, it is important to acknowledge the many ways in which a research project is influenced by our own subjectivity as researchers. Our existing histories, values, and knowledge of the world lead us to make decisions regarding the subject areas we choose to research, assist with our choices concerning research design and methodology, and influence the way in which we analyse and make sense of our data. Etherington (2004) describes reflexive practice as closing the gap between the researcher and the researched, and building a collaborative work between the researcher and participant, encouraging a sense of empowerment and agency. Reflexive practice requires us to situate ourselves within our research, demonstrate a level of self-awareness, and for us to be mindful of our thoughts and feelings throughout the breadth of the research process. Interpretative phenomenological analysis in particular requires constant reflexivity on the part of the researcher. As a double-hermeneutic method of analysis, it likens us as researchers to our participants, and accepts that both parties make use of everyday experiences and phenomena in order to make sense of the wider world. In terms of conducting research, this assumes that we drawn upon our own personal experiences to make decisions based around our studies, and to make sense of our data. Some research journal extracts have been included within the appendices (Appendix 8) to provide some insight into the experiences and decision making involving this study.

Epistemological reflexivity

As a researcher, I prefer to use qualitative methods and usually take a relativist approach to research. I believe that all psychological research is value laden and contingent on personal history and experiences, beliefs and our existing knowledge. I feel that human experience and behaviour cannot be objectively viewed, and that any ‘truths’ surrounding our social worlds will always be obscured not only by a sociocultural lens, but also by the lenses of our own histories and belief systems. Phenomenology has been used as the epistemological stance for this study, however, I also find that I also agree with many tenets of feminist psychology and some aspects of social constructionism. I was initially surprised at the lack of literature surrounding epistemology and ontology for IPA, and was even more surprised upon reading an article co-authored by Paul Flowers which stated that IPA adopts a broadly realist ontology. Having adopted a relativist approach in my own work, I accept that the finished thesis may have been somewhat different had I taken a realist stance. I do defend my decision, however. Realism would argue that the accounts of my participants reflect objective truth about the world in which we live, however, the double hermeneutic nature of IPA colours the experiences through the subjective understandings of my participants, but also through my own subjective understanding of what I am being told. I will not deny that the experiences reflect my participants' truth, only that this truth can be viewed without taking into account existing values, beliefs, and knowledge.

Methodological reflexivity

Braun and Clarke (2013) describe IPA as resonating with 'common-sense' conceptions of what it means to be human. Whereas other methods of analysis such as Narrative Analysis offer also insight into the human lived experience, I wanted my research to focus on the experiences themselves, as opposed to exploring the socio-cultural factors that create these experiences. I feel that as an analytical method, it is a good vehicle for collaborative research as it places the participant as the expert and prioritises their individual experiences in a way that is not possible with other qualitative methods such as Thematic Analysis (TA) or Grounded Theory (GT). Involving my participants in the designing process was aimed to empower them and reinforce that their thoughts, feelings and opinions were important and valid. All of the participants described situations where they felt unheard by or unimportant to professionals, giving rise to the feelings that they were passive in the management of their distress.

I chose IPA as the analytical method for my research as I wanted to highlight the importance of treating participants in research as people with specific and expert knowledge of this particular field rather than subjects. Conducting research in this way provided my participants with some autonomy to be able to discuss the areas that they felt were and allowed for greater investment in the study. My aim was to provide my participants with the opportunity to shape the research in the way that would benefit them the most, and to allow them to provide their own suggestions as to the directions in which mental health research and practice should turn in the future. For example, in this study, most of the participants had children and felt it was important that future practice should be used to benefit young people and to provide them with the tools to effectively describe and cope with any symptoms of distress.

A lot of time would have been saved if the opinions of the mental health support groups had not been sought, but this would have resulted in the finished research being less inclusive and naive. Being more open with my inclusion criteria risked the homogeneity of my sample, but I feel as though this decision was worth the risk as having the opportunity to go back to the drawing board allowed for greater insight into the lived experiences of mental distress, and helped build trust and rapport with the participants.

I am glad that I transcribed the interviews myself, as I felt closer to the data and my participants. This along with the coding and initial analyses was an emotionally difficult process, especially with the requirement to keep the content of the interviews confidential. I found that IPA felt very intuitive and worked well as a method of analysis for this project. This has been a hard process, and I struggled with my own mental wellbeing for a portion of this time. Despite this, I have enjoyed working on this project and meeting all the people who helped tie it together.

Personal reflexivity

I am a twenty-seven year old white, cis-sexual woman, and I currently reside in Gloucestershire with my husband. We do not have any children. I completed my undergraduate degree in psychology as a mature student and remained at the university after graduating to pursue a master of science by research. I have a long standing interest in mental health and wellbeing, and mental health has been an ongoing aspect of my life since childhood. Both of my parents have struggled with their mental wellbeing, and I myself have intermittently experienced symptoms of both depression and anxiety from a young age. Like

Molly, I find that my symptoms surface as a reaction to negative or stressful life events, and I have thus far managed my symptoms without medication. As an adult, I have found that my closest personal friends also struggle with various forms of mental distress, and am lucky enough to be able to hold honest, non-judgemental conversations about mental health on a regular basis.

In terms of my research, I feel that my own experiences have allowed me a more in-depth understanding of what the participants have been through, and have facilitated a greater empathy towards their experiences. This aided the building of rapport and trust with my participants, and encouraged a more natural story-telling feel to their interviews. Whilst conducting the interviews, I found that in many ways, I was able to relate to various things my participants told me. With Ginny, I particularly understand the pressure of working in a fast-paced customer service environment and the feelings of panic when no end is in sight. I appreciate the value of escapist activities to alleviate symptoms of distress, I do not play an instrument or create art, however, I am an avid reader of fiction and will lose myself in immersive video games. In the past, when seeking help for symptoms of mental distress, I have found myself brushed off by my GP. I have sought help over two instances, once after experiencing psychosomatic symptoms of anxiety for the first time, and again several years later when struggling with depression.

Before recruiting for my participants, I approached two local support groups to see if they would speak to me about my research ideas and offer their feedback. Having never attended a support group before, I was not sure what to expect. I found that in both groups, participants were initially suspicious of my presence at their meeting, but after understanding my reasons for participating in their meeting, were very warm and friendly.

The members had a good rapport with one another and seemed to genuinely care about each others lives and wellbeing. They were happy discussing their high and low points with one another, and spoke in a supportive and non-judgemental manner. When talking to group members individually or in smaller groups, I became quickly aware that there were general feelings of resentment and anger towards not only mental health services, but other services such as local councils, the police, and the JobCentre. The feedback I was provided was constructive, and encouraged me to change the design of my study so that it was more inclusive (initially those taking medication or attending therapy were in the exclusion criteria). I was unsure what to expect prior to the interviews, but found that all of my participants were honest, forthcoming, and willing to talk to me about some of the most difficult times in their lives. Despite the sometimes emotional nature of the interviews, some of my participants stated that they had enjoyed taking part, and that they sincerely hoped that they had helped me with my work.

11. Implications for practice and future research

Completion of this IPA has highlighted some areas in terms of treatment and education in which the participants felt that things could be done differently, along with potential areas in which further research could be undertaken.

In their transcripts, two of the participants discussed how they were reluctant to disclose their diagnoses or talk about their mental health with others through worry of how they will be reacted to. Despite campaigns such as the yearly 'Mental Health Awareness' weeks, there is still stigma surrounding mental illness. Public health organisations, the NHS, or the Department of Education could spearhead campaigns that work towards fostering empathy in children and young people. These could build on existing work to help reduce the stigma of mental illness and encourage a dialogue about what it means to experience distress and how depictions and reporting of mental illness in media, along with the language used can affect people's attitudes towards the mentally unwell. Dillon and Laughlin (2017) suggest a number of online videos and games which children can access to assist with 'social emotional learning' (SEL). They argue that SEL can help combat bullying and teach young people to relate positively with one another. Alongside this type of learning, helping people find the words to describe how they are feeling, and providing the tools such as mindfulness to help regulate and manage any negative feelings can build resilience and encourage people to be more open about their wellbeing. Bjørnse, Espnes, Eilertsen, Ringdal, and Moksnes (2019) found that promoting a positive 'mental health literacy' in schools, with a focus on obtaining and maintaining a good mental health, had a positive effect on the adolescents' mental wellbeing. There is relatively little research into the emotional benefits gained from talking about mental health, however, all of the participants of this study reported that they found it helpful to be able to share their experiences and feel listened to without being scrutinised, with one giving this as the reason they agreed to participate in the study. Interestingly, a study into the effects of talking on emotional recovery found that although the social sharing of emotional events did not predict true emotional recovery, the perceived benefits of talking were found to be highly significant (Zech & Rimé, 2005).

All of the participants discussed negative experiences in terms of their treatment by medical professionals, and feeling as though they were being rushed through appointments or not listened to. It has been argued that the outcomes of therapy are more positive if the therapist provides an environment where the service user feels safe, and exhibits openness and warmth (Romano, Fitzpatick, & Janzo, 2008), and this should be taken into account by practitioners. Mental health professionals will have their own ideas and experiences of living with mental distress, but from a different perspective to that of service users. Larkin, Shaw, and Flowers (2019) note that there may often be conflict between differing perspectives as well as how different perspectives may relate to one another which need to be understood before serious suggestions surrounding changes of practice can be made. A ‘multiperspectival’ approach could help close this gap, and further phenomenological research could be undertaken to investigate how professionals experiences of distress relate to and compare to those with a mental health diagnosis.

