Maps, Models, and Narratives: The Ways People Talk About Depression

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Abstract

Many researchers within the social sciences, medicine, and humanities have examined the ways people talk and think about depression. In their research and published literature they have attempted to determine the theoretical frameworks and appropriate language for categorizing such concepts and understandings. Drawing from mental health and broader social science scholarship, in this article we examine three approaches to developing an inclusive understanding of depression experiences: explanatory models, exploratory maps, and illness narratives. Utilizing these terms in the analysis of a single dataset, we identified multiple conceptual terms with potential analytical validity. Furthermore, we argue that variable usage and meanings of these concepts among lay people might contribute to a shared understanding of depression between lay people and experts, and ultimately have positive consequences for clinical practice.

Keywords

depression; health care, primary; lay concepts and practices; research, qualitative

"It is our modern specialty to have localized hell in ourselves." (Cioran, 1998, p.1)

Emile Cioran's reference to "our modern specialty" could well be applied to health practitioners, policy makers, and academics in contemporary Western societies who have given enormous attention to depression as a way of explaining and understanding the "localized hell in ourselves." Similarly, a modern specialty has emerged from the significant investment in resources to discover cures and manufacture remedies for depression. Consequently, Western societies, and increasingly the rest of the world, have been the supposed beneficiaries of a proliferation of knowledge, expertise, and types of discourse on depression that has emerged through the fields of psychiatry, biomedicine, psychology, and social science. This has been apparent in government policy documents, nutrition studies, consumer guides, Web sites, and media reports. This proliferation has made depression one of the most debated "health" issues in the public arena today.

Given contemporary preoccupations with identity, recognition, and self-worth, this attention comes as no surprise. In this article, we begin to examine theory and empirical data to bring some degree of synthesis to one aspect of the depression debate: how people talk about depression. We examine both what they say and how they say it, drawing on published literature and extracts from interviews collected in Australia. We identify the multiple ways that a cohort of primary care patients talked about depression, what it is, and what causes it, and consider the implications of this for clinical practice. We describe how three popular analytical terms, *explanatory models, exploratory maps*, and *illness narratives* were concurrently used by primary care patients. During these interviews patients incorporated in their responses a variety of discursive repertoires that were available within the wider sociocultural environment, including biomedical discourses, which were dominant in media, health-promotion campaigns, and health policy in Australia, while at the same time they incorporated fragmented social and personal narratives.

In the first section of the article we consider why, in the context of so much debate about depression, it is important to consider how people talk about depression. We then

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examine the multiple theoretical terms people use to "talk" about health and illness in academic literature, before focusing on the three theoretical terms noted above used in relation to depression. Using data from structured interviews, we explore how these theoretical terms apply to the way people talk about depression. This revealed the multiple and complex usage of language that related to all three theoretical terms. Finally, we consider the implications of our analysis for clinical practice, particularly primary care, and how clinicians and patients negotiate the diagnosis of depression, its treatment, and illness evolution.

Depression, Medicine, and Society

Factors contributing to what has come to be called a depression pandemic have been debated by researchers from a variety of disciplinary backgrounds. For instance, Martin (1999) argued that depression has become the "presiding discontent" of contemporary society. Similarly, in their book *The Loss of Sadness*, Horwitz and Wakefield (2007) outlined the social processes that contribute to depression's status as a "major social trend." These included the widespread perception that depression is increasing rapidly in the community; the explosion of the number of people in treatment for depression; the manifold increase in the prescription of antidepressant medication in recent years; the explosion of scientific publications on depression; and the media attention on the problem of depression, including an industry of evidence-based, expert-produced, self-help resources detailing how to cope with and overcome depression (Horwitz & Wakefield).

Although the phenomenon of medicalization might have been a significant contributor to the increasing incidence of depression, there are a wide variety of other potential factors. These include both the hyperconnectedness of modern society juxtaposed on the disintegration of family and community relationships, which also need to be considered when attempting to unveil the complexity of the depression pandemic. Among others, Horwitz and Wakefield (2007), and more recently Greenberg (2010), have critically reexamined the dominant understandings of depression prevalent in biological psychiatry and propagated by the global pharmaceutical industry, and demanded a more accurate distinction between "normal sadness" and "depressive disorder." This boundary between "normal" sadness and "clinical" depression is contested both within and beyond the medical paradigm (Armstrong, 2007; Khan, Bower, & Rogers, 2007; Pies, 2008; Pilgrim & Bentall, 1999). The lack of clarity about this boundary has implications for the discovery of appropriate ways of understanding and addressing depression. Although depression might be seen as a useful clinical category, it remains a contested concept in medicine and the social sciences (Dowrick,

2004; Kokanovic, Bendelow, & Philip, 2012; Kokanovic, Dowrick, Butler, Herrman, & Gunn, 2008).