Collaborating with participants in designing this study was a positive experience and particularly appropriate for an IPA study where participants had been recruited for their expertise in a particular phenomenon. Gehart, Tarragona, and Bava (2007) advise that collaboration can be highly rewarding and discuss how the collaborative relationship between the researcher and participant serves to construct experiences through linguistic processes. Conducting research in this way is most effective when considerations are made regarding how the research is seen from the participants’ perspectives. Good communication is required throughout the process, and the creation of an informal environment rather than a laboratory setting is more comfortable and conducive to a more natural conversation.

The final section will present the conclusions arrived at following completion of the analytical process.

12. Conclusions

This study aimed to learn about the participants' experiences of living with mental distress, and how the context of their treatment affected these experiences. It also aimed to find out what self-care practices, if any, the participants found particularly helpful towards the management of their symptoms. An interpretative phenomenological analysis was conducted for each interview in its own right before the emergent themes were compared across the data sets. Each analysis produced its own set of themes but a cross-comparison concluded with four superordinate themes; isolation, feeling inhuman, appropriateness of treatment, and self-care and mindfulness.

All participants reported feelings of isolation and a desire to be properly understood by others. They carry their diagnoses as a burden, and some were hesitant to share their experiences with other people, whether through issues with trust, fear of stigmatisation, or to prevent strain on their existing relationships. Powell and Clarke (2006) found that people seeking help for mental distress also benefited from experiential information provided to them from others with the same diagnoses. This type of sharing left them feeling less alone and provided a level of hope for recovery. Support groups would be an ideal platform for the sharing of experiential information, however, as Ron pointed out in his interview, there is a danger of focussing more on the negative aspects of mental ill health resulting in what he describes as 'group rumination'.

It seems that an element of luck is required when seeking appropriate treatment for mental distress. All participants recounted negative experiences of unhelpful GPs or uncaring therapists. It is worrying that the care received can be inconsistent and, at times, not suited to the patient's needs. Three of the participants expressed a mistrust of medication. Talking therapies appear to be the preferred methods of treatment, depending on the context of the symptoms. Engaging with self-help practices is a key element of symptom management, with all participants finding escape in creative pastimes. Creating photographs or jewellery can instil a sense of pride and achievement, signing or being involved with art groups can reduce feelings of social isolation.

The majority of participants did not envision a symptom free future for themselves. This likens depression and/or anxiety to chronic illnesses, with symptoms that can be managed across good days and bad days but recurring over time. Teaching young people to be able to effectively articulate their emotions, and be comfortable in describing how they feel came up several times throughout the interviews, particularly those with children of their own. Participants who were parents were worried about how their symptoms might affect their children as they grow up, but were determined to teach them to be mindful of their own mental and physiological wellbeing, and that negative emotions are normal and valid. Putman (2008) argues that as many of our attitudes begin to develop from a young age, more needs to be done to encourage more positive attitudes towards those experiencing mental distress during childhood. She goes on to suggest that a system could be developed where schools could invite mental health patients to talk to children about their conditions in an effort to reduce stigma and encourage understanding. Jetten et al. (2017) discuss the interesting idea that the responsibility to ensure that all individuals are raised (from birth) into physically and mentally healthy adults lies within the community in which they are raised. On a wider scale, this community engagement should include nationwide policy decisions that are mindful of the social aspects of health and wellbeing.

The findings highlighted within this study appear to be consistent with existing literature, however there is little literature available which explores the reductive nature of the mental health diagnostic process.

13. References

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14. Appendices

Please note that worked on transcripts have been submitted separately in accordance with the University's confidentiality guidelines.

Appendix 1. Research Poster

An Interpretative phenomenological analysis into living with depression and anxiety.

Research background

Depression and anxiety are the most common forms of mental distress in the UK and are often experienced alongside one another. Symptoms may manifest themselves in a diverse number of ways, therefore a person's individual experiences of depression and/or anxiety are unique to them. As such, there are variety of treatment options available to people, including medication and different forms of therapy.

Previous research into peoples' experiences of using mental health services has largely involved questionnaires and telephone interviews. Although these methods are quick to complete and can reach a lot of people, they do not provide much detail. My proposed project aims to listen to my participants' personal stories and to analyse these in detail, firstly in their own right, and secondly in comparison with the experiences of other participants to see if there are any patterns.

Research Aims

Using one-to-one interviews, I intend to ask my participants to share with me their experiences of living with depression and/or anxiety. I aim to recruit five participants who have a diagnosis of depression and/or anxiety, including those who self-manage their symptoms, those who manage symptoms through taking medication, and those who attend therapy/counselling. My research questions for this project are as follows:

1. What are the participants' subjective experiences of living with their diagnosis?
2. How did the context of the participants' treatment shape these experiences?

I aim to answer these questions through analysing the stories shared with me throughout the interviews. I would also like to explore what (if any) self-help/care techniques my participants feel helped them along their recovery journeys and to manage any recurring symptoms. These could be anything, for example: regular exercise, yoga and mindfulness.

Research Method

The transcripts from each interview will be analysed using a research method known as interpretative phenomenological analysis (IPA). Researchers using IPA consider their participants to be experts, as nobody knows more about their experiences than they do. When reading through the transcripts, I will seek to identify any recurring patterns, and will later see if these same patterns are present within the transcripts from my other interviews. As a method of analysis, IPA does not seek to produce large amounts of generalisable data, but instead aims to explore how each participant creates meaning from their experiences (particularly from significant life events), and how this impacts their sense of identity.

Image credits:mindfulness colouring club, yoga bunny & Mark Hess - all sourced from Google image search

Appendix 2. Participant Information Sheet

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Research Information Sheet

Everyday experiences of depression and anxiety.

What type of data is being collected?

I am collecting data by conducting one-to-one interviews with my participants. I would like to recruit people who hold diagnosis of depression and/or anxiety, including those still receiving treatment for their symptoms. These interviews will be audio-recorded and the transcripts from these recordings will be analysed using interpretative phenomenological analysis (IPA). This is a method which looks for patterns within each transcript and then later compares these with the transcripts from other interviews.

What will participation involve?

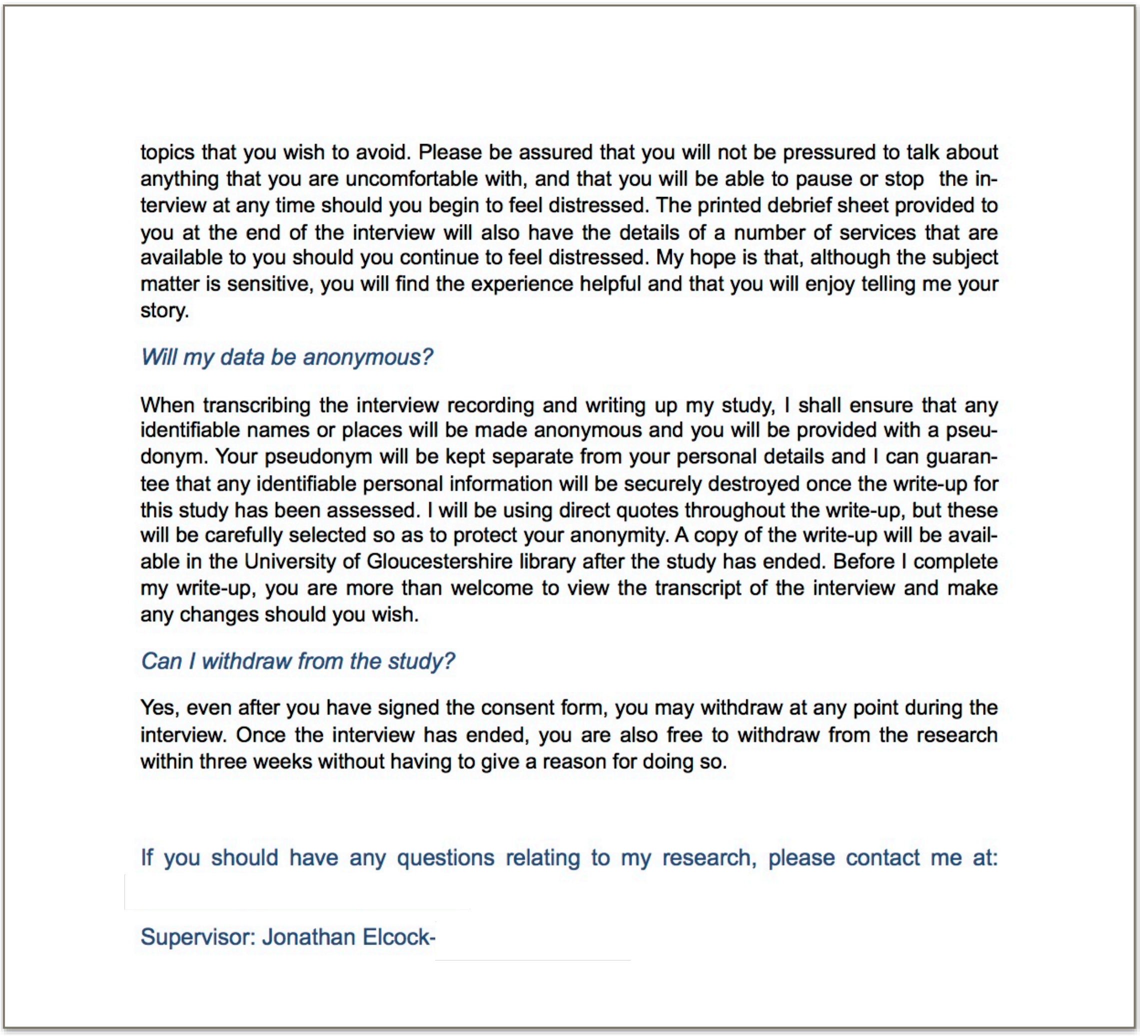
The interview will take place within the Park Campus or Francis Close Hall at the University of Gloucestershire in March, at a date and time that suits you. I shall be conducting the interview myself and expect the session to last for approximately an hour. I am happy to answer any questions or concerns that you may have before and after the interview, and I will provide you with my university email address should you have any questions or wish to withdraw at a later date. During the interview, I shall be asking you to share with me your experiences of living with depression and/or anxiety. As your story is unique to you, I will encourage you to talk naturally about your experiences, but I may ask you some questions to clarify some details. I will provide you with a copy of my list of interview questions in advance so that you can see the sort of topics we will discuss. If there are any topics that you do not wish to talk about, please let me know before the interview begins, and I will remove them from my questions list. You are also free to refuse to answer any questions that come up during the interview that you are not comfortable with, just let me know. Please be aware that I am conducting this research as part of my postgraduate degree, and that I am not a qualified therapist. As such, I will be unable provide any counselling or advice. I am, however, happy to listen to you talk about your current mental wellbeing, and can provide a list of mental health services available to you should you want it.

What will happen during the session?

After you have read the list of interview questions and made any changes, we will have some time for you to ask me any questions that you might have about my research. Before the interview can start, I will provide you with a consent form for us both to sign which confirms that you have read and understood this information sheet and that you are happy to take part. Once this has been signed and we are comfortable, I shall turn on the recording device and begin with the first interview question. Once the interview has come to an end, we shall have some more time for you to ask any further questions. I will give you a printed sheet with a summary of my study and my contact details just in case you should have any concerns or wish to withdraw at a later date.

Are there any risks?

Due to the sensitive nature of the interview topics, there is a small risk that you may feel adversely affected by taking part. There will be time before the interview commences to address any concerns that you might have, and for you to notify me of any potentially triggering



topics that you wish to avoid. Please be assured that you will not be pressured to talk about anything that you are uncomfortable with, and that you will be able to pause or stop the interview at any time should you begin to feel distressed. The printed debrief sheet provided to you at the end of the interview will also have the details of a number of services that are available to you should you continue to feel distressed. My hope is that, although the subject matter is sensitive, you will find the experience helpful and that you will enjoy telling me your story.

Will my data be anonymous?

When transcribing the interview recording and writing up my study, I shall ensure that any identifiable names or places will be made anonymous and you will be provided with a pseudonym. Your pseudonym will be kept separate from your personal details and I can guarantee that any identifiable personal information will be securely destroyed once the write-up for this study has been assessed. I will be using direct quotes throughout the write-up, but these will be carefully selected so as to protect your anonymity. A copy of the write-up will be available in the University of Gloucestershire library after the study has ended. Before I complete my write-up, you are more than welcome to view the transcript of the interview and make any changes should you wish.

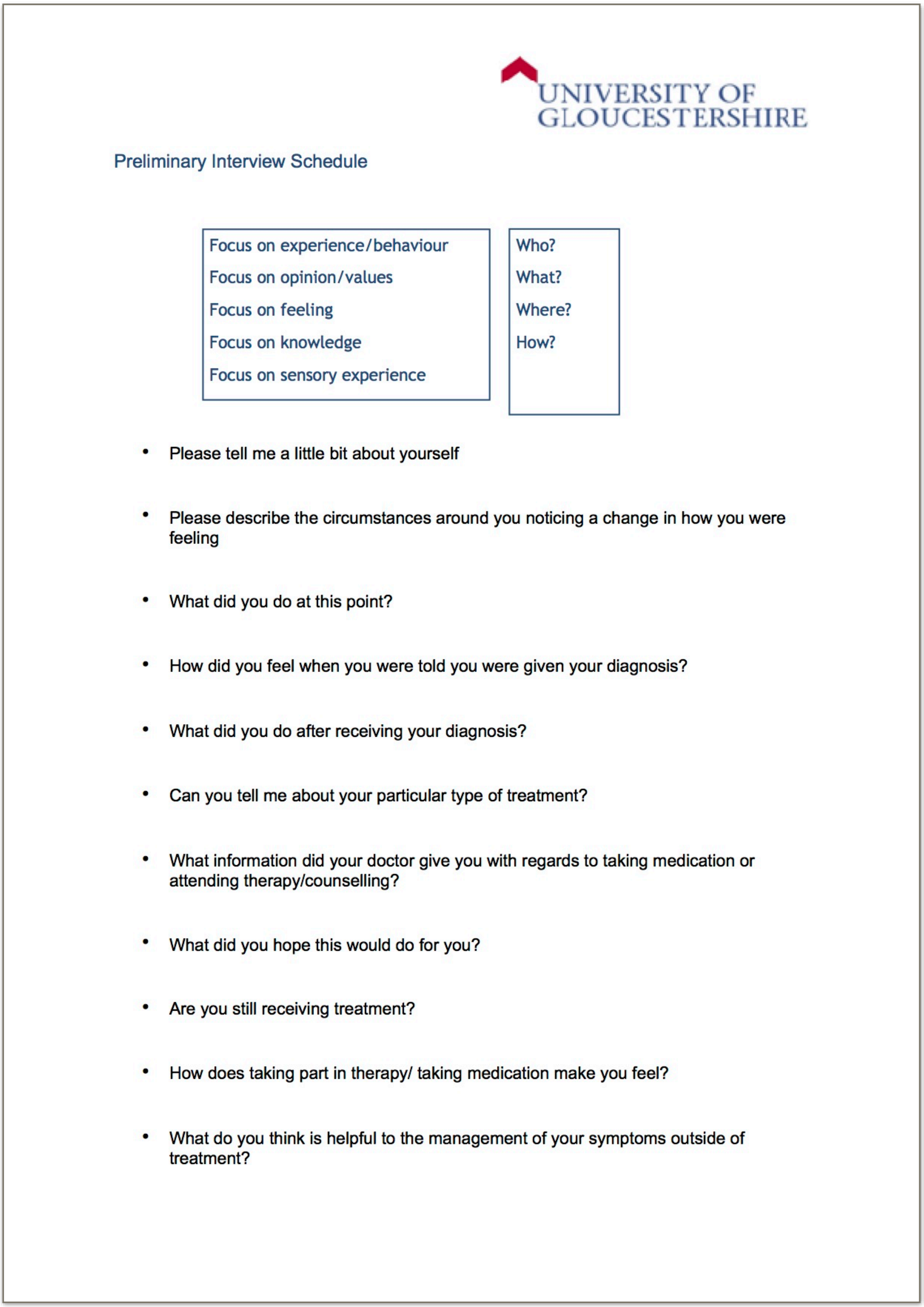
Can I withdraw from the study?

Yes, even after you have signed the consent form, you may withdraw at any point during the interview. Once the interview has ended, you are also free to withdraw from the research within three weeks without having to give a reason for doing so.

If you should have any questions relating to my research, please contact me at:

Supervisor: Jonathan Elcock-

Appendix 3. Interview Schedule



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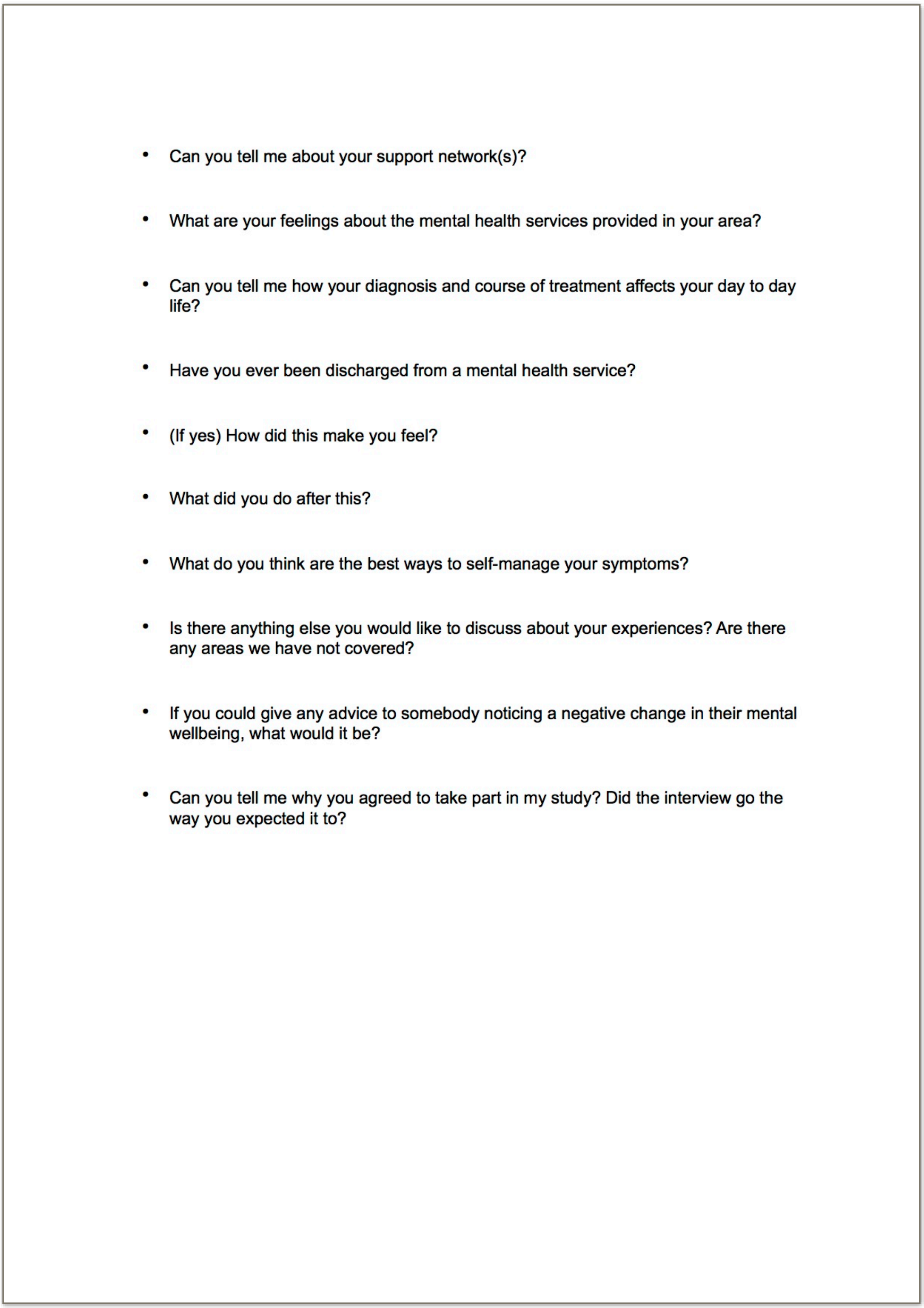
Preliminary Interview Schedule