Social science researchers have devoted considerable attention to lay peoples' understandings of depression as an alternative to the reductionism prevalent in expert-driven biomedical research. Although expert discourses are often incorporated into lay accounts (McClean & Shaw, 2005; Shaw, 2002), an analysis of how lay people describe their experiences of depression is important for understanding its nature. Arguably, this is particularly important for the primary care context, in which a patient-centered approach is advocated (McWhinney, 1985), and in which depression is the most commonly diagnosed mental illness (Rogers & Pilgrim, 1997, 2009).

According to the Australian Institute of Health and Welfare (AIHW, 2007), the number of people presenting with depression in general practice and primary care in Australia is steadily increasing. Ørner, Siriwardena, and Dyas (2004) argued that this increase has contributed to an acknowledgment by primary care practitioners of the importance of considering the interaction of social, psychological, and circumstantial factors related to depression, rather than simply biological factors. This consideration falls outside of the traditional bounds of a biomedical model of the doctor–patient encounter (Woodward & Shaw, 2007). Consequently, there is a demand to consider "distress, which at one time would have been dealt [with] through support mechanisms found within the community," as a medical issue (Woodward & Shaw, p. 51), and growing demand for primary care practitioners—especially general practitioners (GPs)—to address the problem of depression in their daily work.

Increasingly, however, there is a recognition that solutions to depression should also be found within the broader social field (Woodward & Shaw, 2007). Conrad (2007, p. 152) argued that the "medicalization of life problems" obscures the social forces that influence well-being. While acknowledging the complexity of the issues outlined above, social science researchers have suggested that understanding the different ways people talk about and make sense of distress will assist communication in the clinical setting. This, in turn, might contribute to the success of health care (Jenkins, Kleinman, & Good, 1991).

There is also pressure from within general practice to understand the ways people talk about and make sense of distress. The epistemological shift in general practice from doctor-centered to patient-centered care brings with it the added complexity of heterogeneity: "Patients are no longer considered as specific instances of a disease to be locally negotiated, nor are they passive recipients of individualized and authoritative expertise" (May, Rapley, Moreira, Finch, & Heaven, 2006, pp. 1024-1025). Furthermore, May et al. argued that "the clinical encounter has been reframed as a

set of negotiations in general practice's grand narrative of patient-centeredness . . . the very presence of these negotiations assumes a degree of epistemological authority for the patient's story" (p. 1025). For clinicians, Armstrong (2007) has argued that this shift to patient-centered care has also enabled the exercise of a certain amount of clinical agency in the face of evidence-based protocols.

If we consider primary care practice as increasingly emphasizing heterogeneity, we can argue that it is also important to attend to the multiple forms of accounting patients use when describing their experiences and negotiating about the treatment of depression in primary care. In the next section we consider the theoretical literature on how people talk about health and illness, and why it is important to critique the conceptual terminology.

How Do People Talk About Health and Illness?

Lay people have used a myriad of metaphors and "concepts" to describe their experiences of depression (Khan et al., 2007). The ways individuals negotiate, make sense of, and articulate their beliefs regarding the causes of illness have been subject of a number of studies and scholarly debates. This includes, for instance, Kleinman's (1980) and Blumhagen's (1980) explorations of explanatory illness models; Stimson and Webb's (1975) study of patients' multiple, fluid, and conflicting accounts of illness; and Radley and Billig's (1996) description of accounts of health and illness. If one were to peruse the scholarship on lay peoples' accounts regarding illness, one would be struck by the vast range of theoretical terminology that has arisen simply from describing each study's object of research.

As Radley and Billig (1996) argued, the researcher must not term his or her object as "illness beliefs," but rather "illness accounts." In their formulation, illness experiences are revealed through dialogical encounters between interlocutors; therefore they can only be analyzed as "accounts" given in contingent and positioned interactions. In this analytical move we see a turn toward evanescence and mutability more than stasis and coherence. In a similar vein, Williams and Healy (2001) called for a shift from "explanatory models" to "exploratory maps" as a means by which to capture changing and contradictory beliefs about an individual's illness experiences over time. In their research, Williams and Healy examined a group of patients who were in the process of receiving a diagnosis rather than those with an established diagnosis, as in earlier work, which might account for some differences. Nonetheless, the trend in the sociology of health and illness has been to critique static terms such as *model* and *belief* in favor of more fluid concepts such as *account, exploratory map*, and *illness narrative*.

This has been situated within a postmodern paradigm and the contemporary embrace of narrative research, although studies from narrative researchers question whether stories are always coherent and follow logical, temporally ordered plots (Andrews, 2000).

Although this development in the field of health research appears, in our minds, as a shift that brings theory closer to the lived experience of health and illness, there has been very little examination of the various strands of theoretical language. That is to say, at the same time as aiming a critical eye at our conceptual terminology as an object worthy of scholarship for the sake of reflexivity, we are left with a proliferation of various theoretical terms with little analysis of what, if any, relationship these terms have with one another. Furthermore, as each successive article seeks to debunk the terminology that came before it, we are left with an either/or approach: Do we describe our object (lay concepts) as explanatory models or exploratory maps or illness narratives? And what are the attendant consequences that stem from this for research and clinical practice? Are we looking at three different terms that describe essentially the same phenomena, or do all these concepts describe different phenomena?

After all, the ways people talk about illness experiences are fundamentally different and reflect different realities for different people. This could impact on the ways people communicate their experiences and consequently influence the ways people are cared for. For example, Williams (2000) contended that "it is no longer a question therefore of biological versus social accounts of mental health and illness" (p. 566). Does this suggest that we would be better served by utilizing a range of terminology within each study? In the next section we focus on three commonly used theoretical terms that have been separately mobilized in studies of people living with depression, and consider how their use can become self-reinforcing. This is followed by consideration of our empirical data.

The Problem: A Proliferation of Terminology

The concept of explanatory models, as articulated by Kleinman (1980), rendered lay beliefs about illness as an object for analytical attention. Kleinman defined explanatory models as "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (p. 105). More specifically, explanatory models provide an interpretive framework through which disease and illness are made legible (Kleinman). Thus, explanatory models are a kind of conceptual framework within which aspects of physical experience can be positioned to form "coherent patterns." Although this has certainly provided analytic purchase by which to frame the study of concepts of illness, the

"explanatory model" perspective has also received criticism. The "model" of coherent, interlocking conceptual systems has been challenged by researchers who propose alternative views of lay peoples' experiences of illness (Prior, Wood, Lewis, & Pill, 2003).

Williams and Healy (2001), for example, argued that the term *explanatory model* suggested that "beliefs" are fixed models that imply a coherency that is at odds with the mutable nature by which lay people understand illness. They suggested that people's beliefs about the causes of depression are not fixed, but in fact are multiple and can appear contradictory even within the same interview. They argued that rather than an "explanatory model," participants in their study provided an "exploratory map," defined as "the avenues of thought which individuals explored when attempting to understand why they were currently experiencing particular psychological problems" (Williams & Healy, p. 465). In particular, they argued, the beginning of illness is often considered through exploration rather than explanation.

Thus, exploratory maps could be viewed as the kind of thinking that is undertaken when coming to terms with illness and/or diagnosis. Maps represent a discursive train of thought touching on various explanatory possibilities. Therefore, metaphorically speaking, the explanatory model is a fixed destination implying a degree of certainty, whereas the exploratory map can be understood more in terms of a variable journey than a fluid landscape of interpretations, beliefs, and understandings.

A third conceptual framework for understanding depression is illness narratives, which are posited as an object of study, as well as a method for data collection. Hyden (1997) argued that the essential properties of the narrative emphasize "the temporal ordering of events that are associated with change of some kind" (p. 50). The narrative, then, is a story that unfolds across time. The narrative, in its purest sense, diverges from an "explanatory model" and an "exploratory map" in its depiction of chronology. Neither models nor maps, as they are defined, have this essential quality of temporality. This is not to suggest that models and maps do not contain reference to time-based events and descriptions; however, the analytic focus of these is not temporally based as it is for most studies of narrative.

Approaching an individual's experience through narrative is held in opposition to the "explanatory model" method of collecting data, because the former emphasizes particularity, whereas the latter prioritizes abstractions (Ellis & Bochner, 1999). Personal narratives allow individuals to situate their illness accounts within the context of the specificity of their life and provide a social and personal framework within which to connect their experiences. Narrative is implicitly connected with a person's identity formation (Nelson, 2001). As Paul Ricoeur posited, "After all, do not human lives become more readable when they are interpreted in the function of the stories people tell about themselves?" (1991, p. 73). Thus, we understand narrative here as "stories lived and told" (Clandinin & Connelly, 2000, p. 20) as well as the "phenomenological ground of identity and the means for explicit identity construction" (Antze & Lambel, 1996, p. xvi).