Focus on experience/behaviour
Focus on opinion/values
Focus on feeling
Focus on knowledge
Focus on sensory experience

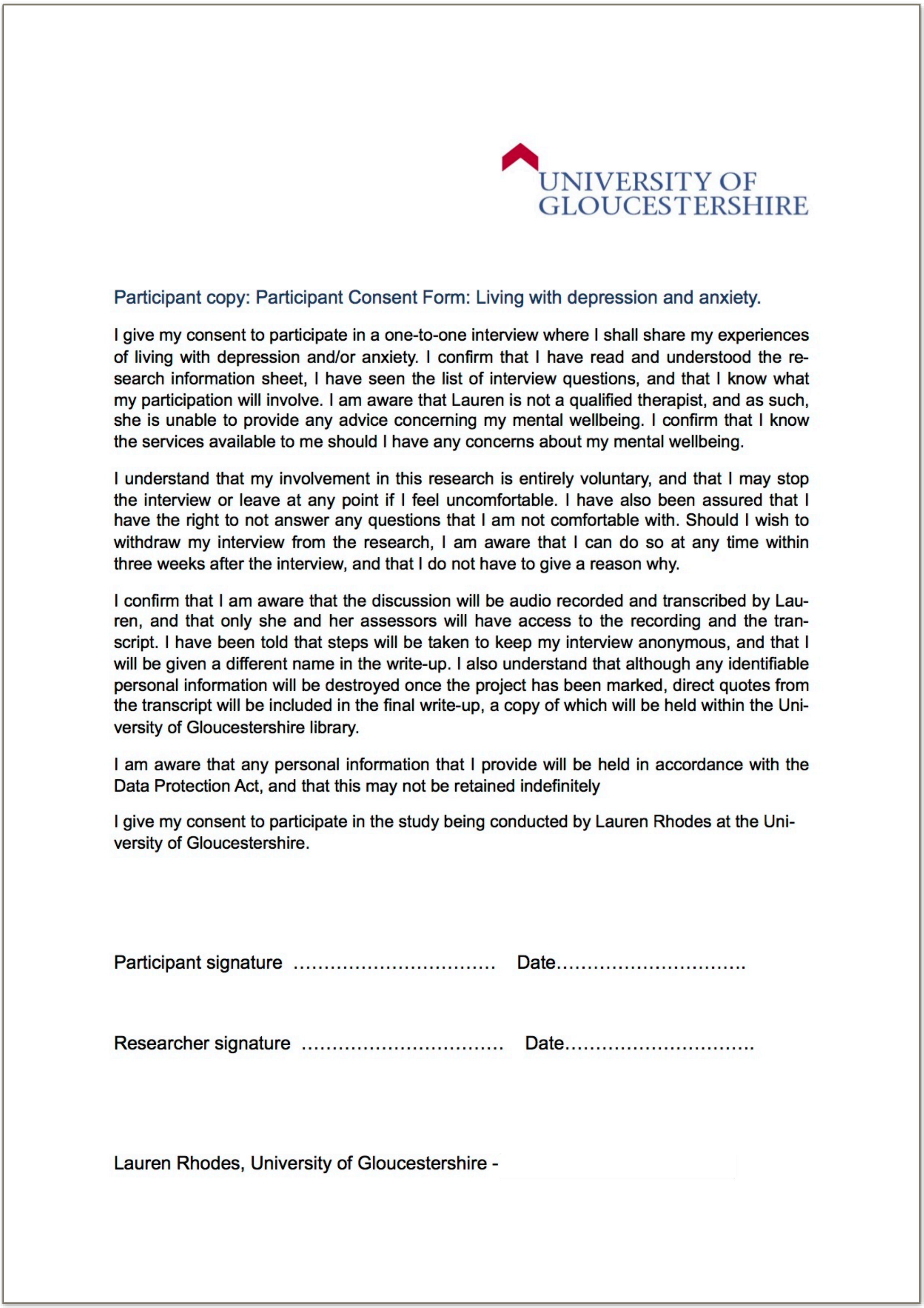
Who?
What?
Where?
How?

- Please tell me a little bit about yourself
- Please describe the circumstances around you noticing a change in how you were feeling
- What did you do at this point?
- How did you feel when you were told you were given your diagnosis?
- What did you do after receiving your diagnosis?
- Can you tell me about your particular type of treatment?
- What information did your doctor give you with regards to taking medication or attending therapy/counselling?
- What did you hope this would do for you?
- Are you still receiving treatment?
- How does taking part in therapy/ taking medication make you feel?
- What do you think is helpful to the management of your symptoms outside of treatment?



- Can you tell me about your support network(s)?
- What are your feelings about the mental health services provided in your area?
- Can you tell me how your diagnosis and course of treatment affects your day to day life?
- Have you ever been discharged from a mental health service?
- (If yes) How did this make you feel?
- What did you do after this?
- What do you think are the best ways to self-manage your symptoms?
- Is there anything else you would like to discuss about your experiences? Are there any areas we have not covered?
- If you could give any advice to somebody noticing a negative change in their mental wellbeing, what would it be?
- Can you tell me why you agreed to take part in my study? Did the interview go the way you expected it to?

Appendix 4. Participant Consent Form



UNIVERSITY OF
GLOUCESTERSHIRE

Participant copy: Participant Consent Form: Living with depression and anxiety.

I give my consent to participate in a one-to-one interview where I shall share my experiences of living with depression and/or anxiety. I confirm that I have read and understood the research information sheet, I have seen the list of interview questions, and that I know what my participation will involve. I am aware that Lauren is not a qualified therapist, and as such, she is unable to provide any advice concerning my mental wellbeing. I confirm that I know the services available to me should I have any concerns about my mental wellbeing.

I understand that my involvement in this research is entirely voluntary, and that I may stop the interview or leave at any point if I feel uncomfortable. I have also been assured that I have the right to not answer any questions that I am not comfortable with. Should I wish to withdraw my interview from the research, I am aware that I can do so at any time within three weeks after the interview, and that I do not have to give a reason why.

I confirm that I am aware that the discussion will be audio recorded and transcribed by Lauren, and that only she and her assessors will have access to the recording and the transcript. I have been told that steps will be taken to keep my interview anonymous, and that I will be given a different name in the write-up. I also understand that although any identifiable personal information will be destroyed once the project has been marked, direct quotes from the transcript will be included in the final write-up, a copy of which will be held within the University of Gloucestershire library.