It has become the established convention in scholarly articles on health and illness to treat these three theoretical terms as separate objects. Data collection is geared toward eliciting a particular form of response from informants, and thus the treatment of one theoretical perspective of illness accounts is inevitable. However, as we argue later in this article, even in structured interviews that allow for open-ended responses, respondents produce accounts that change between the different forms within one section of talk. In the next section we describe the source of the data we used and how we analyzed it to further explore the forms of talk about depression.

Data and Analysis

The data presented in this article were extracted from structured, computer-assisted telephone interviews (CATI) conducted in 2005 with people experiencing probable symptoms of depression. Participants were recruited through primary care from 30 randomly selected general practices across Victoria, Australia. Participants were eligible if they scored $\geq$ 16 on the Centre for Epidemiological Studies Depression (CES-D) Scale (Gunn et al., 2008). Scores of 16 and over are considered to indicate symptoms of depression or probable depression (Radloff, 1977).

The interviews were part of the Diamond Study, a longitudinal, mixed method cohort study exploring the diagnosis and management of depression in primary care, underway in Victoria, Australia since 2004 (Boardman et al., 2011; Gilchrist, Hegarty, Chondros, Herrman, & Gunn, 2010; Gunn et al., 2012; Gunn et al., 2008; Kokanovic et al., 2008; Potiriadis et al., 2008). This is one of the largest studies of its kind in the world, and the researchers aim to collect comprehensive information on depression experiences, the use of health services for treating depression, and the management of depression in the Australian primary care setting. The data used for this article were collected as part of the second round of annual interviews (participants are currently being interviewed for the eighth time). Ethics approval for the study was granted by the University of Melbourne Human Research Ethics Committee. The structured interview guide was developed by a multidisciplinary team of researchers consisting of a medical sociologist, a psychiatrist, general practitioners, and a psychologist. Participants answered a series of open-ended questions aimed to elicit accounts of their experiences of depression and health service encounters, and

their views on depression. The interviews were conducted by trained research assistants.

Data were reviewed for patterns and meanings (Silverman, 2001) about beliefs and causes of depression. The analysis was then discussed and confirmed by other coauthors. We identified three main categories of participant responses based on whether the participant identified single, multiple, or uncertain causes of depression. Once we had identified these categories we grouped the interview responses by category, using qualitative data management software NVivo7 (QSR International, 2006). These groups of data provided the basis from which we analyzed the forms of talk participants used and the different causal attributes participants gave. In the next section we provide an overview of participant responses and illustrate the various causal attributions and how these reflect variable theoretical concepts.

Parallel to the analysis we reviewed the relevant literature, as we have reported throughout this article, which we used to refine our analysis. We present our results in the context of the current debate on depression, the wider literature relevant to our study, and our earlier exploratory work with a subsample of participants (Kokanovic et al., 2008). In the next section we consider in turn each of the three theoretical constructs we discussed earlier in the article, along with data that reflect each of them. We then consider how participants often use a synthesis of these constructs when talking about depression.

Exploring, Modeling, and Narrating Depression Experiences

Exploring

A notable aspect of participant responses was their mobilization of multicausal explanations of depression. Often, participants expressed some uncertainty about the concept of depression. When asked about what causes depression, many participants provided several different possibilities without giving priority to any single cause. Therefore, many responses seemed to be a tracing and exploration of the concept of depression and its cause that was similar in form to the "exploratory map" posited by Williams and Healy (2001). Exploratory responses emphasized the complex and dynamic nature of the concept of depression. There was uncertainty around establishing a definitive diagnosis for depression and identifying the appropriate treatment pathways for clinicians. These responses reflected the difficulties social science researchers face in research on depression.