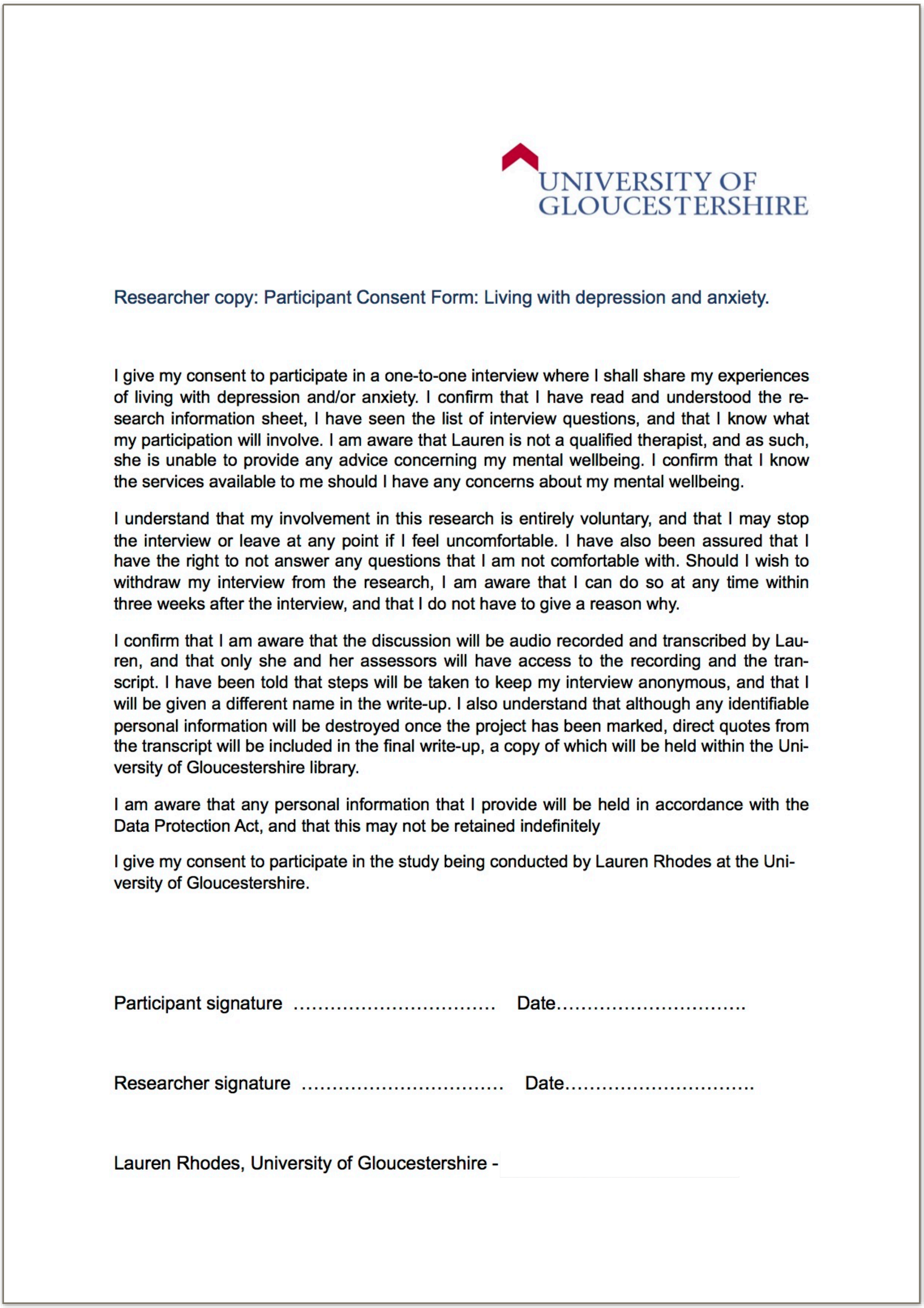
I am aware that any personal information that I provide will be held in accordance with the Data Protection Act, and that this may not be retained indefinitely

I give my consent to participate in the study being conducted by Lauren Rhodes at the University of Gloucestershire.

Participant signature …………………………… Date…………………………..

Researcher signature …………………………… Date…………………………..

Lauren Rhodes, University of Gloucestershire -



UNIVERSITY OF
GLOUCESTERSHIRE

Researcher copy: Participant Consent Form: Living with depression and anxiety.

I give my consent to participate in a one-to-one interview where I shall share my experiences of living with depression and/or anxiety. I confirm that I have read and understood the research information sheet, I have seen the list of interview questions, and that I know what my participation will involve. I am aware that Lauren is not a qualified therapist, and as such, she is unable to provide any advice concerning my mental wellbeing. I confirm that I know the services available to me should I have any concerns about my mental wellbeing.

I understand that my involvement in this research is entirely voluntary, and that I may stop the interview or leave at any point if I feel uncomfortable. I have also been assured that I have the right to not answer any questions that I am not comfortable with. Should I wish to withdraw my interview from the research, I am aware that I can do so at any time within three weeks after the interview, and that I do not have to give a reason why.

I confirm that I am aware that the discussion will be audio recorded and transcribed by Lauren, and that only she and her assessors will have access to the recording and the transcript. I have been told that steps will be taken to keep my interview anonymous, and that I will be given a different name in the write-up. I also understand that although any identifiable personal information will be destroyed once the project has been marked, direct quotes from the transcript will be included in the final write-up, a copy of which will be held within the University of Gloucestershire library.

I am aware that any personal information that I provide will be held in accordance with the Data Protection Act, and that this may not be retained indefinitely

I give my consent to participate in the study being conducted by Lauren Rhodes at the University of Gloucestershire.

Participant signature …………………………… Date…………………………

Researcher signature …………………………… Date…………………………

Lauren Rhodes, University of Gloucestershire -

Appendix 5. Participant Debrief Form

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Participant Debrief Form

Thank you for taking part in today's interview.

The interview has been audio recorded and I shall transcribe it myself. Please be assured that your data will made anonymous and that only my assessors and I will have access to the full recording and transcript. Some direct quotes from our interview will be used in my write-up, but I will take care to ensure that these will be chosen with your anonymity in mind. I am happy to provide you with a copy of the interview transcript before I start my write-up, so that you may check that you are happy with its content. At this point, you may also remove anything from the transcript that on reflection you are not comfortable with. I will give a presentation of my finished work to 'Your Space' once it has been marked, and a copy of the finished write-up will also be available within the University of Gloucestershire library.

You have the right to withdraw your data from the study. Should you wish to do so or if you should have any further queries regarding the session, please contact me within three weeks via email to . You do not have to provide a reason if you want to withdraw.

The interview transcript from today's session will be analysed using Interpretative Phenomenological Analysis – an approach which attempts to understand how people make sense of their own lived experiences. I shall analyse each interview firstly on its own, and then in comparison with the other interviews to see if there are any patterns that repeat themselves.

If you should have an interest in mental health and its surrounding issues, please visit www.mind.org.uk for more information.

If for any reason you should feel adversely affected after the discussion, the contact details below are for organisations dedicated to providing confidential and non-judgmental support free of charge. If you require further help, please contact your GP.

Let's Talk – NHS - 0800 073 2200

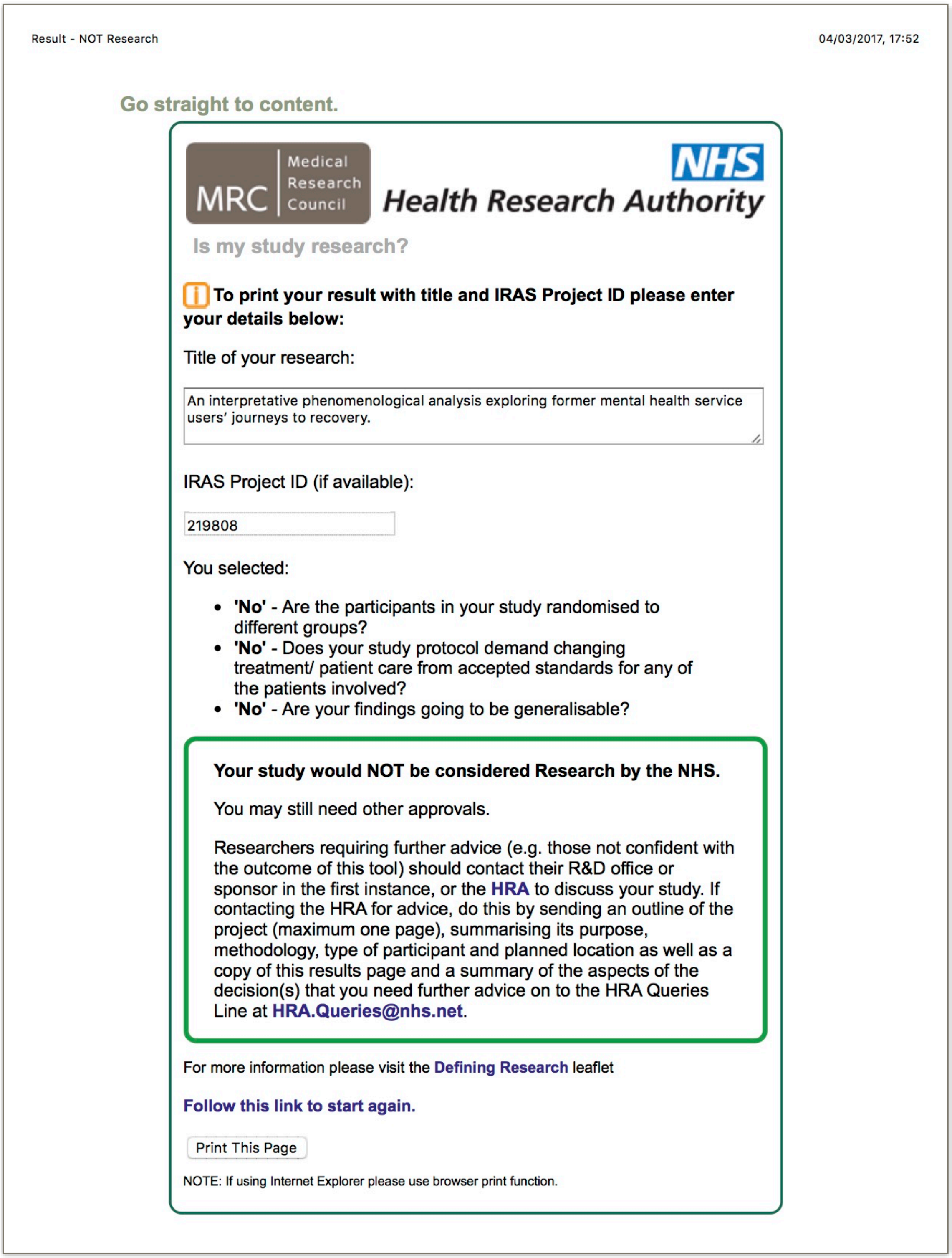
Samaritans – 116 123

Thank you again for taking part, I hope you enjoyed the interview and I look forward to sharing my findings with you.