Martin queried whether depression is "a therapeutic matter—a clinical syndrome or mood disorder, cognitive dysfunction, low self-esteem, and especially chemical imbalance? Or is it a moral matter—a potentially creative

encounter with troubled relationships, activities, values, and self-respect?" (1999, p. 271). Some of our participants interrogated such dilemmas in a similar way:

> I think there are a variety of issues. Part of it can be a chemical imbalance, part of it is environmental, and their environment when they were young, and also social pressures. Our own social mores in Western society contribute a lot to depression. I've sort of covered it globally, but when you're coming to an individual, apart from the food or alcohol issues, the situations that occur to them today can be caused by what happened to them in the past— so their emotional and social environment, family, and stuff like that. . . . Oh God. In relation to me, or what it is? . . . Well, it makes me feel very anxious, not worthy, unattractive. Physically I feel heavy and I can't be bothered. I lose interest in a lot of things and lose concentration. (Woman [W])

Depression scholars have given much attention to the identification of biological, social, or psychological causes of depression. There is an identifiable tension in the literature between what is understood as a biomedical condition called depression and the experience of depression as a normative human response to life events (Pilgrim, 2007). For the participants in this study, a great deal of uncertainty remained around what depression is and what causes it. Most accounts were contextual, and participants often presented multifaceted etiological accounts. Kangas (2001, 2002) similarly found that a single explanation does not structure the entirety of the depression experience. This confirms Williams and Healy's characterization of exploratory maps, whereby "in seeking meaning individuals may hold various explanations simultaneously or they may move rapidly from one belief to another. The process of seeking meaning is therefore characterized by movement and uncertainty" (2001, p. 473). Movement and uncertainty were described in a participant's examination of depression:

> That . . . I can only speak personally on this, as it is a progression. Initially it was constant pain, and stress at work. I was a newspaper reporter at that stage. The pain took over when I experienced pain from several tragic deaths. And you feel like you are teetering and don't know what way you are going to fall. God that sounds pathetic. You are going to [get] ninety-five different perspectives in every one hundred. . . . Oh lord, the biggest problem with describing it, 'cause it falls in the category without meaning and falls into the category of, the lights have turned off and you don't know where the light switch is. And I can't describe it

any other way. It is there or you are having a reprieve. I also use nicotine, which is also unfortunate. (Man [M])

Although some participants offered exploratory maps that illustrated several different factors pertaining to depression, other participants responded in a way more consistent with the concept of modeling. This demonstrates the variety of terminology that can appear within one cohort of participants.

Modeling

Participants also conceptualized depression as in an explanatory model, particularly drawing from biomedical and psychological sciences. For some, the use of a biomedical explanatory model was expressed as relief in discovering a single, clear-cut explanation for their experience:

> Umm . . . the big thing that I have learnt about it is that it is an imbalance in the electromagnetic field of the brain, which is in a sense reassuring because you understand that there is a medically recognized underlying cause for depression, and that's exacerbated by daily life experiences. . . . Umm . . . depression is a sense of inability to cope with not only extreme situations but also the daily routines of life . . . and a sense of an inability to cope or find ways to rectify feelings of usefulness. (W)

Scientifically constructed, physiological explanatory models for depression might be reassuring for some people to structure their understanding of their experience. The attribution of biomedical causes to depression might also be a recovery practice that people utilize to provide a sense of coherency during times when their life map is disrupted by illness. Thus, in spite of social science's emphasis on fluidity and multiple modalities, people might seek forms of certainty when explaining the causes of depression. The following quotation, however, suggests that even reaching for a physiological explanation, for some participants, is not straightforward. The participant provided multiple causes for depression before suggesting a physiological model of explanation, but then described what depression is in vivid terms of what it felt like:

> I think it is probably various reasons. Marriage breakup and loss of job comes up on the top of the list of things; family problems. I could go on and on. People struggling financially and worry about children and going on and on . . . financial worries causes a lot of problems for people. . . . Well, I guess it is probably a chemical imbalance with the serotonin. It is an overwhelming fear of loss of

control. As in you have no control over how your life is going. (W)

The potential comfort provided by a physiological explanatory model coexisted with ideas of multiple explanations and narrative of what depression felt like. So although some participants drew on exploratory maps, others found meaning through an explanatory model.

Narrating

The use of narrative in understanding the meaning of illness has been well documented. Writing in the context of chronic illness, Williams argued that the "genesis of chronic illness may itself be narratively 'read back' legitimately or otherwise, into a set of former life crises and biographically disruptive circumstances: factors which, not infrequently, provide a radical critique of existing social arrangements" (2000, p. 563). In his analysis of the current renewed interest in narrative analysis in the humanities, social sciences, and medicine, Bury (2001) suggested that the study of "illness narratives" reveals the interconnections between embodiment and experience that become narrated as a "biographical disruption."