Lauren Rhodes, School of Natural and Social Sciences, University of Gloucestershire:

Supervisor: Jonathan Elcock

Appendix 6. Confirmation of ‘Not Research’ from the NHS



Result - NOT Research

04/03/2017, 17:52

Go straight to content.

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

An interpretative phenomenological analysis exploring former mental health service users’ journeys to recovery.

IRAS Project ID (if available):

219808

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the **HRA** to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at **HRA.Queries@nhs.net**.

For more information please visit the **Defining Research** leaflet

Follow this link to start again.

NOTE: If using Internet Explorer please use browser print function.

Appendix 7. Thematic Tables

Individual tables

Thematic Table - Ron-1

Superordinate theme	**Subordinate themes**	**Quotes**
Living with mental illness is lonely and isolating	- Loss and loneliness - The impact on relationships - Feelings of abandonment - Searching for understanding and human connections - Community mental health	- *'I've always wanted that deep passionate love, I've wanted to pour myself into someone, and the one point in my life where it actually happened was after I lost the baby, I fell in love with this person, poured myself into her, and then when it ended, I fell apart. The biggest, the biggest crunch point was going back about 4-5-no, time's a bit of a blur, 5-6 years ago, when that relationship ended after 18 months, I fell apart. I just absolutely, I fell apart at work, my professional life ended, as a consequence of it [L: oh really?] yeah, I was working in the [organisation] as a manager, and I couldn't cope, so my working life fell apart. I ended up losing my job, and having to start from [...] bloody scratch.' pg.16, line 2* - *'I think the thing is with the family relationships is that they are-it's such a long history of difficulty and it's not easy to put that right [L: No], with the best will in the world. And some of my family are less able to talk about this than I am. My brother, the one that I'm estranged from, cannot talk about it, cannot deal with it, shuts it away.' pg.19, line 21* -
Mental illness is something to escape	- Distress as its own entity - taking on a role - A skewed sense of self - Self help techniques	-*'Interestingly when I was going through some of my darkest days of my mental health, I've felt more confident about standing up, and doing some stand-up comedy and did some open mic as well. It's crazy that within that difficult time, I found more confidence to do that than I've got right now.' pg. 31, line 16* *- I think photography always helped, you know, when I was making photographs, it was always a form of escape, something, you know, looking at the world through a camera can be quite, quite escapist really.' pg.10, line 2*

Superordinate theme	**Subordinate themes**	**Quotes**
The importance of being understood by professionals	- The idea of an ‘expert patient’ - A ‘mixed bag of care’ - The cumulative effect of treatment - The ‘then and now’ of treatment - Levels of wellness - Searching for the answer	- *‘The last bought of depression I had was before Christmas. Erm, went to the GP, GP said, ‘so what are the options, what have you considered?’ and we talked about health and fitness, we talked about medication, we talked about talking therapy. The last time I was offered talking therapy I said, ‘no I don't think I need it’ [laughs], it’s not always the answer. I think if you understand what-what the causes are, and what’s going on, sometimes there are other, you know, you just need to work through your depression.’ pg.14, line 18* - *‘Erm, there was a, after I lost the baby, we lost the baby, down in [City] I went to see a, a counsellor at the surgery and, I remember her clock-watching, and also, when I was talking about my own feelings about the way that I’d laughed at other people’s behaviour, I, I remember her just, just talking to me in a way that made me feel like I was, you know, a bad person. Erm, that she lacked patience and empathy.’ pg.13, line 9* -*‘Knowledge of mental health, GPs probably wasn’t great back then. And I knew that my mum had been through, erm, being treated for her mental health, and I knew that that had been pretty horrendous for her. I knew that she had been put on tranquillisers, and she’d been in a psychiatric hospital [L: oh right, okay] and she’d tried to commit suicide. So [...] I had anxiety about where mental health treatment might take me.’ pg.7, line 4* - *‘I was still living at home when I went to the doctors for the first time, yeah. I think, my doctor said, ‘there’s nothing wrong with you’ [laughs] yeah, ‘pull yourself together’ basically. And it took a long time for them to-to work out that I was suffering, from anxiety and possibly depression as well.’ pg. 5, line 21*

Thematic Table - Ginny

Superordinate themes	Subordinate themes	Quotes
Living with mental illness is lonely and isolating	- Loss and loneliness - 'Putting on a brave face' - Bottling up emotions	*- 'Um, I used to kind of isolate. So just stay in - but I know that's not helpful [laughs] but you've just got to try and face it, feel the fear but do it anyway. Tackle your fears. Try and- try and get on regardless.' pg.7, line 1* *- 'I would always be a people person, and quite happy, outgoing and then when I got really big [...] I just isolated for like 3 years, and lost a lot of friends, and people all thought I was being difficult on purpose, and I was forgetting things 'cause of medication. Forgetting people's birthdays, or not turning up and things like that.' pg.22, line 17* *- 'I didn't really wanna talk about it, like you say, keep it within [L: Mm] don't wanna talk about it, don't wanna tell anyone, it-it doesn't happen. And I think, blocking it out for so many years was the cause of everything coming out at once' pg.3, line 4*
Wanting to feel 'normal' within and seem 'normal' to others	- The desire to be a 'normal person' - The effects of medication - Being pigeonholed - Acceptance and stigma - Effects of medication	*- 'Um, I find it really hard, like to accept that-my diagnosis? [L: Yep] I just wanna be a normal person [laughs] and like work again, and be able to go food shopping without thinking that everyone is looking at me, or talking about me.' pg.5, line 14.* *- 'I felt a bit like a zombie, I felt like, like just in a haze, like just flat, like no personality. I'd rather have a bit of a fun personality than just be flat.' pg.4, line 4* *- 'There's a big stigma though isn't there? 'They've got mental health, stay away from her' [L: Mm] it's like, depression anxiety- I mean, 'I've got anxiety, accept me as I am' and people try and make you change to be more like them, but it's hard isn't it?' pg.23, line 4*
The importance of being understood by professionals	- A 'mixed bag of care' - The rush to a diagnosis - Inappropriate courses of treatment - Idea of a 'true counsellor' - The NHS do their best	*- 'I think I probably need like, deep counselling, rather than just someone to talk to for an hour a fortnight. Like deep therapy, with a qualified therapist.' pg.17, line 6* *- 'I still see a lady from the NHS, but she's just a 'back to work' therapist, not a true counsellor. And I did go to a psychiatry team in August 2017, but they're so booked up, they haven't had time to see me.' pg.5, line* *- 'I'm seeing a 'back to work' therapist and I'm not ready to go back to work- and she knows this! So she's trying to put me into the thing of like doing a craft fair, and getting out there, and I tried it and it was too much pressure. Because 17 people turned up, and I'm like, 'oh my god, complete meltdown' [L: Mm] and then I told my friend who works in, like a, office environment in [City] - and she's quite an outgoing person, she says, 'I couldn't even do that [Ginny], I can't believe they kind of made you do that!' pg.11, line 4* *- 'Because they did discharge me, sorry, they did discharge me for not being able to concentrate or focus, with the CBT. She said, 'I've tried to give you CBT, but you're not engaging with me', and I'm like, 'Well I've tried my best- maybe the medication they gave me 6 years ago...' - I think it adds too- you're ability to focus, and my memory's rubbish and […]' pg. 16, line 10*

Superordinate themes	**Subordinate themes**	**Quotes**
Being hopeful for a symptom free future	- Learning to face your fears - Living a normal life - 'When I can —' - Feelings of empowerment and achievement	*- 'G: Ah okay, yeah I need to try that. I do go to the gym 3 times a week, but just cardio and weights - that helps a little bit.* *L: Yeah? So how does that feel?* *G: Empowerment [L: Empowerment] because I was doing really well. Because I was a size 18 3 years ago [L: Oh really? Wow!] I was 14 and a half stone, and now I'm- I'm 12, and I did get down to 11, but it's just maintaining that- the weight loss. I gotta try and just-* *L: That's a huge improvement though!* *G: I know! I was really, really big! I was really big-14- and I'm only 5'2" as well [laughs] so I can't let that happen again! It's not healthy.' pg.20, line 16 - 'Eventually I do want to get back out there, but when I feel more well in myself [L: Yeah], when I can concentrate again.' pg.13, line 2 - 'I can eventually try and overcome it. Eventually.' pg.9, line 10*

Thematic Table - Molly-1

Superordinate theme	Subordinate themes	Quotes
Living with mental illness is lonely and isolating	- Loss and loneliness - The impact on relationships - Searching for understanding and human connections - 'Life isn't worth living if —' - Effects on significant others - Loneliness of motherhood - Loss of independence - 'Putting on a brave face' - The effects of long term illness	- *'Erm, really, you know, upsetting- you know, I was in this brand new- this new city hundreds of miles away from home, I didn't know anybody, and I just couldn't get out of bed and it was just horrendous. So, obviously that had a massive impact on my mental health. Erm, and it just kind of [sighs] well, I don't know what to say, obviously I was worried, 'what on Earth is wrong with me?' pg.2, line 6* - *'M: I did go to counselling actually, it was the first thing I did. And they kind of took one look at me and said, 'Oh, you- you look like you're depressed, go to the doctor' which was just [...] not really what I wanted to hear! I mean like, it just seemed like-* *L: So was the counselling part of the- provided by the university?* *M: Yeah, yeah, and I was really surprised to have that reaction- I've actually since trained in counselling myself- and I'm really- I'm still really surprised that any counsellor would say that- 'cause that's not what I was trained at all. Like, you know, basically, 'Go away', you know, 'You're- you're ill, just get some pills' type of thing, just seems completely opposite to the-the, sort of, idea behind counselling.' pg.4, line 5* - *'When I first had it, one of the- one of the sort of after effects from having ME for so long was- I got a real fear about my health, I got a real anxiety about my health, just kind of, you know, going down the pan. Things going wrong, because it just came out of nowhere, and when you have ME, there's no- you may get a diagnosis, but you don't get any treatment, you don't get any explanation, it just appears, and erm, so I was left with that real intense anxiety about health- and I've always kept myself really, really healthy.' pg.8, line 6* - *'I find it quite an isolating- it can be very isolating because a lot of the things I go to, you know, everyone's just, oh full of the joys, 'oh isn't it wonderful having babies? Blah blah blah blah blah, oh I can't wait for this, can't wait for that,' and I just sit there going- I just don't think, I don't agree with any of that, you know? Just like, 'Oh I can't wait for weaning' oh you know, it just fills me with dread, the idea of weaning! Uh god, weaning, no- I just can't be dealing with it, and no I just don't find it adorable and wonderful, and I just find it a drag, you know, most of the time. Looking after a baby is hard, and it's thankless, and it's 24-7 you know?' pg.20, line 11* - *'Unfortunately it's taken it's toll. You know, I mean, years of it. We've been together for over 10 years and, years of years of depression, years of anxiety- it massively takes its toll on- on the partner, I would say. And [sighs] yeah, I mean this last sort of- well since we've had her, has just been the most testing time. I mean yeah, he's angry with me, he's frustrated with me, it's not great.' pg.21, line 11*

Superordinate theme	**Subordinate themes**	**Quotes**
The importance of being understood by professionals	- A 'mixed bag of care' - The cumulative effect of treatment - Searching for the answer - Building tolerance to treatment - Inappropriate courses of treatment - Therapeutic relationships	- *'So when it came time to sort of really think about maybe having kids, it just prompted enorm- like, massive, massive anxiety. It's just huge, there were so many different worries that I had about it, erm, so I was at the point where I was thinking, basically, like my husband and I were thinking, we think we want children, but I was too frightened to actually like go about trying to even, even get pregnant. Erm, so that's when I tried to get help from erm, 'Let's Talk' on that, well, just through my GP I think, she referred me, and it took ages, it was probably about 2 years, I think, by the time I saw somebody, but I had CBT from then, for the anxiety about birth and erm, you know, all the anxiety about the different things I had.' pg.8, line 15* - *'I dunno- there seems to be almost like a lack of empathy often, I think - when you have CBT. You sort of walk into the room, and you say, 'Oh you know, I'm feeling terrible', and they're like, 'Yes, yes, yes, but what about your thoughts? What about your blah', you know, it's-it's all very, kind of erm, formalised, and I still had two sessions left after I had her, and I tried to use one of them as a phone session, and I- I was really- I was really, really distressed, I was physically in so much pain. Erm, because I had a lot of- well I have had, and am still having a lot of problems physically after having her. And erm, I was in so much pain and I- I was saying, 'Oh yeah, you know, I'm in pain', and it was like, 'Yes, okay, well can you get your, you know, notes out? And can you look at this? And can you, you know, formulate that? And blah blah blah' and it was just- I felt like, you know, not being listened to really.' pg.10, line 12*

Superordinate theme	**Subordinate themes**	**Quotes**
What you can do for yourself	- Mindfulness - Efficacy of practice - Keeping up practice - Exercise	*- 'I mean, now with her, it's incredibly challenging, but I used to- because I used to commute to [City]- my train journey in the morning, that was sort of the perfect time, because it's kind of a protected space. You can't really do anything else, so, that's definitely been the most helpful thing.' pg.7, line 10 - 'I think after this long, I have a lot of strategies and ways of dealing with things, I mean, you know, there are so many different things. Journals, and affirmations, and this practice, or that practice, or do this, or have a bath, or read a book, or whatever. But actually being able to- in the moment, be able to get to any of that is, is so difficult. And even more difficult now I have her, because there's no time when you have a baby. There's just zero time.' pg.42, line 14* *- 'Yeah, it's very difficult though, when you're, when you physically can't do activity, and you're constantly being told, 'Oh you should exercise, oh exercise is good for you' [L: I know] Yeah, it's really, it really makes things worse.' pg.37. line 12. - 'I would definitely want to try and teach her to deal with her emotions and, you know, cope better with normal parts of experience, feeling bad is normal. I mean, I remember when I first went to counselling, I didn't know what emotions were. But the counsellor gave me a list of words to describe emotions- because I couldn't think of any! The only thing I could think of was 'upset' it was the only word I could come up with. He had to give me this list, and then suddenly it was like, 'Oh, okay' and I think that emotional awareness [L: Mm-hm] is massively lacking.' pg.38, line 23*

Superordinate theme	**Subordinate themes**	**Quotes**
Distress is a normal reaction to bad experiences	- The pathologising of the human experience - Bad things happen - Distress is a reasonable reaction	- *'I mean yeah, I've been diagnosed with depression, but to me it-it's stemmed from events that have happened in my life. And I had ME for 7 and a half years, and erm, at times I was, you know, unable to get out of bed with it- I had to give up uni, it was, you know, completely devastating. So, yeah, that's when I got depression, but I don't see it as kind of a separate illness, if you know what I mean? It-it's just- It's a reaction to life event.' pg.3, line 10* - *'I think that it's worrying that every time the DSM comes out there's more and more different, you know, illnesses to do with the mind that you can get. And I feel like more and more, kind of quote, 'normal human experience' is being pathologised in to that sort of- yes, I mean - with her I would definitely want to try and teach her to deal with her emotions and, you know, cope better with normal parts of experience, feeling bad is normal.' pg.38, line 18* - *'And slowly, slowly, you know, I've rebuilt my life, I've got, erm, I've got a full time job, didn't work full time until I was 30, so you know, that's made a massive difference. Erm, you know in terms of having something to do, you know? And being able to be healthy and well, and having money to go out and have a nice time, and my husband and I bought our own house - so with that kind of security we got married etcetera so it felt like, you know, it was built up- so yeah. I was really afraid of post-natal depression, and just crashing back down to absolute doom and gloom, and to be honest- it's been horrendous.' pg.16, line 6* - *'I dunno, it's never really felt like things are resolved, but I don't know, I just think that's the way things have gone, I don't know how things can ever really feel like they're completed or resolved.* *L: So do you not feel that you can foresee a future where you're not going to have some form of depression or anxiety, or a combination of the two, on a low level?* *M: Not really, no. To be honest. I mean, it's- it's really difficult because like, most- most of my life, I've just sort of just pretended that it's just a temporary thing- and after it, you know, a period of feeling bad kind of ends, I sort of just forget about it.' pg.31, line 10*

Thematic Table - Fleur-1

Superordinate theme	**Subordinate themes**	**Quotes**
Living with mental illness is lonely and isolating	- Loss and loneliness - The impact on relationships - Feelings of abandonment - Trust and communication - Building support networks	*- 'I'm quite, erm, I find social relationships quite difficult, I find them really challenging, because [...] I think probably I'm quite hard to take. From the other person's perspective sometimes, erm, but also, I read into things a lot, and I worry, and erm, because I haven't had a lot of success in the past with friendships, they've always ended quite badly, I- I don't feel very secure in friendships generally.' pg.16, line 4* *- 'So I'm trying to let my guard down more with- with people and accept that actually, people generally, like-that have you in their life want the best for you. They're not- they're not all trying to trip you up. [L: Mm-hm] You don't have to put on a show all the time. But it's-it's really hard. Like, yeah.' pg.16, line 11* *- 'I get a lot of support from [Partner] my other half, he has reminders and stuff on his phone for when I should take my medication, and sometimes he has to be sort of quite, 'No. Stop. Take your medication now, so I see you take it', he looks after my tablets so I can't hoard them, or run out. Because he will prompt me to order them' pg.14, line 18* *- 'My mum believes that I am a born hypochondriac. And I've always wanted something wrong with me, and now I've found something that I can tell the world is wrong with me. Erm, and I'm not depressed, I was just a cold child from the day I was born.' pg.17, line 13* *- 'My mum always, [sighs] she'd say, 'Turn the- stop the fucking waterworks, [L: Mm-hm] the reason that no-one wants to be your friend is 'cause you're so fucking miserable all the time. Sullen, and you think you're better than everyone else, so you shut them out' pg.32, line 2* *- 'But I'm really disappointed in him. I feel like he's let me down and abandoned me, so [...] I emailed him a few weeks after I was discharged, because I was really struggling. And I got no response, and I thought that he'd resigned- like I thought that he'd retired, because he'd mentioned it, but erm, obviously that was the first bit of information I squeezed out of my mental health nurse, 'where is he now?' [L: Oh right, okay] and he is still there.' pg.13, line 8*