For many participants, as emphasized by Bury (2001), using a narrative modality enabled them to create meaning in the present out of past life experiences. Participants described the interaction of different factors which themselves had varying timeframes: the minute-to-minute and day-to-day social interactions of individuals, the changes with biological aging over a lifetime, and shifts in social organizations such as the workplace and in terms of social norms and culture (Layder, 1997). Participants often attributed their depression to events that occurred decades earlier; the effect of negative experiences in childhood for example. Some also linked the onset and the course of their depression to more recent, quite specific and often traumatic events in their lives, such as the loss of family members, abuse and violence, separation from partners and/or children, getting older, retiring from work, moving to a different place, or losing a job.

The main identified threads running through most of the narratives related to a combination of loss, trauma, loneliness, and alienation. Of course, these are highly subjective terms, which contain multiple meanings that are context-dependent and are most often interrelated. However, they illustrate how narration was developed in each participant's continuous process of rereading their personal history. A typical example of a narrative is given below.

> [I] had to go away from my grandparents to live with my mother and stepfather. I cried myself to sleep, was locked in the house alone on weekends, had to eat my food alone in my bedroom. It was not

a happy home. I'd gone from a very loving home to a nightmare. . . . [Depression] started because I lost eight friends and family all in a row; the last person to die was my own mother. Not long after my mum died my third husband left me. Too much, too quick. It was a nightmare. I've never really recovered since. As a child depression was related to loss. Other episodes were related to marriage breakdowns. I think it was my fault. Other episodes were when I lost two children at birth, separate births. I now have an ongoing problem with my son and his wife. We have problems that I think we need to sort out. . . . I'm under a lot of stress. I've lost my home—I couldn't keep it up financially because I'm on a disability pension. . . . I've lost my home and now I've got a little house that I'm living in. . . . I'm in an abusive relationship at the moment. My aunty died only a few weeks back and my ex-husband died just a few days before her. (W)

A number of narratives we analyzed had a strong focus on social factors, which included social isolation, problems with family members, economic hardship, unemployment, and a plethora of other issues caused by or coming from the individuals' respective social environments. The illness narrative below illustrates this type of narrative:

I can't talk with family and friends because my situation is more than they can cope with. My depression is caused by my situation. Family don't want to know—full stop [period]—because they can't cope with it. . . . There's one question that I don't get asked which I think is relevant, and that is, "What's going on in your life?" . . . Well, I sold my house to move to Queensland to be with my two adult children, and since selling my house they've decided they didn't want me to move to Queensland. And now I'm without a home and without a family and no direction. . . . I don't know how to put it down in a few words. I have to give you some background. Seven years ago I separated from my partner, the father of my two children. Five years ago I moved back to Melbourne, which is where I grew up. I left my two Queensland children in Queensland. And that's caused me a lot of distress; dysfunctional family stuff has been my problem. And twelve months ago I decided to move back to Queensland to reconnect with my two children, and I sold my house to do that, but now I've decided not to go to Queensland because my family relationships are not good. (W)

Many participants linked their depression to one or more physical health problems such as back pain, serious injury, heart attack, and chronic disease. Others linked their depression to substance abuse, anxiety, panic attacks, stress and posttraumatic stress disorder. For instance, one participant stated the following:

Since I had a heart attack, nineteen ninety-seven, initially it was constant pain, and stress at work. I was a newspaper reporter at that stage. . . . About four years ago I had a nervous breakdown and I tried to cut my wrists. . . . I ended up at the cemetery where my mum was buried. I saw the psychiatrist once and saw counselors who came to the house for the next week. I was off work for two months. (M)

Many stories of depression included elements of map, model, and narrative. Within the narratives above there are also suggestions of causes—often many causes—as in an exploratory map and some hints of explanatory models such as bereavement, change of life circumstances, or illness. In the next section we further consider the coexistence of these different concepts in patients' accounts of their experiences of depression.

Toward Theoretical Heterogeneity. The following vignette includes narrative, but intertwined with this is the exploration of multiple causes—exploratory map—and suggestions of explanatory models such as substance dependence:

I had a gambling problem to start off with and I had blown all me [my] money. . . . When I was twenty I was dependent on drugs and alcohol and sex, and then when I realized they had to go it was hard to face and deal with. I've had a lot of problems with aggression and anger. I do believe that when my father went to jail, I believe at thirteen, like most teenagers [I] experimented with drugs and alcohol, like with them I looked at them as an escape. (M)

Many stories told by the participants took an autobiographical turn. In Bruner's explanation of autobiographies he noted how people's accounts are often characterized by "turning points" which reflect profound changes in selfhood. Such statements as, "After that, I was a different person," suggest turning points in someone's life story which are also markers of causal attribution (Bruner, 1997). This is illustrated by the following quotation:

Twelve months ago? Well there've been some major changes in my life and I am now feeling considerably better than I was twelve months ago. Ah, well I've changed my environment, made changes in my life. . . . And this counseling with the psychologist is very helpful. (W)

According to Bruner (2004), the principal function of the mind is story making. We describe our lives and self in stories; our experiences and self-identity are formed into stories that we tell. These stories explain events, situations, and happenings to provide a framework of meaning that inform and reflect our identities and our lifeworlds. Human identity is not fixed, nor does a singular plot or narrative capture the range of life experiences that contribute to its formation. Ricoeur (1984) suggested that "time becomes human to the extent that it is articulated through a narrative mode, and the narrative attains its full meaning when it becomes a condition of temporal existence" (as cited in Hyden, 1997, p. 53). Thus, by speaking our stories we give meaning to our life experiences, and sometimes these are experiences that we believe have caused illness.

Participants acknowledged that depression could be understood as a "normal" response to unfavorable life circumstances, therefore making every individual potentially vulnerable to the condition of depression. Thus, for many participants the concept of depression was inextricable from the narratives with which they described their lives. Through the use of a structured interview guide, we did not actively encourage participants to provide a narrative format for their response. However, even when not specifically asked to provide a narrative, many participants described the experience of depression by telling a story and constructing it as part of their personal history.

Overall, our interrogation of the data illustrates that when responding to structured interview questions about depression and its causes, participants utilized a variety of forms to explain their experiences. As illustrated above, it is possible to categorize these as maps, models, or narratives based on what seems to predominate in the response— particularly when people gave single, multiple, or uncertain explanations. However, as the examples from participants indicate, responses can include elements of all the different forms of talk. When interpreting the interviews, we noticed two dominant styles in terms of how the stories of depression were told by the participants. The styles included either use of the "I" form—for example, the story was told in the first person, or a more detached form of talk about "it"—for example, talking about depression as an external condition. Those who described their depression in the form of exploratory maps or illness narratives were more likely to associate the concept of depression with themselves, and to use "I" when describing the phenomenon. Those using an explanatory model tended to consider depression as something external and beyond their self-world.

The majority of responses from this cohort indicated that depression and its causes were conceived of as heterogeneous rather than homogenous phenomena. Given the complexity, examining explanatory models, exploratory maps, and illness narratives might provide possible avenues for future conversation as to how a greater unity might be reached in the theoretical framing of depression literature. This might allow greater comparability between findings of different studies.

Limitations

Although some participants described their experience of depression in a linear, chronological fashion, others tended to provide more fragmented accounts. Thus, we do not claim that narratives, maps, and models describe the actual trajectories of depression. Another limitation relates to the fact that all participants were recruited to the study on the basis of experiencing "depressive symptoms"; however, not all participants had been told by a health professional that they were depressed. There could be systematic differences in participant descriptions, depending on whether or not they were awarded the diagnostic label of depression by a health professional; for example, those who had been awarded a diagnosis might be more likely to use terms related to modeling, whereas those without a diagnosis might be more inclined to talk in terms of maps or narratives. This potential link between the diagnostic behavior of health professionals and the self-perceptions of patients merits further investigation.

Implications

This article is meant to stimulate further discussion to foster theoretical heterogeneity in accounting for the complex experience of depression. We have reviewed three different forms—explanatory models, exploratory maps, and illness narratives—which are utilized to describe and analyze the way depression is spoken about in lay stories of depression. We embarked on this analysis because there is evidence (Cape et al., 2010; Karasz, 2005; Kokanovic et al., 2012; Kokanovic et al., 2010; Malpass et al., 2009) to suggest that the form of an individual's conceptualization of depression and its causes might be significant in the clinical encounter. This is particularly illustrated by how depression is framed by people, with a tendency to move between different discourses of illness and between certainty and uncertainty about concepts, causes, and treatments. Exactly how forms of conceptualization affect treatment choices and recovery is still the subject of debate. For example, Williams and Healy have argued that the fluidity of exploratory maps might be beneficial to patients who are uncomfortable with the identity of their illness because, "if that identity is unwelcome or carries with it socially unacceptable connotations then uncertainty may be a way of maintaining hope and avoiding that identity" (2001, p. 473).