Superordinate theme	**Subordinate themes**	**Quotes**
Wanting to feel 'normal' within and seem 'normal' to others	- Fading away - The effects of medication - Compliance - Feeling caged - Feeling superhuman - I am underserving of care - Detachment from the self	- *'Because it's- that's always the way I saw myself, just slowly becoming more and more transparent until I just faded away, and no-one noticed.' pg.38, line 4* - *'And I don't like that I'm tied down to where I am, because I- I need a prescription every month, because they will only give me a 1 month prescription [L: Okay] because I've hoarded tablets before. And so I have to- I hate being constricted in that way. It's the same as I felt when I was in the therapy. Like, I had to go every week. I'm tied to that [L: Mm-hm] like, I don't-I don't like the feeling of being boxed in?' pg.12, line 2.* - *'I still really struggle with recognising when I'm going through a bit of a manic phase, which- so I feel so capable, then, and I feel so on top of things, and I feel so unstoppable, that I take on so many things. I will be the person that will do anything for anyone- goes above and beyond in every area, and it literally is like flying- and then, I'll just get to the point where I'm- I'm just starting to crack, because I can't quite keep up with it [L: Mm-hm] and then- admitting that I can't do everything, that will be the peak of the- then we go very rapidly downhill.' pg.15, line 4* - *'Yeah. I do- yeah they're probably like- my biggest worry is that they're probably better off without me, and that I'm having a negative impact on them, that they'll then carry until they're adults. It's just a lot of pressure. I never wanted children. And they are- you know, from someone who has had very few social- long lasting social ties, through choice or not, they're like 'for ever' and I find that suffocating [L: Mm-hm] I feel like the home is a cage, motherhood is a cage.' pg.28, line 18*

Superordinate theme	**Subordinate themes**	**Quotes**
The benefits of learning to be self-aware	- The quest of recognition - Illness as a cycle - Foreshadowing - Educating our children	*-'But yeah, I don't- I think I'm on a quest at the moment, to notice those things. Because I'm not very- I think I'm very very self aware- but I can't really- but only in hindsight? L: So you experience it, and then you look-reflect and you're like, 'Oh, I need to make a note of that' F: Yeah, but then it's really hard to notice, by yourself- and I think this is where the support networking helps [L: Because if people notice you doing it] well like, I'll disappear into my phone [L: Mm-hm] I will just play games, and I talk to men that aren't my fiancé - which he knows about, and is fine with, but I only do it when I'm manic. I know- I've noticed that this time- this time round, because I just- so I go from have this sort of, insatiable sex drive to bam! [L: nothing] Don't. Touch. Me. [laughs] No, but yeah, I don't- I don't really understand it still. I think- I've literally only just realised, like I've only just noticed that it's a cycle' pg.24, line 14 - 'Also I just think that people are going to find out eventually, because eventually, it will show [L: Mm, maybe] because you can't- it's not even that I try and hide it all time, but I can't be okay all the time [L: Mm-hm] and I think I've accepted that, that I can't be okay all the time, and that actually, it's better if people know.' pg.21, line 4 - 'And just because I've never been like that. So when- whenever I'm happy generally, like really happy, it's because I'm- I'm just about to have a real bad downhill. L: And is that consistently true? F: Yeah. And it can last for like, a few weeks, or just a day- but it-it's always followed by something that is really difficult to pull myself out of, and [...] so I think, that-that worries me, but also, I think oh, like, there's something bad just around the corner, like all the time. Like, and whenever I'm really like happy, I can feel it coming, hanging over me, like, it- there's a penance to be paid.' pg.10, line 7 - 'Well she was aware enough at 4 to tell me that she felt sad [L: Mm-hm] deep, deep inside. Like inside sad, which is what prompted us to get her counselling at school which has really helped. So I think, yeah, I think that's a responsibility we all have to children, is to breed this sort of awareness of mental health.' pg.30, line 6 - 'But I do have to tell you that in practice it's really hard. [L: Mm-hm] Because, if they tell you they're sad, then in an ideal world, you'd be like, 'Okay, you know, is there anything in particular? Or do you just feel like that' in the real world, you're like, 'Why? [L: Mm-hm] like, do you not have everything you need? Like why'- because it makes you feel like- It makes you feel like you're not doing a good job, it's really difficult' pg.31, line 3*

Cross-case table

Cross-case Analysis - Table of themes-1

Superordinate theme	**Subordinate themes**
Living with mental illness is lonely and isolating	- Loss and loneliness - Community mental health - The impact on relationships - Loneliness of motherhood - Feelings of abandonment - Fading away - ‘Life isn’t worth living if —‘ - Effects on significant others - Loss of independence - ‘Putting on a brave face’ - Trust and communication - Searching for understanding and human connections
Not knowing what’s happening is scary	- Sudden influx of others - Succumbing to pressure - Effects of medication
Wanting to feel ‘normal’ within and seem ‘normal’ to others	- The desire to be a ‘normal person’ - Compliance - The effects of medication - Feeling caged - Detachment from the self - Being pigeonholed - Acceptance and stigma - Feeling superhuman - I am underserving of care
Mental illness is something to escape	- Distress as its own entity - Taking on a role - A skewed sense of self - Self help techniques
The benefits of learning to be self-aware	- The quest for recognition - Illness as a cycle - Foreshadowing - Educating our children
The importance of being understood by professionals	- The idea of an ‘expert patient’ - A ‘mixed bag of care’ - The cumulative effect of treatment - The ‘then and now’ of treatment - Levels of wellness - Searching for the answer - The rush to a diagnosis - Building tolerance to treatment - Inappropriate courses of treatment - Idea of a ‘true counsellor’ - The NHS do their best - Understanding medication - Therapeutic relationships

Superordinate theme	**Subordinate themes**
Being hopeful for a symptom free future	- Learning to face your fears - Living a normal life - Feelings of empowerment and achievement - Can’t imagine life symptom free - ‘When I can —‘
What you can do for yourself	- Mindfulness - Efficacy of practice - Keeping up practice - Exercise - Finding support networks
Distress is a normal reaction to bad experiences	- The pathologising of the human experience - Bad things happen - Distress is reasonable

Appendix 8. Journal Entries

Thurs 21st Sept ‘17

B— meeting

There were about 10 people in attendance (all female).
A few did not seem particularly interested in talking to me but the majority were very warm and welcoming, were happy that I was ‘on their side’ in terms of my work.
There was a surprising amount of anger and feelings of being let down which were consistent around the room for varying reasons. Aftercare was a huge issue, many felt abandoned after being discharged with no follow-up from services. Not just MH services but councils and police as well. I was told that a group member had gone into crisis and was suicidal, her friend called the police who told her that they wouldn’t do anything unless she actually hurt herself.
The members are very close and treat each other like family - fiercely protective of one another and don’t mind being upfront and blunt.
There was a strong sense of group pride and what they have achieved - working on new initiatives such as a pop up workshop in a local cafe to help people fill out benefit/council forms, and to have informal chats, healthy eating initiatives and food donations etc.
The leader of the group was open about the pressure involved with running this sort of service and became quite emotional. They have some funding and receive donations but many of the members contribute to the running of the group.
All members in attendance currently taking various forms of medication so at this point were unavailable to take part in the study.
Feeling drained but have gained confidence.

Mon 25th Sept ‘17

YS meeting

This was a smaller group with only 6 in attendance, both men and women attended this time. The main issues talked about here were more stigma related, with problems involving workplace bullying and the effect of distress on interpersonal relationships.
Again, the majority of the group were actively taking medication and suggested that my study be altered to be more inclusive and to let them participate. Having spoken to the group, it seems wrong to me that they should be excluded providing they feel that they are personally well enough to participate. I agreed to see if making this change was possible and to get back to them.
Feeling determined

Fri 23rd Feb ’18

After thinking that I would need to abandon this project for various reasons, I have made some progress and feel like I can see this through until the end. I have finally received confirmation that I can proceed with data collection that includes individuals still taking medication, and have sent a call for participants to YS. I have had to update my research materials and interview schedule accordingly but I am happy to be more inclusive in my research. I am hoping to recruit 4 participants with the aim of interviews taking place in March.
Feeling relieved but nervous.

Mon 5th March ’18

I met Ron for my first interview today. We were both a little unsure as to what to expect, but the interview went smoothly and Ron was honest and forthcoming when answering my questions. He had clearly read the interview schedule and the conversation flowed well. I feel I was unprepared for some of the things he told me about his life, and I feel transcribing the interview will be an emotionally difficult process.
Feeling buoyed.

Mon 19th March ’18

I am now most of the way through the transcription process, am currently working full time and am having to do what I can in the evenings - I am glad that I’ve done this myself but it has taken forever and reliving each of the interviews has been draining and upsetting at times. I’ve had to take breaks at certain points, and getting up to do something else for a while helps a lot. It’s hard not being able to properly decompress and discuss the contents of the interviews with others but I feel like I’m coping okay. I’m getting a small idea as to the sorts of themes that will be coming out of the data as I’ve done this and am looking forward to beginning coding and the analysis. Feeling tired but happy with my progress.

Tues 31st August ’18

I have completed nearly 2/3rds of the write up and am about ready to send this to be looked over. I think I have done the discussion correctly but am nervous about getting this back. Analysis so far has been fine so hopefully the rest will be fine too. Still feels like a long way to go but I have an idea about what I want to say - aiming to be completed early September if possible.
Feeling overwhelmed.