Thus, according to Williams and Healy (2001), if a patient conceives of his or her depression through the lens of an exploratory map, then this might be useful in aiding

recovery. However, Lupton considered the reverse to be true, and contended that for some people, the "lack of defining boundaries around their experiences of illness can cause anxiety, confusion and distress" (2003, p. 107). Lupton argued that "for many people the process of undergoing exploratory investigations, with all their uncertainties, is worse than receiving a negative diagnosis, for there is no opportunity for action or psychological adjustment" (p. 106). There is contention, then, as to whether exploratory maps are helpful or not in the clinical encounter. Because Williams and Healy engaged people who presented to mental health services for the first time, it might be that there is a temporal element in differing accounts of depression, with mapping being an initial process of making sense of the experience. Certainly Kangas' (2001) findings about the sensemaking process for depression supported this and the idea that people draw on a holistic theory of depression, combining many explanations of depression when giving their accounts.

Although it has largely been discarded as a theoretical concept in recent scholarly articles on depression, the explanatory model might continue to be useful in some cases. Ridge and Ziebland (2006) found that people recovering from depression often give a biomedical explanation for depression, and might even stridently defend the boundaries of that model. This finding supports our own, and indicates that in some cases identifying a cause for how one feels is an important part of the recovery process. Attributing a biomedical cause to depression might be a recovery technique that people mobilize because it provides a sense of coherency in times of disruption. Perhaps there is some comfort in the idea that chronic sadness can be treated by a chemical restoration of brain functions. In this sense, wherein depression can be unambiguously slotted into an explanatory model, it might offer a form of relief for the individual.

Doctors treating people in distress have a difficult task in deciding which treatment approaches to offer. They must negotiate how to respond to individual preferences and in turn assist in alleviating distress. Summerfield argued that "the fundamental relativity of human experience and the primacy of the subjective appraisal and social meaning, means that there can be no such thing as a universal response to distress" (2004, p. 9). Thus, it might be worth attending to the various forms in which people describe that distress and recognize their common legitimacy.

The attribution of depression to dynamic and complex webs of interacting causal factors that cannot be said to be solely social, individual, or biological in origin needs to be understood by those who diagnose, treat, and support people with depression. The difficulties in tracking and tracing a cause to a fixed point and locating it in a person's life must be highlighted, too. The findings from this exploration into what people think depression is and what they attribute the cause of depression to suggest that the subtle variations and nuances can be lost when we try to definitively explain and categorize illness experiences. In much the same way that people, when recounting their illness narratives, struggle to come to terms with the unforeseeable ending, identifying the beginning of depression is equally difficult for people.

Clinicians need to be aware that causal attributions are likely to be complex; people might or might not attribute their experience of depression to one dominant cause, and these causes often cannot be disentangled from each other. What complicates clinical interaction further is the widely held assumption that treatment choices are determined by explanatory models or maps (Karasz, Sacajiu, & Garcia, 2003). Contrary to this view, Dein argued that "people do have cultural understanding of and explanations for their illness, but this may not directly relate to decisions of treatment" (2003, p. 152). Furthermore, Bury (2001), commenting on the role of illness narratives in seeking treatment, suggested that people learn to give an account of their illness in a form that helps them to gain access to particular treatments.

There is a growing amount of data from medical sociology and anthropology suggesting that treatment "choices" are determined primarily by social and political factors rather than underlying explanatory models or maps (Pelto & Pelto, 1997). We would suggest that this raises questions about the level of explanation, rather than differing types of explanation. Patient treatment choices might well be determined by their explanatory models or exploratory maps, but these in turn might be determined by social and political factors. The participants' responses reflected this uncertainty. Most people reported events and relationship disruptions as the main reasons for depression, but they also entertained the possibility that there was something about "them" that meant that the disruptions resulted in depression; most could not quite work out what it was, and they could not find a clear answer from science.

To conclude, a singular approach to treatment through either one set of guidelines or treating one cause is difficult for depression. The use of narrative by patients seemed to assist when explaining what had happened, whereas maps and models seemed to help them understand why. Although many people viewed depression as having a variety of sociopsychological, individual, and biological causes, for others depression was accounted for using a clearly defined explanatory model. Similarly, there were many who found it difficult to disentangle depression from the narrative of their life, and thus there was uncertainty as to whether depression was a biological illness or a natural response to life circumstances.

We have suggested in this article that lay conceptualizations of illness are important in terms of their form, not

just in terms of their content. For clinicians, the forms that accounts of depression are likely to take have important implications in terms of patient experience and clinical practice. This approach encourages doctors to listen ever more attentively to the ideas, concerns, and expectations of their patients (Neighbour, 2004), and opens a space for the dialogical approach, advocated by patient-centered medicine, between patients and their doctors.

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